DDAS Accident Report

Accident details

Report date:	08/02/2011	**Accident number:**	595
Accident time:	10:27	**Accident Date:**	09/04/2010
Where it occurred:	MF: 1/11105/1626/5471, Qalai Saman Village, QaraBagh District, Parwan Province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Inadequate equipment (?)
Class:	Excavation accident	**Date of main report:**	20/05/2010
ID original source:	OPS/14/08	**Name of source:**	UMACCA
Organisation:	**[Name removed]**		
Mine/device:	PMN AP blast	**Ground condition:**	not recorded
Date record created:		**Date last modified:**	08/02/2011
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 equipment (?)

squatting/kneeling to excavate (?)

handtool may have increased injury (?)

pressure to work quickly (?)

visor not worn or worn raised (?)

Accident report

The only report of this accident that has been made available to date was in a “Lessons Learned” summary provided as a PDF file. The 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 cover letter and *Lessons Learned* summary are reproduced below, edited for anonymity.

United Nations Mine Action Centre for Afghanistan, UNMACA

File: OPS/14/08

To: See Distribution List

Signed: [Name removed] Chief of Operations UNMACA, Kabul

Ref# 104

Date: 20th May 2010

Subject: investigation Report & Lessons Learned of [Demining group] DT# 23 Demining Accident

Attached please find the investigation report and Lessons Learned of Demining Accident, which occurred on 09 April 2010 at 10:27 Hrs in Qalai Saman Village, QaraBagh District of Parwan Province.

Best regards,

Distribution List

Complete Investigation Report to: [Demining group]

Lessons Learned to:

MDC, RONCO, OMAR, MCPA, DDG, ATC, JMAS, PM/WRA, HDI, DAFA, AGMA, EODT, ACL, CMCC, MTI, NDSS, PSS, UXB, AMACs (7).

For Information: MACCA, Chief of Staff DMC, Director, Operations Staff

LESSONS LEARNED SUMMARY OF [Demining group] DT-23 DEMINING ACCIDENT

INTRODUCTION:

An investigation team was convened by AMAC Centre and internal investigation team by [Demining group] to investigate the demining accident involving [the Victim] the de-miner of [Demining group] DT-23. The accident occurred at 10:27 on 09 April 2010 at minefield number 1/11105/1626/[Demining group]5471, located in Qalai Saman village, Qarabagh district of Parwan province.

SUMMARY:

MF # [Demining group] 5471 is contaminated by anti-personnel PMN/MPN 2 mines recorded by [Demining group] on 2 Dec 2008 and then polygon surveyed by [Demining group] survey teams. The Russian troops and their successor government planted mines in this area to protect their positions from the attacks of Mujahidin.

Total area of this task is 42,700sqm and [Demining group] has started demining clearance operations there on March 2010. So far they cleared 11,136sqm and found/destroyed 9 AP mines. Totally four accident had happened there as, three on human and one on animal in the past.

On 9th April 2010 at 10:27 while [the Victim] was working in his clearance lane, busy in excavation drill, the accident happened and caused severe injuries to his right hand

(traumatic amputation) and some minor injuries to his neck and nose. His visor was broken down and separated from headband. As per the investigation report, the deminer has breached the SOPs as dug directly down on top of the mine. It is also possible that he tried to work in a bit hurry to increase the progress. As he was fully dressed with PPE, therefore, remained save from other severe injuries.

CONCLUSIONS:

Carelessness of the victim deminer caused the accident, as he started excavation with his chisel directly on the top of mine.

RECOMMENDATIONS:

However [Demining group] has taken required actions and distributed lessons learned from this accident investigation to all their teams. But the following points are to be considered by all demining teams:

A. The de-miners should not be allowed to work in hurry to achieve the target, if it was not achievable with normal work.

B. The deminers should pinpoint the signal and then start prodding and excavation as per procedures and the command group should strongly control them.

Victim Report

Victim number:	779	**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 Short frontal vest	**Protection used:**	Short vest

Summary of injuries:

INJURIES:minor Face; minor Neck

AMPUTATION/LOSS: Hand

COMMENT

"severe injuries to his right hand (traumatic amputation) and some minor injuries to his neck and nose". No medical report was made available.

Analysis

The primary cause of this accident is listed as a "*Field Control Inadequacy*" because the Victim's facial injuries imply that he was working with his visor raised and this error was not corrected. The secondary cause is listed as "*Inadequate equipment*" because the demining group's body-armour PPE does not include a collar that interfaces with the visor and stops blast getting beneath the visor (despite the requirements of IMAS 10.30).

Typical frontal apron used by this demining group.

While it is unlikely that the visor would have twisted and "broken down" if worn correctly, it is possible that the frontal body armour channeled the blast beneath the visor and caused unusual damage. The hand-tool "chisel" was also in breach of IMAS 10.30 and placed his hand too close to the blast so that a traumatic amputation occurred, so it was also "Inadequate equipment". Because both the PPE and the hand-tool are "approved" by the UNMACCA, severe *Management Control Inadequacies* extend to that control group.

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, also in contravention of the requirements of the IMAS which they are required to apply. The summary of the accident seems to accept the demining group's internal investigation without question, but its presence implies that a full and comprehensive accident investigation was made, although not made available for others to learn from.