

DDAS Accident Report

Accident details

Report date: 11/07/2011	Accident number: 744
Accident time: 09:20	Accident Date: 11/05/2009
Where it occurred: AF/0107/00006, HT-1736, Deh Yaqoob Village, Tapa-e-Bamboori, Shakardara District, Kabul Province	Country: Afghanistan
Primary cause: Management/control inadequacy (?)	Secondary cause: Field control inadequacy (?)
Class: Excavation accident	Date of main report: 22/06/2009
ID original source: None	Name of source: UNMACCA
Organisation: [Name removed]	
Mine/device: PMN-2 AP blast	Ground condition: not recorded
Date record created:	Date last modified: 11/07/2011
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 (?)
inadequate training (?)
visor not worn or worn raised (?)
squatting/kneeling to excavate (?)

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.

File date: 22nd June 2009

LESSONS LEARNED SUMMARY OF [Demining group] EOD-06 DEMINING ACCIDENT

INTRODUCTION:

An investigation team was convened by AMAC Central to investigate the de-mining accident involving [the Victim] the De-miner from [Demining group] EOD-06. The accident occurred at 9:20 hours on 11 May 2009 at minefield number AF/0107/00006/HT-1736, located in Deh Yaqoob village in Tapa-e-Bamboori, Shakardara district of Kabul province.

SUMMARY:

Minefield # AF/0107/00006/HT-1736 is an anti-personnel contaminated site which was surveyed by [Other demining group] on May 2007 under the community # HQ 1300 SHA -01. This area was mined by Russian backed government during the year 1985 and then during internal war in year 1998. This site was a military post and around 11 accidents happened there 9 on human killed 8 and injured 1 and 2 accident on animal.

On 04 April 2009, [Demining group] EOD-01 and 04 started de-mining operation in mentioned MF and then on 04 May 2009 the task has been handed over to [Demining group] EOD-06 and 07. Size of the MF is 4200 sqm and around 514 sqm area has been cleared, not any mine or UXO were discovered/destroyed by the team till the accident happened.

On 11 May 2009 at 09:20 the de-miner [the Victim] was excavating a detected signal in his clearance lane, he stroked the top of a PMN2 mine with his bayonet and the accident happened. As the ground profile is uneven and the accident occurred in an area where the extra soil is brought by seasonal floods and the depth of mine was around 25cm. The deminer failed to go deeper as per procedure and discover the mine properly, so he stroked the mine and caused the accident. According to the investigation report and the pictures of victim deminer the visor was not used properly, but it was kept up during excavation drill. As a result of accident he got injuries on his right eye, face and right ear, he has also got some injuries on his right arm.

CONCLUSIONS:

However the carelessness of deminer and poor supervision are the causes of accident, but the root cause of this accident is going a step back to management level and it is described as below:

- This small size area was started by 2 EOD teams, but their activities have not been measured; it proves inadequate management of the operation.
- The first 2 EOD teams handed over the site to another 2 EOD teams, but without any record and documentation or marking in the site
- The first 2 EOD teams cleared an area of 200 sqm in almost 23 days, but nobody from [Demining group] operations have monitored team's performance during the mentioned period as proper as required.
- There was lack of documentation at all e.g. site clearance plan, minefield report, free hand sketch map, visitor log, daily operations report and any other relevant report with the team.

- There is not any record of internal QA were available with team nor team was visited by operations within the mentioned period.
- As there was lack of documentation at all, the cleared portion of area by previous team was re-cleared by existing 2 EOD teams.
- Both EOD teams need revision course in manual clearance methodology, which has not considered and this was the first manual clearance drill for EOD team since 1998.

All above listed points are non conformity in some cases as major to the [Demining group] operational procedure; consequently they are making the contributing factors to this accident.

RECOMMENDATIONS:

The following points are to be considered:

- The operations and QA department of [Demining group] are recommended to strongly consider the points mentioned in conclusion.
- AMAC Kabul is recommended to prepare a comprehensive QA plan and conduct the QA accordingly.
- Any shortfalls should be covered and reported on the time for immediate remedial action.
- Feedback on any preventive and constrictive 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: 935	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: Frontal apron

Summary of injuries:

INJURIES: minor Arm; severe Eye; severe Face

COMMENT: No Medical report was made available. "he got injuries on his right eye, face and right ear, he has also got some injuries on his right arm".

Analysis

The primary cause of this accident is listed as a *Management Control Inadequacy* because the investigators found that there were significant management failings at the site, including a failing to record the cleared area and to monitor activities. The secondary cause is listed as a *Field Control Inadequacy* because the Victim was working with his visor raised and his error was not corrected. The investigators finding that retraining was necessary was also a significant *Management Control Inadequacy*.

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 those internationals who presume greater responsibility.