

DDAS Accident Report

Accident details

Report date: 19/07/2011	Accident number: 777
Accident time: 08:10	Accident Date: 31/07/2007
Where it occurred: AF/1303/13206, MF0002, Chashma Jungan Village, Dahnai Ghori District, Baghlan Province	Country: Afghanistan
Primary cause: Inadequate training (?)	Secondary cause: Management/control inadequacy (?)
Class: Excavation accident	Date of main report: None
ID original source: (23)	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
squatting/kneeling to excavate (?)
use of pick (?)
visor not worn or worn raised (?)
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.

LESSONS LEARNED SUMMARY OF DEMINING ACCIDENT OCCURRED ON [Demining group] - 08 ON 31 JULY, 2007

INTRODUCTION:

An investigation team was convened by the Area Manager of AMAC Northeast (Kundoz) to investigate the demining accident involving [the Victim] a deminer from [Demining group]- 08. The accident occurred at 08:10 hours on 23 July 2007 at task # AF/1303/13206/ MF0002 located in Chashma Jungan village, Dahnai Ghori district of Baghlan province. The accident resulted injuries to both hands of the victim deminer.

SUMMARY:

The mentioned task is part of SHA #4of impacted community#1001 which is contaminated by AP mines. More than 10 accidents have happened in this area on locals. [Demining group] team number 8 was busy working in the mentioned task. In one of the lane where [the Victim] deminer was excavating the ground to locate a signal made by its detector, suddenly an explosion happened and caused both hands injuries to him. As the deminer had worn the PPE and Helmet with visor down, he did not receive more injuries to other parts of his body. After receiving first aid the casualty was carried to Puli khomri public hospital for more treatment.

CONCLUSIONS:

The following points were found by investigation team:

- Poor command and control was dominated during the operation of the team, because the deminer was working by pick with his visor up, but the command group of the team failed to avoid him of doing such wrong practice.
- According to team leader brief the team was working based on new concept of operation, but they did not know what the new concept of operation is.
- The report of LIS and the task order information clearly mention that the area is contaminated by both AT and AP mine but the deminers of the team were not briefed by team leader that which type of mine is expected in the task.
- It is the second accident happened in this team since 13 February 2007 that clearly shows lack of training and weak command and control of the command group.

RECOMMENDATIONS:

The following points are to be considered:

- Retraining of the team is recommended with focusing on the proper excavation drill, and the training is to be monitored by relevant AMAC.
- The command group of the team is to enhance their control on deminers and avoid them of using wrong tools and ignorance of standards.

- The command group of the team must read completely and thoroughly all the documents given by AMAC and make sure themselves of any misunderstanding, then start their work based on a proper clearance plan.
- The relevant supervisor/field officer should advise the command group of the teams to brief their team members about the key information of the task and operation, prior to commencement of actual daily operation.
- A special training is to be conducted for command group of the team with focusing on better control and manage of team activities as well as new concept of operation.

Victim Report

Victim number: 963	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; Long visor

Summary of injuries:

INJURIES: severe Hands

COMMENT: No Medical report was made available. ". . . injuries to both hands".

Analysis

The primary cause of this accident is listed as *Inadequate training* because the investigators recommend that retraining of deminers and field supervisors was required. The secondary cause is listed as a *Management Control Inadequacy* because failure to have provided effective training and essential information about the task and the procedures to be used to conduct it were significant management failings.

There is an apparent contradiction in the summary which reports that the Victim wore his PPE and this limited his injuries, but also that the Visor was worn raised.

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.