11-20-2010

DDASaccident726

HD-AID
Humanitarian DeminingAccident and Incident Database

DDAS Accident Report

Accident details

Report date:	08/07/2011	**Accident number:**	726
Accident time:	08:10	**Accident Date:**	20/11/2010
Where it occurred:	CDS, Deh Sabz District, Kabul Province	**Country:**	Afghanistan
Primary cause:	Victim inattention (?)	**Secondary cause:**	Management/control inadequacy (?)
Class:	Demolition accident	**Date of main report:**	None
ID original source:	None	**Name of source:**	Restricted
Organisation:	[Name removed]		
Mine/device:	various, HE charge	**Ground condition:**	demolition site (explosives)
Date record created:		**Date last modified:**	08/07/2011
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 (?)

Accident report

Because this accident involved the death of an expatriate it was covered widely in the press. A formal UNMACCA report of the accident was made available (by roundabout means) in early 2011. Its 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 if more information becomes available.

The document is reproduced below, edited for anonymity.

BOARD OF INQUIRY ABOUT FATAL DEMINING ACCIDENT of [the Victim] a member of [Demining group]

INTRODUCTION

Mr. [Name removed], MACCA Chief of Staff convened a Board of Inquiry (BOI) team to investigate the circumstances involved in the demining accident causing the death of [the Victim] Technical Advisor of [Demining group].

The BOI comprised the following personnel:

Dr. [Name removed] Chief of QM MACCA Chairman

[Name removed] Member

[Name removed] Member

[Name removed] Observer

A copy of the appointment of personnel to carry out the formal investigation including the BOI Terms of Reference is at Annex A to this report. [Not made available.]

GEOGRAPHY AND WEATHER

The accident occurred in [Demining group] CDS [Central Demolition Site] in Deh Sabz district of Kabul province which locates in North-East side of Kabul city, it is relatively cold in winter season. The CDS is surrounded by a series of hills and mountains from West, South and Northern sides. Kabul Bagram road is passed through the East side around 800 meters away from CDS. There are 2 antenna installments of AWCC and MTN around 1000 meters to the north side of the CDS.

Priority of Task

The task was of high priority, because the village by village EOD teams of [Demining group] collected munitions/ERW from the villages and were ready for demolition. Therefore, the demolition was planned in said CDS.

SITE LAYOUT AND MARKING

Although the CDS was well prepared, the distance between firing point and demolition pits and the locations of sentries were also maintained properly. But the firing point was small and lack of enough space for required personnel to easily locate there during the demolition operations. The firing point was also lack of sight window to the demolition pits. Presence of 2 antennas of AWCC and MTN telecommunication system in 1km vicinity to the CDS and also presence of Kabul Bagram road in 800 meters distance where military convoys have been passing frequently can create Electro Magnetic Radiation and affect Electrical initiation demolition.

MANAGEMENT, SUPERVISION AND DISCIPLINE ON SITE

The deceased Technical Advisor [the Victim] himself was in charge of the task. Good management, supervision and discipline was in place in the task site.

QUALITY ASSURANCE AND QUALITY CONTROL

The EOD teams of [Demining group]have been visited regularly by MACCA external QA, but the CDS has not been visited in 2010. WRA is also conducting external QA visits on [Demining parent group] EOD teams and the CDS as well.

COMMUNICATIONS AND REPORTING

The communication between CDS and [Demining group] office was maintained on daily basis. And all [Demining group] operations staff in the fields are submitting their reports to their office regularly. The accident report was also communicated immediately from the CDS to the office.

MEDICAL REPORTS

The victim TA expired immediately after accident occurred. But medical support was available in the site.

WITNESS INTERVIEWS AND STATEMENTS

The BOI team met with was able to conduct interview with [Name removed] the representative of [Demining group] to the BOI team. The statement is attached to this report as Annex C.

DETAILS OF THE MINE/ERW INVOLVED

ERW (smoke grenades) items were collected by EOD village by village teams and then were arranged for demolition in CDS in accordance with [Demining group] SOPs.

EVIDENCE OF RE-MINING

As the accident happened in CDS, no mine or re-mining were involved in this accident.

EVIDENCE OF SITE INTERFERENCE OR TAMPERING AFTER THE ACCIDENT

Nil

PERSONAL PROTECTIVE EQUIPMENT

The deceased TA worn his protective jacket and a Helmet, but as it was a heavy demolition, so the PPE could not protect him.

USE OF MINE DETECTION DOGS (MDD)

Not required.

USE OF Mechanical MACHINES (MDU)

Not required.

