DDAS Accident Report

Accident details

Report date:	06/03/2011	**Accident number:**	664
Accident time:	09:30	**Accident Date:**	16/06/2010
Where it occurred:	AIF no. 0040, Barikzia village, Naw Zad district, Helmand Province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Inadequate training (?)
Class:	Other	**Date of main report:**	12/07/2010
ID original source:	Ref.137	**Name of source:**	UNMACCA
Organisation:	**[Name removed]**		
Mine/device:	IED	**Ground condition:**	not recorded
Date record created:		**Date last modified:**	06/03/2011
No of victims:	1	**No of documents:**	1

Map details

Longitude:		**Latitude:**	
Alt. coord. system:	Not recorded	**Coordinates fixed by:**	
Map east:		**Map north:**	
Map scale:		**Map series:**	
Map edition:		**Map sheet:**	
Map name:			

Accident Notes

inadequate investigation (?)

inadequate training (?)

protective equipment not worn (?)

visor not worn or worn raised (?)

Accident report

The only report of this accident that has been made available to date was in a “Lessons Learned” summary provided as a PDF file. The conversion into a DDAS file has led to some of the original formatting being lost. Text in square brackets [ ] is editorial. This record will be revised as more information becomes available.

The cover letter and *Lessons Learned* summary are reproduced below, edited for anonymity.

Mine Action Coordination Centre of Afghanistan (MACCA)

Ref # 137

File: OPS/14/01/10

Subject: Board of inquiry about De-mining Accident of [Demining group] -CBTD-05 in Naw Zad District.

Attached please find the investigation report about the demining accident that happened in Barikzia village Naw Zad district of Helmand Province on 16. June. 2010, at 09.30 hours.

Date: 12 July 2010

LESSONS LEARNED SUMMARY OF [DEMINING GROUP] DEMINING ACCIDENT

INTRODUCTION

[Name removed], Director for the Mine Action Coordination Centre of Afghanistan (MACCA) convened a Board of Inquiry (BOI) team to investigate the circumstances involved in the demining accident causing the death of [the Victim] a deminer from [Demining group]'s Community Based Demining Team (CBDT-05). The investigation had been conducted by MCFA Naw Zad project office, but the information had been compiled by MACCA OM section.

SUMMARY

AIF (Abandoned IED Field) number 0040 is one of the heavily AIED contaminated areas within Naw Zad district. The residential areas, agricultural lands, irrigation systems and orchards were mainly contaminated during the conflict time between Taliban and Coalition forces. After the Taliban insurgents left the area in 2009, the local residents returned to their villages in Naw Zad district. Because of the heavy contamination within the area, several accidents occurred there. The orchards, the agricultural lands, irrigation systems and the houses have been blocked by AIEDs.

On 10 of June 2010 the first day of operation in task 0040, all the team members had been briefed by team leader about the location and extent of contamination in the area. The deminers were tasked to establish admin. parking areas, control marking and create the baseline. The team members also started clearance operations in some lanes and the deminer [the Victim] was tasked to follow the marking of already cleared lanes. But because of the break time he left the area and entered into the task seeking a shadow to take break there. He wanted to enter to a mosque located inside the hazard area, on the way to the mosque he stepped on an IED, caused it to go off, so the fatal accident occurred and [the Victim] died in the spot.

CONCLUSION

It is the BOI conclusion that the deminer, [the Victim] made the mistake in terms of entering to un-cleared area and lack of command and control contributed to this accident.

RECOMMENDATIONS

The BOI recommend the following points to be considered widely by all organizations and by [Demining group] especially:

a.) The command, control and supervision shall be strengthened, specific trainings.

b) Under no circumstances the deminers and other team members are allowed to enter the hazard area, unless an access lane is cleared to proceed through.

c) [Demining group] Office is to organize a comprehensive training and clearly explain the safety procedures during the operations, if there is any points with [Demining group] operations, they can come to MACCA operations department to discuss the issue.

d) [Demining group] should increase the command group to three people, there should be one section leader per each section and team leader should be supervising entire team. Current structure of command group i.e. a team leader and his deputy are not sufficient especially in community based demining projects, as all the team members are hired from the community without having enough experience of demining operations.

e) The internal QA shall be more active and professionalized to get the weak points and recommend remedial actions on time.

The level of supervision should be strengthened in all teams, the [Demining group] should take necessary steps and come up with a practical plan of action and present it to MACCA Programme Director by no later than the 20th of July 2010.

f) MCPA project office for Naw Zad should be more proactive for releasing professional advice to the teams especially about the safety and standard working procedures.

Victim Report

Victim number:	847	**Name:**	[Name removed]
Age:		**Gender:**	Male
Status:	deminer	**Fit for work:**	DECEASED
Compensation:	Not made available	**Time to hospital:**	Not made available
Protection issued:	Not recorded	**Protection used:**	None

Summary of injuries:

FATAL

COMMENT: No Medical report was made available.

Analysis

As identified by the investigators, the primary cause of this accident is listed as a *Field Control Inadequacy* because the Victim was allowed to enter the hazardous area seeking shade in which to rest. The investigators recommend increasing supervision to prevent this because the number of supervisors was not appropriate when using local people as deminers. This might be considered a *Management Control Inadequacy* because the field supervisor numbers and recruitment are controlled by senior managers.

The secondary cause of the accident is listed as *Inadequate training* because it seems that the Victim was a recent local recruit who was unaware of the risks involved in entering the hazardous area.

It is presumed that the Victim was not wearing PPE at the time because it occurred during a rest period.

The “Inadequate investigation” listed under notes refers to the absence of a full accident report. The UN supported MACCA has failed to make these widely available for some years, in contravention of the requirements of the IMAS which they are required to apply. The summary of the accident is good, and its presence implies that a full and comprehensive accident investigation was made, but not made available for others to learn from.