

## Recommendation(s) Status: Dangerous train door incident at Bank station on the Docklands Light Railway, 06 February 2017




This report is based on information provided to the RAIB by the relevant safety authority or public body.

The status of implementation of the recommendations, as reported to us, has been divided into eight categories:

### Key to Recommendation Status

<b>Implemented:</b>	All actions to deliver the recommendation have been completed.
<b>Implemented by alternative means:</b>	The intent of the recommendation has been satisfied in a way that was not identified by the RAIB during the investigation.
<b>Implementation ongoing:</b>	Work to deliver the intent of the recommendation has been agreed and is in the process of being delivered.
<b>Insufficient response:</b>	The end implementer has failed to provide a response; or has provided a response that does not adequately satisfy ORR that sufficient action is being taken to properly consider and address a recommendation.
<b>Progressing:</b>	The relevant safety authority has yet to be satisfied that an appropriate plan, with timescales, is in place to implement the recommendation; and work is in progress to provide this.
<b>Non-implementation:</b>	Regulation 12(2)(b)(iii) = recommendation considered and no implementation action to be taken.
<b>Other Public Body or Authority</b>	The recommendation is also addressed to another public body or authority.
<b>Awaiting response:</b>	Awaiting initial report from the relevant safety authority or public body on the status of the recommendation.

RAIB concerns on actions taken by organisations in response to recommendations are reflected in this report and are indicated by one of the following:

-  The red triangle shows recommendations where the RAIB has concerns that no actions have been taken in response to a recommendation.
-  The blue triangle shows recommendations where the RAIB has concerns that the actions taken, or proposed, are inappropriate or insufficient to address the risk identified during the investigation.
-  The white triangle shows recommendations where the RAIB notes substantive actions have been reported, but the RAIB still has concerns.

Note: The tables which follow, report the status of recommendations on 31 December 2015. In some other cases the end implementer has already sent information to the relevant safety authority about the actions it has taken, or proposes to take and the safety authority is considering whether it is satisfied that those actions and the associated timescales are accepted.

Number/ Date/ Report No/ Inv Title / Current Status	Safety Recommendation	Summary of current status (based on ORR's report to RAIB)
<p>1            06/02/2017    12/2017</p> <p>Dangerous train door incident at Bank station on the DLR</p> <p>Status: Implemented</p>	<p>The intent of this recommendation is to reduce the risk of trap and drag incidents on current Docklands Light Railway rolling stock, caused by clothing and other thin, flexible objects becoming trapped in the closing doors.</p> <p>Keolis Amey Docklands should, in conjunction with Docklands Light Railway Ltd:</p> <p>a) measure the forces required to pull out thin flexible objects trapped by train doors in its current fleet to determine the range of forces, and assess the risk of trap and drag incidents;</p> <p>b) investigate changing the design of the door nosing rubbers on its current fleet to reduce the forces required to pull out trapped objects so that they are in line with good industry practice; and</p> <p>c) where practicable, change the door nosing rubbers on its trains to reduce the pull-out force to the target level identified in (b).</p>	<p>ORR has reported that Keolis Amey Docklands and Docklands Light Railway Ltd have reported that they have completed actions taken in response to this recommendation. ORR proposes to take no further action unless they become aware that the information provided becomes inaccurate.</p>
<p>2            06/02/2017    12/2017</p> <p>Dangerous train door incident at Bank station on the DLR</p> <p>Status: Implemented</p>	<p>The intent of this recommendation is that safety learning from this investigation about minimising extraction forces for objects accidentally trapped in doors, is addressed when new trains for the Docklands Light Railway are specified.</p> <p>Docklands Light Railway Ltd. should ensure that the specification for its forthcoming new trains gives adequate consideration to minimising the force required to remove objects trapped in passenger doors. Particular consideration should be given to the risk of thin, flexible objects such as items of clothing, becoming wrapped around door nosing rubbers.</p> <p>This recommendation could apply to other organisations involved in the specification and procurement of new trains.</p>	<p>ORR has reported that Docklands Light Railway Ltd has reported that it has completed actions taken in response to this recommendation. ORR proposes to take no further action unless they become aware that the information provided becomes inaccurate.</p>
<p>3            06/02/2017    12/2017</p> <p>Dangerous train door incident at Bank station on the DLR</p> <p>Status: Implemented</p>	<p>The intent of this recommendation is that Keolis Amey Docklands has a robust process in place to detect and rectify faults in platform observation equipment used by its PSAs.</p> <p>Keolis Amey Docklands should:</p> <p>a) examine the integrity of its processes for detecting and rectifying defects in platform observation equipment used by PSAs such as mirrors, monitors and CCTV systems. The review should include</p>	<p>ORR has reported that Keolis Amey Docklands and Docklands Light Railway Ltd have reported that they have completed actions taken in response to this recommendation. ORR proposes to take no further action unless they become aware that the information provided becomes inaccurate.</p>

**Safety Recommendation**

consideration of:

training and reminders given to staff on the timely reporting of defects;

how defects which can impact upon the safe operation of the system, are identified, recorded and addressed in a timely manner;

risk mitigation measures in the period between detection and correction for safety-critical defects; and

monitoring processes to verify the effective correction of reported defects.

b) implement a documented procedure to address the shortcomings identified in its existing processes.