8-17-2010

DDASaccident729

HD-AID
Humanitarian DeminingAccident and Incident Database

DDAS Accident Report

Accident details

Report date:	09/07/2011	**Accident number:**	729
Accident time:	11:00	**Accident Date:**	17/08/2010
Where it occurred:	AF/0701/0723, MF289, Tandan village, Paktya Province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Management/control inadequacy (?)
Class:	Excavation accident	**Date of main report:**	None
ID original source:	None	**Name of source:**	UNMACCA
Organisation:	[Name removed] CBDT		
Mine/device:	AP blast (unrecorded)	**Ground condition:**	not recorded
Date record created:		**Date last modified:**	09/07/2011
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 (?)

Inadequate detector pinpointing

protective equipment not worn (?)

visor not worn or worn raised (?)

squatting/kneeling to excavate (?)

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] CBDT-15 DMINING ACCIDENT

INTRODUCTION:

Demining investigation team was convened by AMAC Gardez to investigate and find out the causes of the demining accident involving [the Victim] the deminer of [Demining group] CBDT-15. As this was a fatal case, so the [Demining group] site officer and QA assistant were also called to join the investigation process. The accident occurred around 11:00 hours, on 17 August 2010 in Task #AF/0701/0723/MF289 located in Tandan village, centre of Paktya province.

SUMMARY:

Task #AF/0701/0723/MF289 is located in a hillside, around 13 km towards the Northwest of Gardez city. The anti-personnel mines were laid there by Russian forces during 1987-1992 to secure their positions from Mujahidin attacks. The MCPA LIAT conducted a polygon survey in this area in June 2009.

Mine clearance operations started in this area by [Demining group] as a community based demining project and the deminers from the community recruited for this operation. On 16th June 2010 CBDT-15 started demining operations in mentioned mine field. They found and destroyed 13 anti-personnel mines and cleared 85 % of the area until the accident happened.

On 17 August 2010 while [the Victim] was working in his clearance lane, his excavation tool touched a mine and caused it to go off. According to the investigation report and the injuries sustained by victim deminer, it seems that the de-miner has excavated a detected signal carelessly and in contrary to their SOP. It means signal was not pinpointed correctly and the de-miner had used the excavation tool directly on the top of mine, so the accident happened. Unfortunately the de-miner did not put his PPE on, therefore, he got severe injuries on his eyes, whole face, neck, chest, shoulders, arms, legs and deep wounds on his left ear. The deminer died in the spot.

CONCLUSIONS:

Carelessness of the de-miner in term of not using his PPE and visor during the operation and using the excavation tool directly on the top of signal is the main contributing factor to this accident.

RECOMMENDATIONS:

The following points are to be considered:

- [Demining group] operations department is recommended to come up with a comprehensive plan of action for the improvement of command and control in their demining teams especially for the CBD projects.
- [Demining group] operations department should plan and implement revision and refresher trainings for their CBD projects in order to improve the deminers skills, the plan should be shared with MACCA operations department.
- [Demining group] should strengthen the internal QA visits to CBD projects to find the shortcomings and develop the improvement plans accordingly.

Feedback on any preventive and corrective actions taken by [Demining group] is required to be submitted to the MACCA within 7 days, effective from the issue of this report.

Victim Report

Victim number:	922	**Name:**	[Name removed]
Age:		**Gender:**	Male
Status:	deminer	**Fit for work:**	DECEASED
Compensation:	Not made available	**Time to hospital:**	Not made available
Protection issued:	Frontal apron Long visor	**Protection used:**	None

Summary of injuries:

INJURIES: severe Arms; severe Chest; severe Eyes; severe Face; severe Legs; severe Neck

FATAL

COMMENT: No Medical report was made available. "severe injuries on his eyes, whole face, neck, chest, shoulders, arms, legs and deep wounds on his left ear. The deminer died in the spot.

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the Victim was working without PPE and his error was not corrected. His failure to pinpoint a detector reading accurately and excavate safely imply that he was inadequately trained. The secondary cause is listed as a *Management Control Inadequacy* because the investigators found that there was a need for improved training and command and control systems, both of which are the senior management's responsibility.

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.