DDAS Accident Report

Accident details

Report date:	08/02/2011	**Accident number:**	596
Accident time:	07:42	**Accident Date:**	10/11/2009
Where it occurred:	Task 3226, Surkhi village, Jabalsiraj district, Parwan province	**Country:**	Afghanistan
Primary cause:	Management/control inadequacy (?)	**Secondary cause:**	Inadequate training (?)
Class:	Excavation accident	**Date of main report:**	07/12/2009
ID original source:	OPS, 14101-30	**Name of source:**	UNMACCA
Organisation:	**[Name removed]**		
Mine/device:	POMZ AP frag	**Ground condition:**	not recorded
Date record created:		**Date last modified:**	08/02/2011
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 equipment (?)

protective equipment not worn (?)

visor not worn or worn raised (?)

inadequate training (?)

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)

File: OPS, 14101-30

To: See distribution list

From: [Name removed], Chief of Operations MACCA, Kabul

Date: 07 December 2009

Subject: INVESTIGATION REPORT & LESSONS LEARNED OF [Demining group] DT-12

FATAL DEMINING ACCIDENT

Attached please find the investigation report and lessons learned of [Demining group] DT-12 fatal demining accident occurred on 10 November 2009 in Surkhi village, Jabalsiraj district of Parwan province.

Best regards,

Distribution list:

Complete Investigation: [Demining group]

Lessons Learned:

MCPA, RONCO, MDC, OMAR, DOG, JMAS, ATC, PMIWRA, HDI, DAFA, AGMA, EODT, ACL, CMCC, MTI, NDSS, PSS, UXB, AMACs (7).

For information: MACCA, Chief of Staff DMC, Director Operations Staff

LESSONS LEARNED SUMMARY OF [Demining group]- DT-12 DEMINING ACCIDENT

INTRODUCTION:

A Board of Inquiry (BOI) was convened by MACCA Programme Director to investigate the circumstances caused a fatal accident involving [the Victim] the Team Leader of [Demining group] DT-12. The accident occurred at 07:42 hours on 10 Nov. 2009 at Task No: [Demining group] # 3226 in Surkhi village, Jabalsiraj district of Parwan province. But as the internal and external investigation reports received by MACCA and these reports cover the contributing factors to this accident, so this BOI report is written based on both investigation reports.

SUMMARY:

This site is located close to the residential area of Surkhi village and was a military base during the Russian invasion and time of the Russian backed government. There were anti-personnel mines laid to protect the military positions and base from the attack by the Mujahidin. After the withdrawal of the Russian forces and subsequent fall of the Najibullah government, the Mujahidin had also planted anti-personnel mines around their military positions. To date the area has experienced two accidents to humans and five against animals.

The clearance operation on mentioned task was started by [Demining group] DT-12 on 1st of November 09. On 10th of November 09 at 07:40, while the second break period started, the team leader of the team asked a deminer for his scraper and then walked down to a clearance lane without informing any other team members of his intention. On 07:42 Team leader initiated a POMZ mine causing him to receive the injuries that led to his death. He ignored his job description and the [Demining group] SOPs. He may have been thinking that

this POMZ is of no danger, so that may be why he has removed his PPE and started to disturb the mine.

There was also an incident involving POMZ mines which the Team Leader should have taken them into consideration but were ignored. One POMZ mine was initiated by a deminer by pulling its wire in September 2008 and another more recently when a POMZ was detonated earlier this month as part of the preparation process.

CONCLUSIONS:

The accident occurred because of carelessness of [the VIctim] as he started to work in contrary to [Demining group] SOPs and breached safety by removing his PPE before performing the possible excavation drill on a POMZ mine. He was not assigned to use scraper in the minefield, but his main function was to supervise and control the activities of his team.

RECOMMENDATIONS:

The following points are to be considered:

A. All demining staff is to be informed of the circumstances of the accident and be reminded of the consequences of not wearing PPE during operations.

B. Removal of PPE is not permitted for anyone inside the minefield while conducting any kind of operations.

C. Team leaders should be reminded to strictly adhere to SOPs and ensure they not only control their teams during operations but are also acting in a safe manner at all times themselves.

D. Feedback on any preventive and corrective actions taken by [Demining group] is required to be submitted to MACCA operations department by no later than 7 days, effective to the issue date of this letter.

Victim Report

Victim number: 780 **Name:** [Name removed]

Age: **Gender:** Male

Status: supervisory **Fit for work:** DECEASED

Compensation: Not made available **Time to hospital:** Not made available

Protection issued: Short frontal vest **Protection used:** None

Summary of injuries:

FATAL

COMMENT: No medical report made available.

Analysis

The primary cause of this accident is listed as a *Management Control Inadequacy* because the Victim was a field supervisor who operated in breach of the Demining group's SOPs without correction. The secondary cause is listed as "*Inadequate training*" for the same reason. The provision of body armour that is not IMAS compliant was another Management failing, but not relevant when the PPE was not worn at all.

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, also in contravention of the requirements of the IMAS which they are meant to apply. The summary of the accident includes the statement that two comprehensive accident investigations were made, but not made available for others to learn from.