DDAS Accident Report

Accident details

Report date:	21/01/2008	**Accident number:**	495
Accident time:	09:35	**Accident Date:**	06/02/2007
Where it occurred:	Qala-e-Shater Village, Injeel District, Herat Province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Management/control inadequacy (?)
Class:	other	**Date of main report:**	Not recorded
ID original source:	None	**Name of source:**	UNMACA
Organisation:	[Name removed]		
Mine/device:	AP blast (unrecorded)	**Ground condition:**	rocks/stones
Date record created:		**Date last modified:**	21/01/2008
No of victims:	1	**No of documents:**	1

Map details

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

Accident Notes

protective equipment not worn (?)

visor not worn or worn raised (?)

inadequate training (?)

inadequate investigation (?)

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

DEMINING ACCIDENT (February 06, 2007)

INTRODUCTION:

1. As a result of a demining accident on [the Victim], the deminer of [National demining agency], MCT-17 at 09:35 Hrs, February 06, 2007 in task # AF/2002/17610/MF0337, located at Qala-e-Shater village, Injeel district of Herat province, investigation team was convened by UNAMAC Hirat to conduct the investigation and find out the main causes of mentioned accident.
2. The accident caused face and right eye injuries and right side hearing loss to mentioned deminer.

SUMMARY:

3. The investigation report concluded that the accident occurred because of the following faults:
    - Poor command and control: as the victim deminer was getting ready to wear his PPE prior to start operation in his clearance lane on the edge of a steep part of minefield, accidentally a stone has fallen dawn on the mine and the accident occurred, but the command group should have ensured that all the deminers are equipped with PPE prior to entering in the minefield and remained equipped throughout the operations hours till coming back to the admin/rest area. This point of safety measures was missed by team leader and section leader.
    - The fact (observation and photograph) clearly indicates that, the distance to the seat of detonation from where the deminer was standing and wearing his PPE is much closed. He should have got up his PPE in the rest area and then comes to the clearance lane, but he missed that and had not been controlled by his section leader or team leader.

CONCLUSIONS:

4. The lack of some key command and basic strategies were contributing factors to the accident, if the basic rules and standard working procedures are adhered, the number of accidents will decrease.

RECOMMENDATIONS:

5. The following points are to be considered:
    - All the MAPA deminers and team members who are directly involved in demining operations are recommended to wear their PPEs in admin area and then to start their operations.
    - The command group shall ensure that all demining personnel carrying out demining activities in the field are equipped with personal protective equipment in safe and secure area prior to commence operations.
    - More attention to be paid to those deminers who are working on mine built or actual mined areas to be closely supervised and controlled.

- A refresher training to be held for whole team members focussed on safety measures.

Signed: Chief of Operations, UNMACA Kabul

Victim Report

Victim number:	656	**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:	Long visor Frontal apron	**Protection used:**	None

Summary of injuries:

severe Eye

severe Face

severe Hearing

COMMENT: No Medical report was made available.

Analysis

The primary cause of this accident is listed as a “Field control inadequacy” because the field supervisors allowed deminers to enter the mined area without wearing PPE.

The secondary cause is listed as a “Management control inadequacy” because it is implied that this is common practice, so the quality of training and supervisor preparation is called into question.

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