6-14-2007

DDASaccident507

HD-AID
Humanitarian DeminingAccident and Incident Database

DDAS Accident Report

Accident details

Report date:	24/01/2008	**Accident number:**	507
Accident time:	09:45	**Accident Date:**	14/06/2007
Where it occurred:	MF023, Chorian Village, Jaji District, Paktya Province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Unavoidable (?)
Class:	Excavation accident	**Date of main report:**	Not recorded
ID original source:	None	**Name of source:**	UNMACA
Organisation:	[Name removed]		
Mine/device:	AP blast (unrecorded)	**Ground condition:**	metal fragments
Date record created:		**Date last modified:**	24/01/2008
No of victims:	0	**No of documents:**	1

Map details

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

Accident Notes

metal-detector not used (?)

inadequate training (?)

non injurious accident (?)

squatting/kneeling to excavate (?)

Accident report

A letter about this accident was made available in August 2007 as a PDF file. Its conversion to a text file for editing means that some of the formatting has been lost. The substance of the letter is reproduced below, edited for anonymity. The original PDF file is held on record. Text in [ ] is editorial. This record will be revised if the full investigation report is made available in future.

LESSONS LEARNED SUMMARY

OF DEMINING ACCIDENT OCCURRED ON [National demining agency] DEMINER ON JUNE 14, 2007 AT JAJI DISTRICT OF PAKTYA.

INTRODUCTION:

As a result of a demining accident on [the Victim] deminer of [National demining agency], DT-19 at 09:45 am, June 14, 2007 in task # 07/0719/032/MF023 located at Chawni Chorian village, Jaji district of Paktya province, investigation team was convened by UNAMAC Gardiz to conduct the investigation and find out the main causes of the accident.

Fortunately the accident did not have any casualty.

SUMMARY:

The mentioned area is located to a hill side which is contaminated by AP mines and is a dense area of fragments. The area is steep and raining over the past years washed down the soil from the top of the hill and changed the position of some mines. [The Victim] deminer was excavating the ground while suddenly the accident happened. As the deminer had worn his PPE and visor, he did not receive any injuries and he is in good health situation. The investigation result shows that the negligence of the deminer and poor control of command group contribute the happening of the accident.

CONCLUSIONS:

The following points were found by investigation team:

1. The deminer was fully equipped by PPE and visor which saved his life and prevented the injuries to him.
2. The team two section leaders were sent to attend the new concept of operation training and two deminers who have not attended TLC were assigned to do the job of section leaders.
3. It is found that the deminer was excavating the ground carelessly that caused the accident.
4. The bayonet and the visor received damages.

RECOMMENDATIONS:

The following points are to be considered:

1. The relevant organization is to ensure that they have spare qualified replacement while sending the command group of the team to training.
2. Refresher training with focusing on prodding and excavation drill is recommended to be conducted for the team to prevent further wrong practice.
3. In the area which is expected that the position of the mine could be changed, the deminers should not use more pressure during using any excavation tool; instead they should be more cautious and careful while investigating the signal.

4. Team leader of the team should brief team members of any possible danger related to the area that change position of the mine is presumed.

Signed: Chief of Operations, UNMACA Kabul

Analysis

The primary cause of this accident is listed as a “Field control inadequacy” because the investigators found that the senior field staff had gone on a training course, leaving untrained people in their roles. The Victim was apparently breaching SOPs in his work, and these errors may have been corrected if the qualified field supervisors had been there.

The secondary cause is listed as “Unavoidable” because there is always a chance of an initiation when excavating a mine, and the deminer was wearing his PPE correctly so he may have been working in an approved manner.

This record will be revised if the full investigation report is made available in future.