7-3-2001

DDASaccident387

HD-AID
Humanitarian DeminingAccident and Incident Database

DDAS Accident Report

Accident details

Report date:	19/05/2006	**Accident number:**	387
Accident time:	10:00	**Accident Date:**	03/07/2001
Where it occurred:	Gecheguzlu Yatagy	**Country:**	Azerbaijan
Primary cause:	Inadequate training (?)	**Secondary cause:**	Victim inattention (?)
Class:	Handling accident	**Date of main report:**	[Not dated]
ID original source:	EC UNOPS	**Name of source:**	ANAMA
Organisation:	Name removed		
Mine/device:	Fuze (TM57 AT blast)	**Ground condition:**	not recorded
Date record created:	22/02/2004	**Date last modified:**	22/02/2004
No of victims:	1	**No of documents:**	1

Map details

Longitude:		**Latitude:**	
Alt. coord. system:		**Coordinates fixed by:**	
Map east:		**Map north:**	
Map scale:	MF GY002	**Map series:**	
Map edition:		**Map sheet:**	
Map name:			

Accident Notes

inadequate training (?)

inadequate investigation (?)

Accident report

A summarised Board of Inquiry report was made available in January 2004. It is reproduced below, edited for anonymity.

Report of Board of Enquiry investigation of Mine Accident at Gecheguzlu Yatagy on 3rd July 2001

1. Introduction

Following the mine accident that happened at Gecheguzlu Yatagy on 3rd July 2001 a board of Enquiry was convened by the director of ANAMA to investigate the incident. The board was comprised of: -

UNOPS RTA, Chairman ANAMA Operations Manager (Acting) ANAMA Quality Assurance Officer Relief Azerbaijan Operations Manager ANAMA Regional Administrator.

Contributions to the enquiry were also submitted to the board by the ANAMA doctor.

2. Background to Accident

The demining team were carrying out demining operations at minefield GY002 as directed in task order number 15/01 dated 14April 01, under the supervision of the team leader and the overall supervision of the [International demining group] Technical Trainer.

3. Summary of the Accident

The mine accident happened at 10:00 hrs on the 3rd July 2001 while the [Demining group] were conducting manual clearance operations at minefield GY002. During manual clearance operations using the one-man drill on Gecheguzlu Yatagy 002, deminer [name excised] was involved in a mine accident that resulted in blast injures to the deminers right hand.

The deminer had a signal when using his mine detector which he investigated with a prodder and then excavated using a trowel. After exposing the item that had given the signal the deminer removed it from the ground using his right hand. The item exploded when it was picked up resulting in the traumatic amputation of part of the index finger and part of the thumb. The preliminary investigation has established that the item was the detonator assembly from a TM57 mine fuse.

3. Reasons for and causes of the accident

The Board of Enquiry have established the following facts: -

a. The demining site had been established and organized in line with national standards and agency SOPs and include the correct layout, safety facilities and medical cover.

b. The correct levels of supervision were being applied.

c. The deminer [the Victim] was carrying out the correct procedures for manual demining as he had been taught and as is specified in the RA agency SOPs. He also carried out the procedures for investigation of a mine detector signal as he had been taught and as is specified in the RA agency SOPs.

d. The emergency response to the accident and the subsequent casualty evacuation was carried out correctly and efficiently.

The accident was caused by the fact that the deminers did not recognise the item that he found as being dangerous, he therefore considered the item to be a piece of scrap metal and handled it accordingly. During the deminers' training they were taught how to recognise mines and UXOs as well as their fusing systems but not the component parts of fuzes. They have also been taught how to handle items based on their being dangerous items or scrap items.

4. Recommendations

The board of enquiry recommends the following: -

a. Additional training should be given to the deminers to enable them to recognise component parts of mines, UXOs and fuses that may be dangerous.

b. Scrap handling procedures should be changed in line with the attached proposed SOP amendment and deminers should be taught the new procedures.

Details of the recommendations are attached at Annex C. [Reproduced below.]

Signed: UNOPS RTA, RA Operations Manager, Regional Administrator, Acting Operations manager, Quality Assurance Officer

ANNEX C:

Date: 18 July 2001

To: Director ANAMA

CC: BOE Members

From: UNOPS RTA

Subject: Board of Enquiry Recommendations

It has been identified by the Board of Enquiry into the mine accident at Gecheguzlu Yatagy on 3rd July 2001 that certain changes to deminer training and to RA SOPs will be necessary.

Training should be undertaken at the earliest opportunity to teach the deminers how to identify the hazardous component parts of mine and UXO fusing systems.

National Standards and agency SOPs should be amended to include 3 categories of items found during demining operations. They should be as follows:

a. Dangerous

b. Suspect

c. Safe

Dangerous: All items that are positively identified as Mines, UXOs or hazardous component parts.

Suspect: All items that cannot be identified as Mines UXO or Hazardous component parts but cannot be positively identified as being safe.

Safe: Items that can be positively identified as being non hazardous.

The procedure for dealing with these items should be as follows:

Dangerous: Destroy in situ.

Suspect: Deminer should request assistance from section or team leader to assist with identification, when in doubt suspect items should be destroyed in situ.

Safe: Deminer should remove and place in scrap bucket/container.

Victim Report

Victim number: 503 **Name: Name removed**

Age: **Gender:** Male

Status: deminer **Fit for work:** not known

Compensation: not made available **Time to hospital:** not recorded

Protection issued: Not recorded **Protection used:** not recorded

Summary of injuries:

INJURIES

severe Hand

AMPUTATION/LOSS

Fingers

COMMENT

No medical report was made available.

Analysis

The primary cause of this accident is listed as “Inadequate training” because the investigators determined that the Victim did not know that what he had found was dangerous, and recommended extending the training.

The accident investigation is listed under “Notes” as inadequate because it does not cover the topics recommended in the IMAS, including the PPE worn and the medical and evacuation details. The report provided was a “summary” and will be replaced with a full version when possible.