DDAS Accident Report

Accident details

Report date:	15/07/2011	**Accident number:**	754
Accident time:	10:00	**Accident Date:**	07/05/2009
Where it occurred:	AF/13/1301/12978, MF-5284, Wali Khail village, Baghlan District, Baghlan Province	**Country:**	Afghanistan
Primary cause:	Inadequate equipment (?)	**Secondary cause:**	Management/control inadequacy (?)
Class:	Excavation accident	**Date of main report:**	28/05/2009
ID original source:	None	**Name of source:**	UNMACCA
Organisation:	[Name removed]		
Mine/device:	AP blast (unrecorded)	**Ground condition:**	not recorded
Date record created:		**Date last modified:**	15/07/2011
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 detector pinpointing

use of pick (?)

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 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: 28th May 2009

LESSONS LEARNED SUMMARY OF [Demining group] MDG-17 DEMINING ACCIDENT

INTRODUCTION:

An investigation team was convened by AMAC Kunduz to investigate the demining accident involving [the Victim] the De-miner from [Demining group] MDG-17. The accident occurred at 10:00 hours on 07 May 2009 at minefield number AF/13/1301/12978/MF-5284, located in Wali Khail village, Baghlan district of Baghlan province.

SUMMARY:

Minefield # AF/13/1301/12978/MF-5284 is located in an area which was front line between different belligerent groups (northern Alliance and Sayed Kayan forces) during the year 1999 to 2001. From the military point of view this area was important to the involved parties of the war, therefore, was exchanged between them for several times and each time they laid AP mines there to stop the attacks of opposition. So far 7 accidents happened there on human including 3 were fatal accidents.

On 01st of April 2009 the [Demining group] MDG-17 was tasked to start clearance operation in mentioned area. The area was divided to 2 tasks by polygon survey team of [Other demining group]. The size of task under [Demining group] operations is about 61000 sqm. Around 37700 sqm of the total size was cleared by MDG-17 till the accident time, they found/destroyed 34 AP mines.

On 07th of May at 10:00 hours the de-miner [the Victim] was working in his clearance lane excavating a detected signal by unsuitable excavation tool (Pick). He hit the top of mine with a pick and caused it to go off. According to the investigation report the signal was not pinpointed correctly and the de-miner has used his pick carelessly. As a result he sustained multiple superficial injuries on his eyes, chest, Face, and both hands, the injured parts of the deminer body and his PPE clearly indicate that he had not used his PPE during operation. Because there is no any damage on his PPE to show that it was used properly.

CONCLUSIONS:

However the investigation report concluded that the deminer was careless during operation and poor supervision has also had its role in this accident. But this is not the first case of using picks by [Demining group] teams. There are Non-conformity reports on [Demining group] teams for using picks during investigation of signals. And also there is another accident of the same nature in 2008. The NCRs and lessons learned reports were shared with [Demining group] but no action is taken so far.

RECOMMENDATIONS:

The following points are to be considered:

- Standard and appropriate tools of prodding and excavation should be used during operations.
- The de-miner should pinpoint the signal properly, mark and then start excavation according to the set procedure.
- Full PPE must be worn correctly during operations on a hazard area. There is no exception to the involved personnel.
- The command group should strengthen their supervision during operation and stop the de-miners from conducting drills in contrary to SOPs.
- [Demining group] operations department is to take this issue serious and come up with practical solution to it.

Victim Report

Victim number:	944	**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:**	None

Summary of injuries:

INJURIES: minor Chest; minor Eyes; minor Face; minor Hands

COMMENT: No Medical report was made available. ". . multiple superficial injuries on his eyes, chest, Face, and both hands".

Analysis

The primary cause of this accident is listed as *Inadequate equipment* because the investigators found that the Pick-axe was inappropriate and was being used in defiance of earlier instructions. The secondary cause is listed as a *Management Control Inadequacy* because the group's management has the responsibility for the issue of appropriate tools and training. The Victim's failure to pinpoint the Ceia detector reading appropriately implies a failure of training or equipment (or both).

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.