6-10-2010

DDASaccident749

Humanitarian Demining Accident and Incident Database
AID

DDAS Accident Report

Accident details

Report date:	11/07/2011	**Accident number:**	749
Accident time:	09:05	**Accident Date:**	10/06/2010
Where it occurred:	AF/2306/31829, MF0040, Barakzai village, Naw Zad district, Helmand Province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Inadequate training (?)
Class:	Other	**Date of main report:**	05/07/2010
ID original source:	None	**Name of source:**	UNMACCA
Organisation:	[Name removed] CBDT		
Mine/device:	IED	**Ground condition:**	not recorded
Date record created:		**Date last modified:**	11/07/2011
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 training (?)

Accident report

Two reports of this accident that have been made available by UNMACCA are reproduced below, edited for anonymity. The first is the Board of Inquiry, the second is the Lessons Learned from that inquiry. Their conversion into a DDAS file has led to some of the original formatting being lost. Text in square brackets [ ] is editorial.

BOARD OF INQUIRY ABOUT FATAL DEMINING ACCIDENT of [the Victim] THE DEMINER OF [Demining group] CBDT-05

INTRODUCTION

Dr [Name removed], Programme 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 BOI comprised the following personnel:

Dr. [Name removed] Chief of QM MACCA: Chairman

[Name removed] from [Demining group]: member

[Name removed] [2nd Demining group] Project Manager in Naw Zad: Member

[Name removed] [2nd Demining group] OPS Assistant in Naw Zad: Member

[Demining group] Representative ([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.

GEOGRAPHY AND WEATHER

Helmand province locates in South-Western part of Afghanistan; it is relatively hot in the summer season. The accident site (AF/2306/31829/MF0040) is an abandoned IED field located in Barakzai village, Naw Zad district of Helmand province. The terrain of the area is flat with some housing.

Priority of Task

AIF (Abandoned IED Field) number 0040 along with other surrounding areas within Naw Zad district are heavily contaminated by abandoned IEDs. 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 with IEDs several accidents have occurred. The orchards, the agricultural lands, irrigation systems and the houses have been blocked by IEDs. Therefore, the area was counted as high priority to be cleared as soon as possible to prevent further local accidents.

SITE LAYOUT AND MARKING

It was the first day of operations in AIF 0040, the site layout and marking being employed till the accident time, is in place. The team was busy establishing admin area, base lane and control marking, the team members were briefed by team leader about the scope and extent of hazards and the safe areas around AIF 0040.

MANAGEMENT, SUPERVISION AND DISCIPLINE ON SITE

Although the team members had been briefed about the location and extent of contamination in the area, the deminer [the Victim] entered to hazardous area and ignored the information provided by the team leader. 10th of June was the first day of operations in task 0040 and the team members were busy in establishing control marks, admin, parking areas and creating base lane for further clearance. The team has also started clearance of some lanes and the deminer [the Victim] was tasked to follow the marking of already cleared area. But because of break time he left the area and entered into the task seeking a shadow to take break there. According to the team structure, the command group consists of one team leader and a deputy team leader, no section leader is available.

Therefore, the poor supervision was the main contributing factor to this fatal accident. The deminer was not stopped from going into the task by either another deminer or the command group while he was entering to contaminated area. As Naw Zad project is a community based demining project and all the deminers are hired from the community i.e. they are not experienced deminers, therefore, strong and extra numbers of command element should had been assigned to supervise such teams.

In general there was lack of command and control in the team and this caused the accident.

QUALITY ASSURANCE AND QUALITY CONTROL

The team was visited by external QA on 23rd of May 10; the result was a conformity report.

External QA is being conducted by [2nd Demining group] as representative of MACCA in Naw Zad project.

COMMUNICATIONS AND REPORTING

In general there is communication problem in Naw Zad district, as it is recently released by one side of conflict faction. The communication within the team was maintained. But the team informed investigators around 1 hour after the accident happened.

MEDICAL REPORTS

The paramedic reached the accident site in 10 minutes, but due to the severity of injuries the victim passed away on the spot.

WITNESS INTERVIEWS AND STATEMENTS

The team leader, deputy team leader and the paramedic of the team were interviewed by the BOI team. The statements are attached at Annex C to this report. [Not made available.]

DETAILS OF THE MINE INVOLVED

The main problem in Naw Zad is the IED contamination; abandoned IED fields are the main target for clearance. So the item caused this fatal accident was an IED planted in the entrance of a mosque.

EVIDENCE OF RE-MINING

The BOI found no evidence of re-mining of the clearance site and this therefore did not contribute to the accident.

