

2-17-2011

DDASaccident722

Humanitarian Demining Accident and Incident Database
AID

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DDAS Accident Report

Accident details

Report date: 08/07/2011	Accident number: 722
Accident time: 11:30	Accident Date: 17/02/2011
Where it occurred: AF/3211/0728, MF074, Bagi Khail Village, Gurboz District, Khost Province	Country: Afghanistan
Primary cause: Field control inadequacy (?)	Secondary cause: Management/control inadequacy (?)
Class: Vegetation removal accident	Date of main report: 14/03/2011
ID original source: None	Name of source: UNMACCA
Organisation: [Name removed]	
Mine/device: Type 72 AP blast	Ground condition: steep slope
Date record created:	Date last modified: 08/07/2011
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 (?)
safety distances ignored (?)
visor not worn or worn raised (?)
protective equipment not worn (?)

Accident report

The only report of this accident that has been made available to date is a UNMACCA Lessons Learned document. Its 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 if more information becomes available.

The document is reproduced below, edited for anonymity.

LESSONS LEARNED SUMMARY OF [Demining group] DT-17 DEMINING ACCIDENT

INTRODUCTION:

Investigation team was convened by AMAC Gardez to investigate the demining accident involving [Victim No.1] and [Victim No.2] the deminers of [Demining group] DT-17. A separate investigation team was also assigned by [Demining group] for internal investigation of this accident. The accident occurred at 11:30 hours, 17 Feb 2011 in task number AF/3211/0728/MF074, located in Bagi Khail village, Gurboz district of Khost province.

SUMMARY:

Task No AF/3211/0728/MF074 is located in a hillside with a sloping terrain in southern side of Bagi Khail village. This area was mined by Russian troops in 1982 to secure their positions from the attacks of Mujahedeen and also some parts of the area were mined by Mujahedeen after they captured this area.

Mentioned area was polygon surveyed by [Another demining group] LIAT in November 2009, and then [Demining group] DT-17 started clearance operations there on 02/Nov/2010 as per [Demining group] work plan. The team has cleared 37940 sqm and destroyed 22 AP mines and 03 ERW up to the accident happened. Their clearance progress was about 55 %.

According to external investigation report, the witness statements, injuries of involved deminers and physical observation of the accident point, the accident occurred when [Victim No.1] was cutting bushes with scissor. During cutting off bushes in his clearance lane, he moved his right foot forward beyond the base stick, stepped on a Type-72 mine and caused it to go off. This accident caused traumatic amputation to his right foot below the ankle joint and left leg injuries. This also caused multiple injuries to the second deminer [Victim No.2], who was busy in marking the same lane in a 5 meters distance without having his PPE worn, his right leg, right arm, face and eyes were injured. Section leader of mentioned party was absent, but this issue was not reported to [Demining group] office by the team leader. The party was working without any acting section leader in the minefield. The internal investigation report outlines that the accident occurred during the rest period outside the boundary of MF in a contaminated area. Both deminers entered to contaminated area without considering safety measures and have not been stopped by team leader.

CONCLUSIONS:

Both internal and external investigation reports concluded that this accident occurred due to poor command and control of team leader and carelessness of deminers in terms of moving forward from their clearance lane without considering safety measures.

RECOMMENDATIONS:

Although [Demining group] has taken disciplinary actions, but the following points need to be considered by [Demining group] operations department:

- The issue of poor supervision requires to be addressed by [Demining group] operations department. A capacity development plan for the command group of their teams should be developed and implemented.
- [Demining group] operations, QA and Training departments/section are recommended to have a meeting on demining accidents of last 12 months, conduct

analysis, find the root causes and develop management solutions to recurrent accidents.

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

Victim Report

Victim number: 917	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: Not recorded

Summary of injuries:

INJURIES: severe Leg

AMPUTATION/LOSS: Leg Below knee

COMMENT: No Medical report was made available. "traumatic amputation to his right foot below the ankle joint and left leg injuries".

Victim Report

Victim number: 918	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 Arm; minor Face; minor Leg; severe Eyes

COMMENT: No Medical report was made available. "right leg, right arm, face and eyes were injured".

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the investigators found that the Victims were without any field supervision. Had there been a field supervisor, their compound errors (failure to wear PPE, working too close together and failure to pay attention about placing feet beyond the base-stick) should have been corrected and the accident avoided altogether. The secondary cause is listed as a *Management Control*

Inadequacy because the group's senior management failed to ensure that appropriate field supervision was in place.

At five metre distance, a 50g TNT AP blast mine does not generally cause significant secondary injury. It is likely that Victim No.2 was much closer to Victim No.1 than was admitted.

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. National staff have been more responsible than the internationals with overall responsibility.