DDAS Accident Report

Accident details

Report date:	08/07/2011	**Accident number:**	718
Accident time:	09:30	**Accident Date:**	22/06/2010
Where it occurred:	AF/0101/00096, MF0874, Waisalabad area, Ward-07, Kabul City	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Management/control inadequacy (?)
Class:	Excavation accident	**Date of main report:**	08/07/2010
ID original source:	None	**Name of source:**	UNMACCA
Organisation:	[Name removed]		
Mine/device:	PMN-2 AP blast	**Ground condition:**	rocks/stones steep slope
Date record created:		**Date last modified:**	08/07/2011
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 (?)

visor not worn or worn raised (?)

squatting/kneeling to excavate (?)

protective equipment not worn (?)

Accident report

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

LESSONS LEARNED SUMMARY OF [Demining group] MDG-09 DMINING ACCIDENT

INTRODUCTION:

An investigation team was convened by AMAC Kabul to investigate the demining accident involving [the Victim] the deminer of [Demining group] MDG-09. The accident occurred at 09:30 hours, 22 June 2010 in Task # AF/0101/00096/MF 0874 located in Waisalabad area, Ward-07 of Kabul City.

SUMMARY:

Task # AF/0101/00096/MF 0874 is located in a mountainous area contaminated with anti-personnel mines planted by Russian forces. The area is mined several times after the Russian withdrawal up to the end of internal conflict. This area is recorded by LIS under the community No. 096 then confirmed by LIAT in 2008. Around 12 accidents have been occurred on locals in mentioned area.

As per the request of local people, AMAC Central tasked MDG-09 of [Demining group] on 15th May 2010, to start clearance operation there. Total size of the task is 44515 m2 out of which 34500 m2 has been cleared so far, 12 AP PMN2 mines and 329 different types of ERW found/destroyed by MDG-09 up to the accident time.

The accident occurred on 22 June 2010, 09:30 AM in clearance lane of [the Victim], located in a steep sloping area within the MF. He was busy in full excavation there, suddenly some stones and soil slipped down in front of him and caused a PMN2 mine to go off. The ground where [the Victim] was working was of a loose and sliding nature, so it slipped down and directly hit the mine and caused the accident. So this was an unpreventable accident in nature, but as it seems from the location and severity of injuries, the visor was not used properly during the operation. Although he got some injuries on his face and shoulders, but the victim deminer was finally evacuated to Pakistan for the treatment of his eyes injuries.

CONCLUSIONS:

The investigation team concluded that the poor supervision and carelessness of victim deminer are the main factors for this accident and eye injuries. As it seems the visor was not used properly by the deminer during the operations, but he was permitted to continue operation without being controlled by the command group of MDG-09.

RECOMMENDATIONS:

The following points are to be considered:

- Inappropriate use of visor resulted in severe injuries to the eyes and face of involved de-miner, therefore all the command group are strongly recommended to reinforce their focus to this point and never allow their de-miners to use the PPE inappropriately.
- Working in such complicated areas requires strict control of command group, especially the section leaders should pay more attention and control their deminers and stop them when working in contrary to standards.
- [Demining group] operations department is recommended to develop a plan for the improvement of supervision, command and control in their teams.

Feedback on any preventive and constructive actions taken by [Demining group] is required to be submitted to the MACCA office by no later than 7 days, effective to the issue date of this letter.

Victim Report

Victim number:	910	**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:**	Not recorded

Summary of injuries:

INJURIES: minor Shoulders; severe Eyes; severe Face

COMMENT: No Medical report was made available.

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the Victim was working with his visor raised (or removed) and his error was not corrected. The investigators recognised the lack of control and urged the group's management to improve command and control, so the secondary cause is listed as a *Management Control Inadequacy*.

Because the Victim also has "shoulder injuries", it is not clear whether he was wearing any body protection. The absence of hand injuries implies that the Victim did not detonate the mine with a hand-tool so the rocks slipping in front of him may have been the real cause of the detonation.

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, so ignoring the requirements of the IMAS. It is noteworthy that the Afghan national staff have been more responsible than the internationals with overall responsibility.