

DDAS Accident Report

Accident details

Report date: 19/07/2011	Accident number: 773
Accident time: 09:05	Accident Date: 25/08/2007
Where it occurred: AF/0102/00347, MF0056, Chinar Village, Dehsabz District of Kabul Province	Country: Afghanistan
Primary cause: Field control inadequacy (?)	Secondary cause: Inadequate training (?)
Class: Excavation accident	Date of main report: None
ID original source: (26)	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 training (?)
Inadequate detector pinpointing
visor not worn or worn raised (?)

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 ACCIDENT OCCURRED ON [Demining group] DT- 01 ON 25 AUGUST 2007

INTRODUCTION:

An investigation team by the Area Manager of AMAC Centre (Kabul) and a BOI by the Chief of Operations were convened to investigate the demining accident involving [the Victim] a deminer from [Demining group] DT- 01. The accident occurred at 09:05 hours on 25 August 2007 at task # AF/0102/00347, MF0056 located in Chinar village, Dehsabz district of Kabul province.

SUMMARY:

The mentioned task is part of SHA # 4 of impacted community #1079 which is contaminated by AP mines. The clearance of the task was started by [Demining group] DT-01 on 7 July 2007. On 25 August 2007 at 0905 hrs while [the Victim] a deminer of Party-01, Section-1 of the mentioned team was working in his clearance lane on a detected signal his bayonet stroke on top of an anti personnel PMN-2 mine; as a result the mine exploded and since helmet was not on his head, the victim deminer lost one eye, sustained serious injuries to other eye and some injuries to his face and hand with active bleeding.

The casualty was first shifted to Eye Hospital, and after 20 minutes delay he was shifted to Emergency Hospital. After 30 minutes as per requirement he was shifted again to the Eyes Hospital, and as per recommendations of the doctors that there is possibility of losing his other eye, the casualty was shifted to Peshawar of Pakistan for more treatments.

CONCLUSIONS:

The following points were found by investigation team:

- The loss of deminer's one eye, serious injuries on face and other eye; also not being any sign of explosion on the visor of the victim deminer reveal that helmet was not on his head, and that is why he sustained such serious injuries and loss of one eye.
- Excavation drill was not practiced in accordance with SOP because the deminer without considering excavation safety distance and excavation depth has worked directly on centre of the located signal which shows lack of proper training for the team.
- Team leader and relevant section leader has failed to notify the deminer to wear the visor, and not to practice such wrong excavation drill which shows lack of command and control in the team.
- The team leader and relevant section leader claim that as a result of explosion the victim Deminer's bayonet has been thrown away and has been missed, so the investigation team could not see the bayonet to find and see any sign of explosion on it. So they are not sure whether the victim deminer was using the bayonet or another tool for excavation of the reading.
- The accident occurred at 09:05 am and the AMAC investigation team reached to the site at the same day at 10:45 am, but team all members had already left the site and hand tools of the victim deminer were also shifted from accident site to the team base camp.

RECOMMENDATIONS:

The following points are to be considered:

- Refresher training, focusing on excavation drills, is recommended to be conducted for the team.
- The team command group has to strictly control the deminers to be dressed with PPE and their visors.
- Command group should strictly control the deminers, do not permit practicing incorrect drill, and ensure that they are working in accordance with set procedures and NGO SOP.
- [Demining group] field supervisor and OPS Officer are recommended to visit the teams' worksites more frequently in order to identify operational failures in site and avoid their occurrence in future.
- The team command group must not disturb the accident point, not to remove the accident involved equipment from site and remain at site till arrival of investigation team to the site.
- As [Demining group] management did not take any disciplinary action on the previous demining accident which took place with the same team. So it is recommended that the command group of the team should be immediately demoted and qualified replacements should be appointed for the team.

Victim Report

Victim number: 959	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: severe Eye; severe Face; severe Hand

AMPUTATION/LOSS: Eye

COMMENT: No Medical report was made available. ". . . the victim deminer lost one eye, sustained serious injuries to other eye and some injuries to his face and hand with active bleeding".

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the investigators found that the field controllers had failed to correct the Victim's errors and had removed evidence of the accident before the investigation, possibly to conceal the tool that was in use at the time.

The secondary cause is listed as *Inadequate training* because the investigators found that the deminers needed training in safe excavation drills as they appear in the demining group's SOPs. Failure to provide effective training is 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 over sharing data than those internationals who presume greater responsibility.