12-13-2010

DDASaccident740

HD-AID
Humanitarian DeminingAccident and Incident Database

DDAS Accident Report

Accident details

Report date:	11/07/2011	**Accident number:**	740
Accident time:	10:37	**Accident Date:**	13/12/2010
Where it occurred:	AF/2401/21529, MF-613, Khushab area, Kandahar 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:	POMZ AP frag	**Ground condition:**	not recorded
Date record created:		**Date last modified:**	11/07/2011
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

use of pick (?)

squatting/kneeling to excavate (?)

safety distances ignored (?)

disciplinary action against victim (?)

protective equipment not worn (?)

handtool may have increased injury (?)

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-01 DMINING ACCIDENT

[CBDT – Community Based Demining Team]

INTRODUCTION:

The demining accident investigation team was convened by AMAC South to investigate and find out the causes of demining accident involving Victim No.1] and Mr.[Victim No.2] the de-miner and Section Leader of [Demining group] CBDT-01. The accident occurred on 13 Dec 2010 at 10:37 in task # AF/2401/21529/MF-613 located in Khushab area of Kandahar province.

SUMMARY:

The above mentioned task is located in the southwest of Kandahar Airfield (KAF). This area was heavily mined by Russian forces. The AP mines (POMZ and PMN) are laid in four rows as belts surrounding the KAF in order to secure their positions from the attacks of Mujahideen.

On the 13th Dec 2010 at 10:37, the deminer [Victim No.1] was operating in his clearance lane excavating a detected signal, his prodder touched on a subsurface tripwire of POMZ mine which caused it to explode. According to the investigation report the signal was not pinpointed correctly and the de-miner has used pick in contrary to set procedure, during the excavation, he pulled the subsurface tripwire connected with POMZ mine. The accident resulted in superficial injuries to deminer's hands, left thigh and left side of abdomen.

The report also adds that the Section Leader [Victim No.2] has also got some superficial injuries on the right side of his body. He was busy in other clearance lane around 10 metres away from the first victim deminer. He was removing bushes and other obstacle from a clearance lane.

As the de-miner and section leader had not used PPE (vest & apron) correctly during the clearance operations, therefore they got multiple injuries.

This is the second demining accident occurred in the same task, this accident clearly indicates lack of proper command and control within the team, showing that the command elements of the team were extremely careless about safety precaution. There was no any attention paid to safety distance and having vest & apron worn correctly.

CONCLUSIONS:

Clearance operations without having PPE (vest & apron) worn properly and using pick in contrary to approved procedures, showing the carelessness of de-miner. In addition the command element was also busy in clearance operations, this is against his job description and he also did not wear PPE properly, this indicates that there is a serious problem in command, control and supervision of the team.

RECOMMENDATIONS:

However, disciplinary and corrective action was taken by [Demining group] immediately after the accident happened, the immediate section leader were punished with 15 day loss of pay and refresher training were recommend for the team. But this is not enough to eliminate such accidents in the future; [Demining group] should strongly consider the following points:

A complete review of command, control and supervisory staff throughout the CBD [Community Based Demining] projects and take necessary actions.

[Demining group] operations department is recommended to come up with a comprehensive plan of action for the improvement of command and control and supervision in their demining teams especially in CBD projects.

[Demining group] should review, improve and strengthen current internal QA system to make sure that the shortcomings are identified and the appropriate actions are taken immediately.

For the clearance operation in current task appropriate mechanical asset should be deployed.

[Demining group] should ensure the use of PPE correctly and completely throughout their teams during demining operations in the field.

[Demining group] operations department should plan a quality circle meeting to find out the root cause(s) of their demining accidents, develop appropriate plan and implement it in order to reduce such accidents.

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:	929	**Name:**	[Name removed]
Age:		**Gender:**	Male
Status:	deminer	**Fit for work:**	presumed
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; minor Hands; minor Leg

COMMENT: No Medical report was made available. "superficial injuries to deminer's hands, left thigh and left side of abdomen".

Victim Report

Victim number:	930	**Name:**	[Name removed]
Age:		**Gender:**	Male
Status:	supervisory	**Fit for work:**	presumed
Compensation:	Not made available	**Time to hospital:**	Not made available
Protection issued:	Frontal apron, Long	**Protection used:**	None

visor

Summary of injuries:

INJURIES: minor Body

COMMENT: No Medical report was made available. "superficial injuries on the right side of his body".

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the investigators found that the field control was inadequate on several counts (use of PPE, inadequate pinpointing, use of a pick-axe, ignoring safety distances). The secondary cause is listed as a *Management Control Inadequacy* because the investigators required the demining group's management to review and revise its procedures to improve field command and control.

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.