10-7-2010

DDASaccident753

HD-AID
Humanitarian DeminingAccident and Incident Database

DDAS Accident Report

Accident details

Report date:	14/07/2011	**Accident number:**	753
Accident time:	08:40	**Accident Date:**	07/10/2010
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:**	29/11/2010
ID original source:	None	**Name of source:**	UNMACCA
Organisation:	[Name removed]		
Mine/device:	PMN AP blast	**Ground condition:**	not recorded
Date record created:		**Date last modified:**	14/07/2011
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

visor not worn or worn raised (?)

protective equipment not worn (?)

use of pick (?)

squatting/kneeling to excavate (?)

inadequate medical provision (?)

inadequate training (?)

handtool may have increased injury (?)

Accident report

The only report of this accident that has been made available to date is a UNMACA 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 as more information becomes available.

The document is reproduced below, edited for anonymity.

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

INTRODUCTION:

The demining investigation team was convened by AMAC South to investigate and find out the causes of demining accident involving Mr. [the Victim] the de-miner of [Demining group] CBDT-04. The accident occurred on 07 Oct 2010 at 08:40 in task # AF/2401/21529/MF-613 located in Khushab area of Kandahar province.

SUMMARY:

The abovementioned task is located in the southwest of Kandahar Airfield (KAF). This area was heavily mined by Russian forces in order to create a security belt around the KAF and prevent Mujahidin's attack on their positions.

On the 7th Oct 2010 at 08:40, the deminer [the Victim] initiated a PMN anti-personnel mine with a pick outside of his clearance lane which caused the accident. The section leader was around 60 meters away busy in taking coordinates of a found mine with GPS and the team leader was busy in admin area updating the attendance sheet. The deminer was busy in the minefield without being observed by the command group for almost 15 minutes during the operation while the accident happened.

The observation of accident scene, broken pieces of pick's handle, PPE, visor and mine detector around the accident point and the injuries of victim's eyes, face and leg shows that the deminer had not used the visor and PPE properly during the clearance operation and was working with a pick. As per the investigation report, the deminer used the pick directly on the top of the signal, hit the mine and caused it to go off, so the accident happened and resulted in severe injury to the right eye, minor injury to the left eye, amputation of two fingers of right hand and multiple minor injuries on both legs of the deminer.

The medic was avoided to provide first aid to the victim, first aid is critical to be done before the evacuation takes place.

CONCLUSIONS:

Clearance operations without having PPE and visor worn properly, and using pick directly on the pinpointed spot showing the carelessness of deminer. Therefore, he got preventable injuries. As the deminer was not stopped from doing such operation and the medic was not permitted to conduct first aid show the poor supervision and lack of command and control in the team.

RECOMMENDATIONS:

- [Demining group] should strengthen the internal QA visits to CBD projects to find the shortcomings and develop the improvement plans accordingly.

- [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 for the CBD projects.
- [Demining group] operations department should plan and implement revision and refresher trainings for the Kandahar CBD project's teams.

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:	943	**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 Eye; minor Legs; severe Eye; severe Face

AMPUTATION/LOSS: Fingers

COMMENT: No Medical report was made available. ". . the injuries of victim's eyes, face and leg shows that the deminer had not used the visor and PPE properly".

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the Victim was not wearing PPE and was excavating with a pick (which may have been permitted) and these errors were not corrected. The Field supervisors also seem to have not allowed the field medic to treat the Victim before evacuation, which implies that they were inadequately trained (and that they had not conducted a successful Medevac exercise before starting work at the Task). The secondary cause is listed as a *Management Control Inadequacy* because the selection and training of field supervisors is a management responsibility.

The investigators found that the Victim did not pinpoint a detector reading properly and then use a pick-axe on top of the mine. The failure to pinpoint detector signals accurately (very common in this theatre at this time) implies that either the training or the equipment was inadequate.

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