

4.3.11

Extracts from the Delay Attribution Board

Guidance No.DAB-14

Hearing on 2nd October 2007

2. Information Received

2.6 The facts of this matter are: 3K21 travelling from Moorgate to Bedford stopped abruptly just north of Elstree tunnel. It was established shortly afterwards that an air filter was missing from the unit. This caused the train to lose air pressure, resulting in the unit coming to a complete stand.

6. Consideration of the Issues

6.2.5 No other train passing through the tunnel prior to the incident or subsequently had reported any obstruction.

6.2.6 The Board were concerned that there appeared to be a significant gap in the audit trail following the identification of damage to the unit. No attempt had been made to find any external object which might have caused the damage or the missing air filter. If there were an obstacle which still remained present in the tunnel then it might have given rise to safety concerns. However, in the absence of any evidence as to the cause of the damage, the Board had no choice but to conclude that what the train had struck and the circumstances in which the damage was caused were matters of speculation. In those circumstances, the Board concluded that the determinations in AD 29 and AD 39 and the Board's own guidance in DAB 5 all pointed to the same conclusion – that the prime cause of the delay which occurred was the failure of the unit just outside Elstree tunnel.

7. Guidance of the Board

7.1 The Board agreed unanimously that the prime cause of the delay was the failure of the unit 3K21.

7.2 In this case the Board could see no reason why the incident could be construed as anything other than a 'circumstance originating from or affecting rolling stock operated by or on behalf of the Train Operator.'

7.3 The Board understood that until the unit failed there was no delay incident.

7.4 Any delay should be allocated to the fact of the unit failure and not to any speculation as to what had caused that failure.

7.5 On this basis it was unanimously agreed by the Board that the incident was coded correctly.

7.6 The Board concluded that there was no requirement to amend the Delay Attribution Guide.