EVIDENCE OF SITE INTERFERENCE OR TAMPERING AFTER THE ACCIDENT

Actually the accident occurred inside the task, where no operations had been conducted. Only a lane was cleared to evacuate the casualty after the accident happened. The site was not tampered after the accident.

PERSONAL PROTECTIVE EQUIPMENT

The deminer was issued a standard issue ROFI protective jacket and a Helmet complete with visor. This PPE comes in two parts with the lower part (apron) fixed to the upper (jacket) by way of plastic clips. But in such accidents the PPE is not effective as the deminer stepped on an IED consisting several kg of explosives.

USE OF MINE DETECTION DOGS (MDD)

The MDDs were not used in this AIF, as it was a community based demining team.

USE OF Mechanical MACHINES (MDU)

The MDU was not used in this site.

DATE OF LAST REVISION COURSE FOR TEAM INVOLVED IN THE ACCIDENT

The basic demining course was started from March 10 and completed in April 2010 to all [Demining group] CBDTs in Naw Zad project. A staff member from [Demining group] training cell is assigned as teacher to the community based teams of Naw Zad to provide continuous training to their teams there.

DETAILS OF MEDICAL EVACUATION AND TREATMENT

The deminer was killed in the spot.

PARTICULARS OF DEMINERS INSURANCE

The victim was covered for death and trauma insurance under a standard policy held by all Implementing Partners in Afghanistan with the State Life Insurance Corporation of Pakistan.

DETAILED ACCOUNT OF THE ACTIVITIES ON THE DAY OF THE ACCIDENT

The team started work on site in the morning and everyone received briefing from the team leader. It was the first day of operations in this specific AIF 0040; they started to establish control marking, admin and parking area. Some of the deminers were tasked to start clearance operations in base lane and create cross lanes. The deceased deminer [the Victim] was tasked to conduct marking in already cleared lanes.

On 09:05 during the break time [the Victim] entered into the hazard area in order to proceed to a mosque located inside the AIF to get his break there. Unfortunately one metre away from the gate of mosque he stepped on an IED and caused it to detonate which resulted in a fatal accident. According to the statements of team leader and deputy team leader, they were busy with measuring Turning Points and tasking of the deminers in their clearance lane. After 5 minutes the deputy team leader and paramedic arrived to the site, cleared a lane towards the accident point to evacuate the casualty. But the deminer had died on the spot.

TECHNICAL POINTS CONTRIBUTED TO ACCIDENT

The accident happened during the break time in a portion of task which was located inside the AIF and has not been processed yet. However the deminers were briefed about the extent of hazard, but [the Victim] the deminer of CBDT-05 was trying to get to the mosque located inside the task.

There are two technical misses contributed in this fatal accident:

- The deminer was un-experienced person as he was recently hired from the community.
- Lack of proper command and control in the team i.e. lack of section leader and poor supervision of team leader and deputy team leader.

SUMMARY

It is the view of the BOI team that the deminer entered to contaminated area, he was not stopped by command group. The deputy team leader and team leader failed to stop the deminer from entering to un-cleared area.

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 TO PREVENT REOCCURRENCE

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

The command, control and supervision shall be strengthened, specific trainings should be held to the command groups of the teams.

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.

[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.

[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.

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.

[2nd Demining group] project office for Naw Zad should be more proactive for releasing professional advice to the teams especially about the safety and standard working procedures.

Signed: Dr. [Name removed], BOI Chairman

ANNEXES: [Not made available]

Annex A: BOI - Terms of Reference

Annex B: Site Map

Annex C: Accident Site Photos

Annex D: Witness Interviews and Statements

LESSONS LEARNED SUMMARY OF [Demining group] DEMINING ACCIDENT

INTRODUCTION

Dr [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 [2nd Demining group] Naw Zad project office, but the information had been compiled by MACCA QM 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 Rahmatullah 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:

- The command, control and supervision shall be strengthened, specific trainings should be held to the command groups of the teams.
- 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.
- [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.
- [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.
- 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.

[2nd Demining group] 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:	940	**Name:**	[Name removed]
Age:		**Gender:**	Male
Status:	deminer	**Fit for work:**	DECEASED
Compensation:	Not made available	**Time to hospital:**	Not made available
Protection issued:	Frontal apron Long visor	**Protection used:**	Not recorded

Summary of injuries: FATAL

COMMENT: No Medical report was made available. Major blast injuries.

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the inexperienced deminer was allowed to enter the unsafe area during a break time. There is an inconsistency in the report because, although this was a break, the supervisors were apparently busy with marking. The secondary cause is listed as *Inadequate training* because the Victim appears to have been unaware of the risk he was running. Lack of training and supervision were both highlighted as causes, and both represent a significant *Management Control Inadequacy*.