5-4-2010

DDASaccident594

Humanitarian Demining Accident and Incident Database
AID

DDAS Accident Report

Accident details

Report date:	08/02/2011	**Accident number:**	594
Accident time:	08:45	**Accident Date:**	04/05/2010
Where it occurred:	AF10809/09388/ MF 0189, Sorkhdiwal village, Rodat district, Nangarhar province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Inadequate equipment (?)
Class:	Excavation accident	**Date of main report:**	07/06/2010
ID original source:	Ref: 114	**Name of source:**	UNMACCA
Organisation:	**[Name removed]**		
Mine/device:	PMN AP blast	**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 investigation (?)

inadequate equipment (?)

visor not worn or worn raised (?)

handtool may have increased injury (?)

squatting/kneeling to excavate (?)

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)

Ref # 114

File: OPS/14/09

To: See Distribution List

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

Date: 07 June 2010

Subject: Investigation Report & Lessons Learned of [Demining group] DT 07 Demining Accident

Attached please find the investigation report and lessons learned of demining accident occurred on 04 May 2010 at 08.45 in sorkhdiwal village, rodat district of Nangarhar province.

Best regards,

Distribution List

Complete investigation Report to: [Demining group]

Lessons Learned to: [All demining agencies active in Afghanistan at the time.]

MDC, RONCO, HT, MCPA, DDG, ATC, JMAS, PM/WRA, HDI, DAFA, G4S, 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- 07 DEMINING ACCIDENT

INTRODUCTION:

An investigation team was convened by AMAC East to investigate the demining accident involving [the Victim] the De-miner DT-07 of [Demining group]. The accident occurred at 08:45 hours on 04 May 2010 at minefield number AF108091093881 ME 0189, located in Sorkhdiwal village, Rodat district of Nangarhar Province.

SUMMARY:

AF10809/09388/ MF 0189 located about 25km to the east of the Jalalabad City. This area is contaminated with anti-personnel mines by Russian troops in 1984. Because of its strategic location, this area was used as security belt around Jalalabad city and nearby military areas and positions.

[Demining group] DT-07 was tasked to start clearance operation on 01 April 2010. Size of the area is 83912sqm. During the clearance operations, 22194sqm area cleared and one AP mine was found/ destroyed by team before the accident happens.

On 04 May 2010 at 08:45 am while [the Victim] the de-miner was excavating a detected signal in his clearance lane, his bayonet hit top of an anti-personnel PMN mine and caused it to go off. According to the investigation report, it seems that the de-miner started excavation directly from the pinpointed spot with his bayonet and caused the explosion and accident. Unfortunately improper use of PPE caused catastrophic injuries to the face and eyes of the

victim deminer. He has lost his right eye, traumatic amputation of right-hand fingers and sustained some superficial injures on different parts of his body. The command group of mentioned team failed to control the deminer during the operations and let him work without visor and in a careless manner.

CONCLUSIONS:

Lack of proper supervision and poor command and control is identified as main contributing factor, as the deminer was not stopped while he was working without proper use of PPE/visor. The deminer himself was in a good health condition before the accident, and had not been suffered from any serious issue to affect his performance, so the next contributing factor for this accident is carelessness of deminer.

RECOMMENDATIONS:

However corrective actions have been taken by [Demining group] after the internal investigation, but the following points are to be considered and distributed to the team level by all demining organizations:

1. Full PPE and visors shall be worn appropriately during the period of demining operations in the field.

2. The poor performance of command group should be taken into account seriously and appropriate actions to be taken by operations management team.

3. Strong internal QA system can guarantee the improvement in operations and reduce the risk of unintended detonation and severe consequence of accidents, so more attention should be paid to internal QA system.

4. [Demining group] management should provide MACCA Operations department with a written feedback on all aspects of corrective/preventive actions taken within 7 days, effective to the issue date of this letter.

Victim Report

Victim number:	778	**Name:**	[Name removed]
Age:		**Gender:**	Male
Status:	deminer	**Fit for work:**	not known
Compensation:	Not made available	**Time to hospital:**	Not made available
Protection issued:	Frontal apron Long visor	**Protection used:**	Frontal apron

Summary of injuries:

INJURIES: minor Body, severe Face, severe Hand

AMPUTATION/LOSS: Eye, Fingers

COMMENT: No Medical report was made available

Analysis

The primary cause of this accident is listed as a *Field control inadequacy* because the Victim was working without a visor and his error was not corrected. The secondary cause is listed as *Inadequate equipment* because the deminer was working with an inappropriate hand-tool that does not meet the recommendations of IMAS 10.30 and severe hand injury resulted. This is also a *Management Control inadequacy* at all levels, because the tool used had been approved by the UN supported MACCA. The “Inadequate equipment” listed under notes refers top the issue of an inappropriate tool, the unsafe AK bayonet.

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 This is in contravention of the requirements of the IMAS which they are required to apply. The summary of the accident is good, and its presence implies that a full and comprehensive accident investigation was made, but not made available for others to learn from.