DDAS Accident Report

Accident details

Report date:	21/01/2008	**Accident number:**	494
Accident time:	06:50	**Accident Date:**	05/07/2007
Where it occurred:	SHA# 1 of HQ 1232, Kharoti Village, Bagram District, Parwan Province	**Country:**	Afghanistan
Primary cause:	Inadequate survey (?)	**Secondary cause:**	Field control inadequacy (?)
Class:	Mechanical excavation	**Date of main report:**	Not recorded
ID original source:	None	**Name of source:**	UNMACA
Organisation:	[Name removed]		
Mine/device:	YM-11 AT blast	**Ground condition:**	building rubble route (verge)
Date record created:		**Date last modified:**	21/01/2008
No of victims:	0	**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 survey (?)

inadequate training (?)

mechanical detonation (?)

inadequate investigation (?)

non-injurious accident (?)

Accident report

A letter about this accident was made available in August 2007 as a PDF file. Its conversion to a text file for editing means that some of the formatting has been lost. The substance of the letter is reproduced below, edited for anonymity. The original PDF file is held on record. Text

in [ ] is editorial. This record will be revised if the full investigation report is made available in future.

LESSONS LEARNED SUMMARY

OF DEMINING ACCIDENT OCCURRED ON DAFA MDU ON JULY 05, 2007 AT

KHAROTI VILLAGE, BAGRAM DISTRICT OF PARWAN

INTRODUCTION:

As a result of a demining accident on [National demining agency] MDU-1 backhoe machine at 06:50 am, July 05, 2007 in task # AF/0308/01663/MF146 located at Kharoti village, Bagram district of Parwan province, investigation team was convened by AMAC Kabul to conduct the investigation and find out the main causes of the accident.

Fortunately the accident had no any casualty.

SUMMARY:

The mentioned mine contaminated area is a township for refugees consist of routes and ruined houses recorded by LIS as SHA# 1 of HQ 1232.

The area was not anticipated to be contaminated by AT mine, so [National demining agency] MDU # 1 Backhoe machine and DT # 2 were deployed for clearance of this task.

The machine was preparing the ground for manual parties in one of the routes that the teeth of bucket hit top of an anti tank YM-11 Iranian mine and caused it to explode.

As a result of the explosion four teeth of bucket were broken and scattered to different distances, damaged one side of bucket, armoured front wind shield of cabin, one hydraulic pipe and foot shield of cabin.

CONCLUSIONS:

1. The following points were found by investigation team:
2. The area was recorded by LIS as AP contaminated area and was confirmed by LIAT on 03/02/006.
3. The task was surveyed as anti personnel mine contaminated area, but contrary to expectation an anti tank mine was exploded under the bucket.
4. There was not a proper site plan for the clearance of the task which shows lack of supervision and monitoring of the task.
5. Before the accident an empty case of AT mine was found/observed by the team in the area, which indicated the presence of AT mine, but the team ignored it and continued to use the MDU.
6. The team documentation and recording system was poor, the MDU leader could not present all required documents and the records of MDU activities to the investigation team.

RECOMMENDATIONS:

The following points are to be considered:

1. Explosion of anti tank YM-11 mine in the task proved that AT mines also exist in the area, which requires changing the clearance method.
2. Reassessment of the area is to be done by AMAC operations Associate/Assistant, [National demining agency] supervisor/ team leader and LIAT for further course of actions.
3. The site clearance plan is to be approved by AMAC and a copy of the approved operational plan is to be retained with AMAC.
4. When DT team leader found some facts that indicate the need for change of the plan, he should inform AMAC through chain of command and bring the required changes to the clearance plan.
5. Retraining of team command group is recommended with focusing on the preparation of task clearance plan and its flexibility for change.
6. The relevant site supervisor should ensure that the team properly records its daily activities.

Analysis

The primary cause of this accident is listed as “inadequate survey” because the survey had not identified a threat from AT mines in that area.

The secondary cause is listed as a “Field control inadequacy” because the field controllers did not adjust the clearance plan after they found evidence of AT mines at the site. It is likely that was an indication of inadequate training.

This record will be revised if the full investigation report is made available in future.