



Havarikommissionen

Accident Investigation Board Denmark

2025-203, Summary, Conclusion and Recommendations



A Track worker was struck and fatally injured by a train on 22-4-2025

SEPTEMBER 2026

PREFACE

The Danish Accident Investigation Board for Civil Aviation and Railway (the Accident Investigation Board) is an independent government body whose purpose is to investigate accidents and incidents within the aviation and railway sectors.

The Accident Investigation Board investigates railway accidents and incidents with a view to improving railway safety and preventing accidents.

In accordance with the Danish Railway Act, this report sets out the Accident Investigation Board's investigation and safety assessments of the circumstances of the accident or incident, as well as its causes and consequences.

The investigations are conducted solely for railway safety purposes and are not intended to apportion blame or liability. Accordingly, any use of this report for purposes other than improving railway safety or preventing railway accidents and incidents may lead to erroneous or misleading interpretations.

This document contains an English translation of the chapters Summary, Conclusion and Recommendations from the published Danish investigation report.

The full report in Danish can be found under this link:

Link:

<https://havarikommissionen.dk/undersogelsesresultater/soeg-i-jernbane/2026/rapport-2025-203>

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1 SUMMARY

On 22 April 2025, a track worker was struck by a train passing on the track adjacent to the site where the track worker was involved in infrastructure works. The work included, among other activities, the replacement of rails. The track worker sustained fatal injuries as a result of the collision.

The accident occurred because the track worker entered the safety distance of an adjacent track that was open to traffic.

The investigation found that there were insufficient physical barriers to prevent this and identified several contributing factors, including errors and deficiencies in the railway safety plan, inadequate risk assessment, time pressure during the planning phase, and an incorrect assessment of train speeds, which resulted in the use of an insufficient safety distance.

In addition, a cable trough was used as a boundary marker instead of the protective measures specified in the approved railway safety plan.

The Danish Accident Investigation Board concluded that both organizational and human factors played a role. A culture characterized by deference to authority, loyalty, and a reluctance to question safety arrangements meant that no one challenged the errors and deficiencies in the planning and execution of the work.

Following the accident, Banedanmark introduced an immediate safety measure requiring physical fencing when work is carried out adjacent to a track that remains open to traffic. Following internal review by Banedanmark, this immediate measure was subsequently replaced by revisions to the relevant provisions of the operational rules.

The Danish Accident Investigation Board issued one safety recommendation.

5 CONCLUSION

The accident occurred because, during the execution of infrastructure works, sufficient barriers had not been implemented to prevent a track worker from entering the safety distance of an adjacent track open to traffic and consequently being struck by a passing train.

The investigation found that several human and organizational factors, both during the planning and execution phases, contributed to the hazards associated with working close to an adjacent track open to traffic, not being adequately managed or mitigated.

The planning and approval of the work was carried out under considerable time pressure, as the planned work was due to start the following day. This contributed to several items in the railway safety plan not being completed, which were not in accordance with the infrastructure manager's own procedures and guidelines for the preparation of railway safety plans. The time pressure may also have contributed to the railway safety plan being approved without prior dialogue or comments.

In particular, the required safety distance had not been determined. This was a key factor in an incorrect safety distance of 1.75 meters being instructed instead of the 2.25 meters required at the accident site.

The investigation found that the contractor and the infrastructure manager had different understandings of the validity of the railway safety plan, including in relation to changes between work stages and conditions of use, and consequently also differed in their understanding of when a railway safety plan was required to be revised.

When a railway safety plan had been prepared and approved by persons regarded as having authority, despite the fact that it did not comply with the specified safety provisions and procedures and could not, in practice, be followed, no one, despite having the necessary professional competence, knowledge and experience, raised concerns or questioned either the plan or the way in which the work was carried out.

As a result, situations occasionally arose in which rules had to be interpreted or bent in order for the work to be carried out. Banedanmark's monitoring and supervision had not been able to prevent such deviations from its procedures, rules and guidelines, as identified in this and previous occurrences.

The reasons why concerns were not raised regarding inadequate planning or errors in a railway safety plan can be found in human factors.

The employees placed a high degree of trust in the authority of those responsible for planning the infrastructure work and demonstrated strong loyalty to their work, their company and their colleagues.

Furthermore, group dynamics contributed to a situation in which no one wanted to be the person who raised concerns.

5.1 Additional information

Based on an overall analysis of this accident and previously investigated accidents and incidents involving infrastructure works, the Danish Accident Investigation Board found that, in most cases, the accidents and incidents had occurred when workers were on or near the track without the direct supervision of an SR work supervisor/railway work supervisor.

7 RECOMMENDATIONS

The investigation found that the barriers implemented by the company did not adequately ensure that people who were working on or near the railway were kept at a safe distance from passing trains.

It was the assessment of the Danish Accident Investigation Board that human factors contributed to the barriers intended to ensure that persons working on or near the railway were kept at a safe distance from passing trains being insufficient. Deviations from procedures and guidelines appeared to have become so normalized that no employees, either during the planning phase or during the execution of the work, took responsibility for raising concerns.

DK-2026 R 3 of 29 September 2026

The Danish Accident Investigation Board recommends that the Danish Civil Aviation and Railway Authority ensures that Banedanmark implements measures to strengthen the safety culture among both internal and external personnel. The measures should encourage personnel to raise concerns during both the planning and execution phases of infrastructure work whenever deviations from procedures, safety provisions or guidelines occur.

The Danish Accident Investigation Board has previously investigated accidents and incidents that occurred in connection with infrastructure works on Banedanmark's infrastructure. In this context, the Danish Accident Investigation Board issued recommendations that had not yet been implemented at the time of publication of this report.

Some of these recommendations concern issues that were also identified in the present investigation. On this basis, the Danish Accident Investigation Board has decided not to issue further recommendations concerning these matters.

Instead, the Danish Accident Investigation Board draws attention to the following recommendations:

DK-2024 R 6 of 5 September 2024

The Danish Accident Investigation Board recommends that the Danish Civil Aviation and Railway Authority ensures that Banedanmark reviews its rules and guidelines for railway safety plans, including Banedanmark's control of such plans, to ensure that they function as effective barriers against the relevant hazards. This should include ensuring that railway safety plans in use comply with the applicable rules and guidelines.

DK-2021 R 3 of 1 October 2021

The Danish Accident Investigation Board recommends that the Danish Civil Aviation and Railway Authority ensures that Banedanmark introduces procedures to ensure that railway safety plans are continuously reassessed together with the parties involved and updated to reflect changes in the work being carried out, for example at construction meetings.

Banedanmark should also carry out effective supervision to ensure both that the railway safety plan adequately addresses the relevant safety conditions and that it is followed.

If the positioning of equipment used for work within a track possession may affect railway safety, it should be ensured that the necessary safety measures are implemented.

DK-2021 R 2 of 28 April 2021

The Danish Accident Investigation Board recommends that the Danish Civil Aviation and Railway Authority ensures that Banedanmark provides relevant groups of personnel, including contractors, with descriptions of safety-related conditions that leave no room for interpretation.