DATE OF LAST REVISION COURSE FOR TEAM INVOLVED IN THE ACCIDENT

Deceased Technical Advisor was trained by the British Royal Air Force, and had over nine years experience in EOD; worked all over the world and had been in Afghanistan nearly two years. No refresher training was required to him.

DETAILS OF MEDICAL EVACUATION AND TREATMENT

[The Victim] was killed in the spot.

PARTICULARS OF DEMINERS INSURANCE

To be filled by [Demining group]

DETAILED ACCOUNT OF THE ACTIVITIES ON THE DAY OF THE ACCIDENT

The demolition team of [Demining group] arranged the smoke grenades in demolition pit in their CDS on 07:00 and then started Ordnance Disposal Operation, disposing of smoke grenades using electric demolition procedures. On 07:33 they conducted first fire by the exploder machine from their firing point. They waited for almost 18 minutes and then Technical Advisor started conducting Electric Misfire Procedures, he made manual approach

to correct misfire. On 08:10 the accident occurred and TA was killed immediately after accident.

TECHNICAL POINTS CONTRIBUTED TO ACCIDENT

Accident occurred due to Electro Magnetic Radiation and Time on Target; Technical Advisor had cell phone in close proximity and most likely using a satellite phone in very close proximity to electric demolition set up; Technical Advisor spent nearly 19 minutes correcting misfire.

SUMMARY

It is the view of the BOI team that the accident occurred due to Electro Magnetic Radiation (EMR) and Time on Target; Technical Advisor had Cell Phone in close proximity and most likely using a Satellite Phone in very close proximity to electric demolition set up.

CONCLUSION

It is the BOI conclusion that the Technical Advisor, [the Victim] made the mistake in terms of having electric devices while working on a misfire case in a very close proximity to the demolition pit.

RECOMMENDATIONS TO PREVENT REOCCURRENCE

The BOI recommend the following points to be considered by [Demining group] in their future demolition operations:

- The location of CDS requires to be reviewed by [Demining group] in order to make sure that the Electrical demolitions are not disturbed by any EMR.
- Extreme care should be taken by CDS supervisors and those who conduct misfire checks to avoid keeping and using electronic devices such as mobile phones and hand held radios during this drill.
- The firing point should be prepared in a way to position required personnel during the demolition and have a well protected sight window to the demolition pit.

Signed Dr. [Name removed], BOI Chairman

ANNEXES: [Not made available]

Annex A BOI - Terms of Reference

Annex B Site Map

Annex C Witness Interviews and Statements

Annex D Internal investigation report

A *Lessons Learned* document reads: “LESSONS LEARNED SUMMARY OF [Demining group] FATAL DEMINING ACCIDENT. This lessons learned was filed due to some legal issues in DI’s legal department.”

Victim Report

Victim number:	916	**Name:**	[Name removed]
Age:	34	**Gender:**	Male
Status:	supervisory	**Fit for work:**	DECEASED
Compensation:	Not made available	**Time to hospital:**	Not made available
Protection issued:	Frag jacket Helmet	**Protection used:**	Frag jacket; Helmet

Summary of injuries:

FATAL

COMMENT: No Medical report was made available. The Victim "expired immediately after accident occurred".

Analysis

The primary cause of this accident is listed as *Victim Inattention* because the investigators concluded that the Victim made an error by using an electronic device that caused a detonation while he was close by. However, from the limited details made available in the report, the proximity of other possible sources of electronic interference mean that the detonation could have had another cause. The selection of a demolition site in a place where there was a poor overview and where electronic disturbance might cause problems was a management responsibility, so the secondary cause is listed as a *Management Control Inadequacy*.

The Victim waiting 18 minutes after the misfire before “starting electronic misfire procedures”. After a further 19 minutes the detonation occurred. This is a longer “soak time” than most consider necessary after an electrical misfire. The number of smoke grenades involved was not recorded and it is presumed that the number was irrelevant and that it was the demolition charge itself that caused the fatal injuries. The Victim may have been handling the charge at the time.

This report was made available by an unusual route and the report was stamped “This BoI should not be released”. The suppression of the report is another example of the UN supported MACCA failing to make accident reports available and so ignoring the requirements of the IMAS. Afghan national staff have often been more responsible than the internationals with overall responsibility. In this case, the BoI report lacks detail and does not offer any compelling explanation of the events surrounding the accident. The statement that the Victim was “most likely using a satellite phone in very close proximity to electric demolition set up” requires some evidence to back it up. If the Satellite phone was in use, the timed billing regime could have confirmed that, making it more than “most likely”. If there is no evidence that he was using the phone, it was not “most likely”, merely a possibility.