11-5-2009

DDASaccident620

Humanitarian Demining Accident and Incident Database
AID

DDAS Accident Report

Accident details

Report date:	05/03/2011	**Accident number:**	620
Accident time:	08:45	**Accident Date:**	05/11/2009
Where it occurred:	AF/2008/00324/H4533 -F, Kandak-e-921 Sarhadi area, Kohsan district, Herat province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Management/control inadequacy (?)
Class:	Excavation accident	**Date of main report:**	Not recorded
ID original source:	OPS/14/01- 31, Ref: 397 -12-2009	**Name of source:**	UNMACCA
Organisation:	**[Name removed]**		
Mine/device:	AP blast (unrecorded)	**Ground condition:**	not recorded
Date record created:		**Date last modified:**	05/03/2011
No of victims:	2	**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 (?)

disciplinary action against victim (?)

visor not worn or worn raised (?)

safety distances ignored (?)

squatting/kneeling to excavate (?)

Accident report

The only report of this accident that has been made available to date was in a UNMACA accident summary. 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 summary is reproduced below, edited for anonymity.

United Nations Mine Action Centre For Afghanistan, UNMACA

File: OPS/14/01- 31. Ref: 397 -12-2009

Date: 28th December 2009

Subject: Investigation Report & Lessons Learned of [Demining group] DT# 11 Demining Accident

Attached please find the investigation report and Lessons Learned of Demining Accident, which occurred on 05 Nov 2009, at Chah Rig District of kushan Hirat Province

LESSONS LEARNED SUMMARY OF [Demining group] DT- 11 DEMINING ACCIDENT

INTRODUCTION:

An investigation team was convened by AMAC West to investigate the demining accident involving [Victim No.1] and [Victim No.2] the Deminer and Section Leader from [Demining group] DT-11. The accident occurred at 08:45 hours on 05 Nov 2009 at minefield number AF/2008/00324/H4533-F, located in Kandak-e-921 Sarhadi area, Kohsan district of Herat province.

SUMMARY:

AF/2008100324/H4533-F is anti-personnel mine contaminated area, the mines laid by government forces during the Russian invasion in Afghanistan The mines were laid in 2 rows as a belt around Kandak-e-921 Sarhadi Border division # 921 in order to secure their positions from the attacks of Mujahedeen During last 15 years, 16 accidents have happened in the area (3 on human, 13 on animals). [Demining group] DT-11 was tasked to clear mentioned area.

On 5th Nov 2009 at 08:45 am deminer [Victim No.1] was working in his clearance lane: he was removing excavated soil from the target spot that suddenly his excavation tool touched a mine and caused it to go off. As a result of the accident, the deminer got severe injuries to his face, eyes and left hand (lost his one eye).

Section leader [Victim No.2] who was standing close to him also received severe injuries to his face, eye and right arm.

This accident clearly indicates that lack of proper command and control was dominated within the team, showing that the command elements of the team were extremely careless about safety precautions. There was no any attention paid to safety distance and having visor worn properly.

CONCLUSIONS:

This accident happened because of lack of command and control in the team and poor performance of deminer.

RECOMMENDATIONS:

However disciplinary action was taken by [Demining group] immediately after accident happened, the team leader, section leader and victim deminer were terminated from their jobs. But the following points are to be considered by all concerned:

1. Full PPE and visors should be worn correctly all over the working period demining operations in the field.

2. The poor performance of command group should be taken to account and appropriate actions to be taken by all concerned, as it is a program wide issue now.

3. [Demining group] operations department is to present their management solution to prevent such accidents in future and provide MACCA OPS department with written documents in 7 days after this lessons learned being circulated.

Victim Report

Victim number: 802
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: severe Eyes, severe Face, severe Hand

AMPUTATION/LOSS: Eye

COMMENT: No Medical report was made available.

Victim Report

Victim number: 803
Name: [Name removed]
Age:
Gender: Male
Status: supervisory
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: severe Arm, severe Eye, severe Face

COMMENT: No Medical report was made available.

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because both Victims were not wearing visors when the accident occurred, although one of them was a field supervisor. The secondary cause is listed as a *Management Control Inadequacy* because the investigators and the Demining Group managers recognised that the field supervisors did not do their jobs correctly. The selection and training of appropriate field supervisor is a management responsibility, so the appointment of bad field supervisors is a management failing.

The severity of the injuries to Victim No.2 imply that he was alongside Victim No.1 and perhaps looking over his shoulder (so having his head within the fragmentation cone associated with an AP blast). Both Victims having hand/arm injuries imply that they both have been working to expose the mine at the same time. Supervisors are permitted (in the IMAS) to approach close to the deminer to watch them work but all work must cease when they come within a few metres.

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 in contravention of the requirements of the IMAS. The existence of a good summary implies that the Afghan investigators carried out a professional investigation and generated a detailed report that should be shared.