DDAS Accident Report

Accident details

Report date:	08/07/2011	**Accident number:**	723
Accident time:	11:07	**Accident Date:**	21/07/2007
Where it occurred:	Task: AF/1208/12494/MF0009, Datshte Chinar Village, Rostaq District, Takhir Province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Management/control inadequacy (?)
Class:	Excavation accident	**Date of main report:**	08/08/2007
ID original source:	OPS/ 03/ 01 - 45	**Name of source:**	UNMACCA
Organisation:	[Name removed]		
Mine/device:	PMN-2 AP blast	**Ground condition:**	rocks/stones
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

use of pick (?)

use of shovel (?)

inadequate training (?)

inadequate equipment (?)

inadequate investigation (?)

visor not worn or worn raised (?)

protective equipment not worn (?)

squatting/kneeling to excavate (?)

handtool may have increased injury (?)

Accident report

The only report of this accident that has been made available to date was in 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.

File: OPS/ 03/ 01 - 45

To: See distribution list below [List removed]

From: [Name removed]

Date: 8 August 2007

Subject: Investigation Report and Lessons Learned – [Demining group] Demining Accident

Reference:

Please find attached the Investigation Report and Lessons Learned from the demining accident involving [Demining group] Demining Team 01 that occurred at Datshte Chinar Village, Takhir Province on 21 July 2007.

Regards, [Name removed, Chief of Operations

United Nations Mine Action Centre for Afghanistan, Kabul, AFGHANISTAN

Lessons learned from [Demining group] demining accident on 21 July 2007

INTRODUCTION

An internal investigation team was convened by the Area Manager of AMAC North East (Kunduz) into the demining accident involving [the Victim] a deminer from [Demining group] Demining Team 01. The accident occurred at 11.07 hours on 21 July 2007 at Task: AF/1208/12494/MF0009 located near to Dashti Chinar Village, in Rostaq District of Takhar Province. The accident resulted in face, eye, hand and chest injuries to the deminer and destroyed his helmet and PPE.

SUMMARY OF EVENTS

The demining task site was located on a hillside in rocky terrain that was heavily contaminated by Anti-Personnel mines (AP mines). Over the period of the clearance operation Demining Teams had located and destroyed 59 x PMN-2 Russian AP mines and 2 x UXO. Just prior to the accident the deminer was performing excavation drills using a folding shovel and pick and requested to take a break as he was bored, which was granted.

Demining team management claim the deminer was injured when he laid his helmet and PPE down onto a mine, which was in an un-cleared area, as he was moving back to take a break from his work. The Section Leader who had previously been observing him work was moving to observe another party when the accident occurred.

The casualty was first evacuated to Rustaq Hospital, Kunduz and then moved to the German PRT Hospital in Kunduz for further treatment.

CONCLUSIONS

The investigation team made the following conclusions regarding the accident;

- The accident site had not been preserved intact as is required in AMAS.
- The injuries received by the deminer were not conducive to him wearing his helmet and PPE at the time of the accident as is required when ever inside a hazard area.
- There was no evidence of the helmet and PPE having been destroyed at the scene of the deminers work place. There was however evidence that indicated the helmet and PPE may have been destroyed approximately 7 metres away from the scene of the accident in a previously cleared area.
- There was a 250 gram discrepancy in the total usage of explosive recorded in the teams Explosive Records and physically in the explosive store.
- There was a 50 km discrepancy between the team's vehicle odometer and its log book.
- Local villagers confirmed some demining team members returned to the clearance site after normal working hours.
- The Team and Section Leader display very poor management, supervision and command and control of the work performed by its team.

RECOMMENDATIONS

The following recommendations shall occur;

- All IPs are to be reminded of their responsibility to take immediate photographs of a demining incident sites, and then preserve the site intact until it is inspected and released by the investigation team. This means nothing should be tampered with or removed!
- All staff are to be reminded that PPE shall be worn at ALL times once moving into the hazard area after leaving the administration area.
- The Team and Section Leader of [Demining group] DT 01 shall be demoted immediately to Section Leader and Deminer respectively and re-employed into other teams.
- Accreditation for [Demining group] DT 01 is to remain suspended until such time as a new Team and Section Leader has been found and the new team has undergone refresher training to be observed by QA Staff from AMAC North East and new accreditation is issued.
- The Area Manager of AMAC North East shall provide a detailed program of revision subjects for the [Demining group] DT 01 to achieve prior to it undertaking accreditation. This program is to include specific benchmarks and timelines so as not to delay the team's return to work when all standards have been met.

Victim Report

Victim number: 914 **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 **Protection used:** None

Long visor

Summary of injuries:

INJURIES: severe Chest; severe Eye; severe Face; severe Hand

COMMENT: No Medical report was made available.

Analysis

The activity at the time of the accident is inferred from the injury range and the attempt by the field managers to conceal the truth about the activity at the time of the accident.

The primary cause of this accident is listed as a *Field Control Inadequacy* because the investigators found that the Victim was not wearing his visor at the time. Chest injuries also imply that he was not wearing his body protection. The secondary cause is listed as a *Management Control Inadequacy* because the investigators found that the group's managers had sought to conceal the real circumstances of the accident after the event. The suspension of the group's accreditation implies that this was not in any doubt.

Inadequate training is listed under Notes because the investigators determined that retraining was necessary – it is notable that this was also necessary for the supervisors.

The use of a pick-axe and shovel to excavate are the *Inadequate equipment* listed under Notes.

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 in contravention of the requirements of the IMAS. That said, the *Lessons Learned* summary implies that a comprehensive and objective investigation was conducted, for which those responsible should be applauded.