NOTE

Date 15-12-2025
Casenr. 2024-562

Summary, Conclusion and Recommendation

1 SUMMARY

On 30-10-2024, a boarding door opened twice while travelling between Østerport Station and Odense. No one was injured in the incidents. After the second incident, the train set travelled at reduced speed to Odense, where it was taken out of service.

The door had been faulty and had undergone repairs in the days leading up to the incidents. At the time of the incidents, the door was locked. This means that the compressed air supply to the door had been disconnected and the door had to be held in the closed position by the door's mechanical construction alone.

The Accident Investigation Board's investigation showed that two of the door system components were not adjusted according to the door manufacturer's instructions. The mechanical locking force could be overcome by a relatively small influence on the door's closing mechanism.

After the incidents, DSB updated its work instructions to reflect the door manufacturer's instructions.

The Accident Investigation Board has issued one recommendation.

5 CONCLUSION

When a boarding door opened during the journey between Kildebrønde and Jersie Fjern, and again on the Great Belt Bridge, it was due to a combination of two of the door's mechanical parts not being adjusted according to the manufacturer's instructions, and the compressed air supply to the door having been interrupted in an attempt to avoid false 'door open' messages.

DSB had not converted significant parts of the door manufacturer's installation and maintenance instructions into its own work and maintenance instructions, which is why the maintenance personnel did not have sufficient knowledge of adjusting parts that the door manufacturer had pointed out as essential in terms of ensuring that boarding doors are held in the closed position

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5.1 Supplementary information

The personnel who carried out the repair and adjustment of the boarding door on 24-10-2024 had experience from similar tasks, but had not formally obtained the competence to carry out this work. The team leader who assigned the task to the employee was not aware that the intended task, for about a year, had required competence acquired by a training course. DSB's competency management system did not prevent the assignment of a competency-based task to an employee without the proper competency.

The investigation has not uncovered any circumstances that could indicate that an employee with acquired competency to repair and adjust the boarding door would have performed the task in such a way that the incidents on 30-10-2024 could have been avoided.

7 RECOMMENDATIONS

The investigation has shown that DSB's work and maintenance instructions did not address matters that a manufacturer of safety-critical components had stated as necessary for the supplied parts to function fully safely. DSB has taken care of this after the incident.

At the time of publication of this report, DSB had not yet carried out a basic adjustment of all Hard points on ER train sets with Tebel doors.

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The Accident Investigation Board recommends that the certification body that has issued DSB's ECM certificate and that supervises the maintenance system, through its supervision efforts at DSB, ensures that DSB's maintenance system meets the requirements of ECM Regulation (EU) 2019/779 Annex II, Section II, point 5 a, and Section IV, point 2 a. (see Appendix 1), including ensuring that DSB has carried out a basic adjustment of all Hard points on ER train sets with Tebel doors, according to the door manufacturer's installation and maintenance instructions.