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DDAS Accident Report

Accident details

Report date:	06/03/2011	**Accident number:**	665
Accident time:	08:54	**Accident Date:**	17th August 2008
Where it occurred:	MF 081, Dragi village, Tani district, Khost Province	**Country:**	Afghanistan
Primary cause:	Field Control Inadequacy	**Secondary cause:**	Management Control Inadequacy
Class:	Excavation Accident	**Date of main report:**	17th October 2010
ID original source:	Ref # 214	**Name of source:**	UNMACCA
Organisation:	**[Name removed]**		
Mine/device:	AP blast	**Ground condition:**	mountainous
Date record created:		**Date last modified:**	06/03/2011
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 (?)

Squatting/kneeling to excavate (?)

Visor not worn or worn raised (?)

Inadequate equipment (?)

Inadequate detector pinpointing (?)

Inadequate training (?)

Accident report

The only report of this accident that has been made available to date is a UNMACCA Lessons Learned Summary supplied as a PDF file. Its conversion into a DDAS file has led to some

formatting being lost. Text in square brackets [ ] is editorial. This record will be revised as more information becomes available.

The accident summary is reproduced below, edited for anonymity.

Mine Action Coordination Centre of Afghanistan (UNMACCA)

Ref # 214: File: OPS/14/17 /October /2010

Subject: Investigation Report & Lessons Learned of [Demining group] CBDT-23 Demining Accident.

Attached please find the investigation report and lessons learned of demining accident happened on 17 August 2010 at 08:54 hrs, in Dragi village Tani district of Khost province.

LESSONS LEARNED SUMMARY OF [Demining group] CBDT-23 DEMINING ACCIDENT

INTRODUCTION:

Demining investigation teams were convened by AMAC Gardez and [Demining group] to investigate and find out the cause of the demining accident involving [TheVictim] the deminer of [Demining group] CBDT-23. The accident occurred at 8:54 hours, on 17 August 2010 in Task # AF/3203/00398/MF 081 located in Dragi village, Tani district of Khost province.

SUMMARY:

Task # AF/3203/00398/MF 081 is located in a mountainous area contaminated with anti-personnel mines, in Dec 2009 the area polygon surveyed by [Demining group] LIAT–1 1. Mines planted by Russian forces during the year 1984 to protect their position from the possible attacks of Mujahiddin.

Mine clearance operations in Tani district started by [Demining group] as community based demining approach and deminers from the community are engaged in this operation. On 8th July 2010, CBDT-23 started demining operations in mentioned minefield, the progress was around 20% till the demining accident happened. The team found/destroyed 4 anti-personal mines up to the accident time.

On 17 August 2010 [the Victim] the deminer was working in his clearance lane excavating a detected signal, his excavation tool touched a mine and caused it to explode. According to the investigation report the signal was not pinpointed correctly and the deminer has used his bayonet directly on the top of anti-personnel mine, so the accident happened. Unfortunately the victim deminer was not fully dressed with PPE, so he got severe injuries on his eyes, whole face and finger of his left hand.

As the majority of minefields in Tani district are located on the hillsides, and the likelihood of mines with changed position due to seasonal flood is high. Therefore, a comprehensive site operations plan was required covering all the predictable scenarios during the clearance operations e.g. changes in direction of mines, mine displacement etc. But this point was missed in the site operations plan.

CONCLUSIONS:

The main contributing factor to this accident was the carelessness of deminer himself. In addition, as the deminer was working without having worn his PPE appropriately and had not been controlled by the command group, therefore, the weakness of command and control is also noticeable.

RECOMMENDATIONS:

The following points are to be considered:

A. [Demining group] operation department is recommended to take necessary action in terms of strengthening command and control element in their teams especially in community based projects.

B. A strong discipline should be emplaced in all community based projects as this is the third accident within Tani CBD project of the same scenario.

C. As Tani is a tribal area and all the people are strongly following their elders, therefore, the issue of carelessness of deminers should be discussed with elders and the possible consequences of the situation should be detailed to them.

D. [Demining group] operations department is recommended to develop a plan for the improvement of supervision, command and control in their teams.

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

Victim Report

Victim number:		**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, Visor	**Protection used:**	Frontal apron

Summary of injuries:

INJURIES: Severe eyes, Severe face, Severe hand

COMMENT: No Medical report was made available.

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the investigators found that the Victim was working without pin-pointing his metal-detector reading and without wearing his visor but his errors were not corrected. The secondary cause is listed as a *Management Control Inadequacy* because the "community" deminer appears to have been inadequately prepared for his role and not overseen by suitably competent field supervisors.

The Inadequate training under Notes refers to the Victim's inability to use his detector appropriately, dangerous excavation technique and failure to wear PPE correctly. The Inadequate equipment under Notes refers to the issue of a short handtool that does not meet the IMAS recommendation for blast-resistant tools.

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 the accident summary implies that the Afghan investigators did make a comprehensive report and the failure of the UN to share it with others is regrettable.