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DDAS Accident Report

Accident details

Report date:	07/03/2011	**Accident number:**	702
Accident time:	08:10	**Accident Date:**	28/07/2009
Where it occurred:	MF 0321, Navy Deh Village, Daman district, Kandahar province	**Country:**	Afghanistan
Primary cause:	Inadequate training (?)	**Secondary cause:**	Field control inadequacy (?)
Class:	Excavation accident	**Date of main report:**	04/10/2009
ID original source:	OPS, 14/01-21	**Name of source:**	UNMACCA
Organisation:	[Name removed]		
Mine/device:	AP blast (unrecorded)	**Ground condition:**	hard
Date record created:		**Date last modified:**	07/03/2011
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 (?)

use of pick (?)

visor not worn or worn raised (?)

squatting/kneeling to excavate (?)

inadequate training (?)

protective equipment not worn (?)

Inadequate detector pinpointing

Accident report

The only report of this accident that has been made available to date was a UNMACA "Lessons learned 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.

File: OPS, 14/01-21 Ref: 09/03/325

Date: October 04, 2009

For Information: MACCA, Chief of Staff; DMC, Director; Operations Staff

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

LESSONS LEARNED SUMMARY OF : [Demining group] DT-13 DEMINING ACCIDENT

INTRODUCTION:

An investigation team was convened by the AMAC South to investigate the demining accident involving [the Victim] the Deminer of : [Demining group] DT-13. The accident occurred at 08:10 hours on 28 July 2009 at the minefield number AF/2402/21188/MF 0321, located in Navy Deh village, Daman district of Kandahar province.

SUMMARY:

MF321 is an anti-personal mine contaminated area, part of a big mine belt around Kandahar Airfield (KAF). The area was of great importance from the military point of view, so the Russian troops planted mines there to protect their positions from the attacks of Mujahedeen and secure the KAP.

On 28 July 2009 at 08:10 hrs when Ahmed de-miner was working on a signal in his clearance lane by using a pickaxe instead of bayonet, he hit the mine on its top and caused it to go off. According to the investigation report the ground surface was uneven, hard and impossible to work in sitting position, so he has started to investigate the signal in standing position. This was the main reason of initiating mine and accident.

As the victim deminer was not fully dressed with PPE including helmet/visor so he has got multiple superficial injures on his body, and sustained injures on his face/eyes as well. This is the second de-mining accident.

CONCLUSIONS:

Non professional operations, without using PPE and investigation of signal with pick directly on the pinpointed spot. Poor supervision is the main contributing factor in this accident.

Appropriate action had not been taken by command group in order to properly manage this problematic part of the minefield by using some alternative ways for safe operations.

RECOMMENDATIONS:

The following points are to be considered:

A. The : [Demining group] Operations deportment is to take more professional steps to build up a strong capacity of command and control mechanism within their teams under a sound quality assurance system.

B. Good planning and site study for recognizing alternative solutions to safely handle operations in problematic portions of the clearance site through supervisor and team leaders is highly recommended.

C. It is also the responsibility of command group to urge and advise the Deminers to strictly adhere to the SOP.

D. Hot weather can not be a logical reason to not use PPE, so the command group shall manage the team's operations throughout the working period.

E. As this is the 2nd accident with the same scenario, so it is required that team to undergo in a proper refresh training in consideration of the contributed factors to this accident.

F. The : [Demining group] management should take necessary action in order to prevent recurrence of such accidents in future and prepare a plan of action and present it to MACCA Chief of operations by no later than 09 October 09.

Victim Report

Victim number:	888	**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:**	None

Summary of injuries:

INJURIES: minor Body, severe Eyes, severe Face

COMMENT: No Medical report was made available.

Analysis

The primary cause of this accident is listed as *Inadequate training* because the investigators found that there was a need for group refresher training. The secondary cause is listed as a *Field Control Inadequacy* because the investigators found that the field supervisors allowed the Victim to leave off his PPE and work in a dangerous manner (with a pick-axe). Both of these constitute a serious *Management Control Inadequacy* which the investigators highlighted.

Apparently the Victim did not pinpoint a detector reading properly and so used his pickaxe directly on top of the mine.

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. That said, the Afghan investigators deserve praise for apparently conducting a professional and objective investigation.