DDAS Accident Report

Accident details

Report date:	19/07/2011	**Accident number:**	770
Accident time:	09:00	**Accident Date:**	30/11/2008
Where it occurred:	AF/0809/00954, MF0052, Kohna Deh Village, Kuz Kunar District, Nangarhar Province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Management/control inadequacy (?)
Class:	Excavation accident	**Date of main report:**	None
ID original source:	(50)	**Name of source:**	UNMACCA
Organisation:	[Name removed]		
Mine/device:	AP blast (unrecorded)	**Ground condition:**	not recorded
Date record created:		**Date last modified:**	19/07/2011
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

inadequate training (?)

non injurious accident (?)

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] DT- 18 DEMINING ACCIDENT

INTRODUCTION:

An investigation team was convened by AMAC East to investigate the demining accident involving [the Victim] the De-miner from [Demining group] DT-18. The accident occurred at 9:00 AM on 30 December 2008 at minefield number AF/0809/00954/MF0052, located in Kohna Deh village, Kuz Kunar district of Nangarhar province.

SUMMARY:

AF/0809/00954/MF0052 is located in a mined area contaminated by Russian forces and their successor government in order to block the attacks of their opposition on Kuz Kunar district headquarter and security positions around it. [Demining group] DT–18 started clearance operation in said area on 18 November 2008, during the period of operation they cleared 28368m2 area and found/destroyed 3 AP mines and 132 different types of UXO. On 30 December 2008 deminer de- miner [the Victim] was busy in excavation of a detected signal in his clearance lane, his scraper touched on the top of a mine and caused it to explode. It seems from investigation report that the deminer has started to excavate a detected signal in his clearance lane, but not succeeded in first attempt, he got a louder signal again in the same point and then started excavation directly from the top of the signal, therefore, his scraper touched the top of mine and the accident occurred. As the deminer was fully dressed with PPE and his visor was in down position, therefore, he remained safe, without any injuries to his body. He only got some dust in his eyes.

CONCLUSIONS:

The investigation team concluded that the contributing factors to this accident were Carelessness of de-miner in terms of started excavation direct from the top of detected signal and poor command and control. As the command group failed to stop him from wrong drills and also he was not provided with proper information regarding the task.

RECOMMENDATIONS:

The following points are to be considered:

- The de-miners should pinpoint the signal properly, mark it and then to start excavation according to the procedure.
- The de-miners should not hurry up during the excavation and be careful and not to use the scraper forcefully and carelessly.
- The team should undergo a refresher training focussing on prodding/excavation drill. The responsibilities of command group should also be covered in the training.

Victim Report

Victim number:	956	**Name:**	[Name removed]
Age:		**Gender:**	Male
Status:	deminer	**Fit for work:**	yes
Compensation:	Not made available	**Time to hospital:**	Not made available
Protection issued:	Frontal apron Long visor	**Protection used:**	Frontal apron; Long visor

Summary of injuries:

COMMENT: No Medical report was made available. The Victim "got some dust in his eyes".

Analysis

The primary cause of this accident is listed as *a Field Control Inadequacy* because the investigators found that the Victim was working incorrectly and his errors were uncorrected. The secondary cause is listed as a *Management Control Inadequacy* because the investigators found that the Victim was not given the correct information about the task, and this is a management responsibility. Because the investigators recommended improved training, a cause may have been *Inadequate training*, which would also be a *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.