

DDAS Accident Report

Accident details

Report date: 15/07/2011	Accident number: 763
Accident time: 10:15	Accident Date: 05/07/2010
Where it occurred: Task # AF/3203/07956, MF 0034, Gusha village, Tani district, Khost Province	Country: Afghanistan
Primary cause: Field control inadequacy (?)	Secondary cause: Inadequate training (?)
Class: Other	Date of main report: None
ID original source: None	Name of source: UNMACCA
Organisation: [Name removed] CBDT	
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 equipment (?)
inadequate training (?)
protective equipment not worn (?)
visor not worn or worn raised (?)
inadequate investigation (?)

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] CBDT-47 DEMINING ACCIDENT

INTRODUCTION:

Investigation teams were convened by AMAC Gardez and [Demining group] to investigate the demining accident involving [the Victim] the deminer of [Demining group] CBDT-47. The accident occurred at 10:15 hours, 05 July 2010 in Task # AF/3203/07956/MF 0034 located in Gusha village, Tani district of Khost province. As Tani district is out of access area to MACCA HQ staff, so it was decided that the accident should be investigated internally by MCPA and externally by AMAC Gardez.

SUMMARY:

Task # AF/3203/07956/MF 0034 is located in a mountainous area contaminated with anti-personnel mines planted by Russian forces. Mine clearance operations in Tani district started by [Demining group] as a community based approach local people are engaged in this operation. Community based demining team # 47 (CBDT-47) established in 03-April-2010, and their DC course was completed on 19-April-2010. On 24-May-2010 CDBT-47 started mine clearance operations in mentioned task of Tani project.

According to the investigation reports, the accident occurred on 05 July at 10:00 during the break time of the team. The deminer [the Victim] left his clearance lane after the break started, and walked ahead around 100 meters towards the mountain top, where the boundary lane of Task # 0033 was located. He was carrying a saw and wanted to cut a shovel or axe handle there from the trees. But the area was mined and he knew about that. Around one metre away from the boundary lane of MF 0033, he started to cut a shovel or axe handle, but stepped on a mine and caused it to explode and cut his foot from the ankle joint. This explosion threw the deminer around one meter away on the other mine, the second mine also exploded and caused severe injuries to the hip joint and abdomen of deminer, so he lost his life in the spot. The deminer had left his PPE and visor in his clearance lane and without informing the command group he left his clearance lane and entered into hazard area.

CONCLUSIONS:

Lack of discipline and poor command and control are the main contributing factors to this accident. However the carelessness of deminer and lack of experience can also be counted as contributing factors to this accident.

RECOMMENDATIONS:

The following points are to be considered:

- Experienced command groups are required for community based projects, as the deminers are hired from the community without having demining experience, therefore, [Demining group] is recommended to take necessary action in order to strengthen the command and control in their community based projects.
- A strong discipline should be emplaced in all community based projects as this is the second accident in mine action organizations of the same scenario.
- [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 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: 949	Name: [Name removed]
Age:	Gender: Male
Status: deminer	Fit for work: DECEASED
Compensation: Not made available	Time to hospital: Not made available
Protection issued: Frontal apron Long visor	Protection used: Not recorded

Summary of injuries:

INJURIES: severe Abdomen; severe Leg

AMPUTATION/LOSS: Leg Below knee

FATAL

COMMENT: No Medical report was made available. "he lost his life in the spot".

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the investigators identified that as the main cause. The secondary cause is listed as *Inadequate training* because it seems that the Victim deliberately entered a mined area to cut a pick-axe handle and so cannot have understood the risks he was taking.

The "Inadequate equipment" listed under Notes refers to the Victim's need for a pick-axe handle. It seems likely that he was trying to repair his tools so that he could work efficiently when he entered the uncleared area. The issue of a pick axe and/or shovel is another issue.

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, ignoring the requirements of the IMAS. National staff have been more responsible than the internationals with overall responsibility.