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Humanitarian Demining Accident and Incident Database

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DDAS Accident Report

Accident details

Report date: 11/07/2011	Accident number: 742
Accident time: 10:25	Accident Date: 12/03/2011
Where it occurred: Task: AF/1302/00342/MF585 7, Dood Kash village, Pulikhumri district, Baghlan province	Country: Afghanistan
Primary cause: Inadequate training (?)	Secondary cause: Field control inadequacy (?)
Class: Excavation accident	Date of main report: None
ID original source: None	Name of source: UNMACCA
Organisation: [Name removed]	
Mine/device: PMN-2 AP blast	Ground condition: hard rocks/stones
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 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
inadequate training (?)
squatting/kneeling to excavate (?)

Accident report

The only report of this accident that has been made available to date was in 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 report is reproduced below, edited for anonymity.

LESSONS LEARNED SUMMARY OF [Demining group]-04 DEMINING ACCIDENT

INTRODUCTION:

Investigation team was convened by AMAC Kunduz to investigate the demining accident involving [the Victim] the deminer of [Demining group] MDG-04. A separate investigation team was also assigned by [Demining group] for internal investigation of this accident. The accident occurred at 10:25 hours, 12 Mar 2011 in task number AF/1302/00342/MF5857, located in Dood Kash village, Pulikhumri district of Baghlan province.

SUMMARY:

Task No AF/1302/00342/MF5857 is located on the top of hill, which had been contaminated with anti-personnel mines by Kaya Militias during 1992 to 1998. This area was mined by militia forces in order to protect their positions from the attacks of government forces. The terrain of area is hilltop and rocky.

Presence of mines there posed a direct risk to the workers of coal mine and local people, therefore, they requested clearance of the site. This area was polygon surveyed by [Other demining group] in Feb 2009 with a size of 64000 sqm. According to [Demining group] 1389 plan, clearance operations started there on 17 Feb 2011, [Demining group]-04 cleared 7640 sqm and destroyed 6 PMN2 mines till accident time.

According to external investigation report, the accident happened during the prodding operation on a detected signal. According to the witness statements the deminer may have failed to pinpoint the signal or he may have started prodding directly from the top of it and not maintained the right angle of the prodder. The density of rocks there and hardness of the ground required more attention to be paid by deminer during the operation, but it seems that he was working in hurry without considering standard operating procedures to be applied during signal investigation. The record of QA shows that this team had not been visited by internal QA. Fortunately the deminer was dressed with PPE, so he got superficial injuries on his body and dust in his eyes.

CONCLUSIONS:

The accident happened due to inattention of deminer to standard operating procedure when he was investigating a detected signal.

RECOMMENDATIONS:

The deminers should be briefed by command group about the worksite conditions and the obstacles in the task and advise them to be careful and follow the standard operating procedures.

The command group of the teams should make sure that the deminers are well aware about the worksite conditions and taking due care during the operations.

[Demining group] internal QA section is recommended to increase QA visits to the teams, find the shortfalls and recommend appropriate corrective/preventive actions.

Refresher training is recommended to the team covering the use of detectors, pinpointing signals and prodding and excavation drills.

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: 933	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: Frontal apron; Long visor

Summary of injuries:

COMMENT: No Medical report was made available. "Superficial injuries on his body and dust in eyes."

Analysis

The primary cause of this accident is listed as a *Inadequate training* because the investigators found that the Victim had either not used his detector properly, not used the correct excavation procedures, or both. The secondary cause is listed as a *Field control inadequacy* because the field supervisors should have corrected these errors.

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.