3-15-2010

DDASaccident733

HD-AID
Humanitarian DeminingAccident and Incident Database

DDAS Accident Report

Accident details

Report date:	11/07/2011	**Accident number:**	733
Accident time:	08:55	**Accident Date:**	15/03/2010
Where it occurred:	AF/0105/01625, MF 0268, Ashraf Khail Village, Qara Bagh District, Kabul Province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Management/control inadequacy (?)
Class:	Excavation accident	**Date of main report:**	03/05/2010
ID original source:	None	**Name of source:**	UNMACCA
Organisation:	[Name removed]		
Mine/device:	PMN AP blast	**Ground condition:**	bushes/scrub steep slope
Date record created:		**Date last modified:**	11/07/2011
No of victims:	1	**No of documents:**	1

Map details

Longitude:		**Latitude:**	
Alt. coord. system:	Not recored	**Coordinates fixed by:**	
Map east:		**Map north:**	
Map scale:		**Map series:**	
Map edition:		**Map sheet:**	
Map name:			

Accident Notes

inadequate investigation (?)

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] DT-04 DEMINING ACCIDENT

INTRODUCTION:

An investigation team was convened by AMAC Kabul to investigate the demining accident involving [the Victim] the de-miner of [Demining group] DT-04. A separate investigation team was also assigned by MCPA for internal investigation. The accident occurred at 08:55 hours, 15 March 2010 in Task # AF/0105/01625/MF 0268, located in Ashraf Khail village, Qara Bagh district of Kabul province.

SUMMARY:

MF # 0268 was contaminated with anti-personnel mines laid by Russian troops in 1984 in order to create a security built around their military position for the protection of Bagram Air Base. For the second time, during the armed conflicts between Taliban and Northern Alliance in 1997-2000, this area was re-contaminated.

[Demining group] DT-04 started clearance operation on mentioned task on 3rd Feb 2010, they cleared 16250 sqm out of 34370 sqm area, they have found/destroyed 20 anti-personnel (PMN and PMN2) mines before accident happening.

On 15 March 2010 at 08:55 hrs while [the Victim] was busy in excavation of a detected signal, suddenly the accident happened. As a result the deminer got severe injuries on his face, eyes and his right hand.

According to the investigation report the terrain of the ground where the accident happened was steep sloping. Therefore, the deminer created staircases there to get himself stable for further working. He started excavation on the top of the sloping area; the position of mine might had been changed due to seasonal floods, so the excavation tool touched the pressure plate of the mine and caused it to go off. From the injuries to the face and eyes of the deminer, it seems that the deminer has not used his visor properly. The area was bushy and required MDU support which had been identified in site clearance plan, but it was not provided to the team on timely manner.

CONCLUSIONS:

Poor supervision by the command group is a contributing factor to this accident. As in a proved high threat area, the deminer was working carelessly without being controlled by his section leader. Being late in providing MDU support to the team was another contributing factor to this accident.

RECOMMENDATIONS:

- It is the responsibilities of respective IP’s operations department to make sure that a proper system of command and control exists in the field.
- Inappropriate use of visor resulted in injuries to the eyes and face of the deminer; therefore, it is highly recommended that the command and control element should be more supported by operations department.
- The operations department should strongly follow the site operations plan and provide any support required for the clearance operations on timely manner.

Feedback on any preventive and corrective actions taken by MCPA 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:	926	**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 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 there was no “proper system of command and control” in the field and the Victim was working with his visor raised and this error was not corrected. The secondary cause is listed as a *Management Control Inadequacy* because the investigators found that the demining group’s Operations department had failed in its responsibilities.

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, so ignoring the requirements of the IMAS. National staff have been more responsible than the internationals with overall responsibility.