DDAS Accident Report

Accident details

Report date:	19/07/2011	**Accident number:**	781
Accident time:	10:45	**Accident Date:**	20/01/2009
Where it occurred:	AF/0112/0042, MF 0340, Shirin Village, Surobi District, Kabul Province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Management/control inadequacy (?)
Class:	Excavation accident	**Date of main report:**	17/02/2009
ID original source:	None	**Name of source:**	UNMACCA
Organisation:	[Name removed]		
Mine/device:	PMN AP blast	**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 (?)

visor not worn or worn raised (?)

Inadequate detector pinpointing

protective equipment not worn (?)

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: 17th Feb 2009

LESSONS LEARNED SUMMARY OF [Demining group] DT- 26 DMINING ACCIDENT

INTRODUCTION:

An investigation team was convened by AMAC Centre to investigate the demining accident involving [the Victim] the De-miner from [Demining group] DT- 26. The accident occurred at 10:45 hours on 20 January 2009 at minefield number AF/0112/0042/MF 0340, located in Shirin village, Surobi district of Kabul province.

SUMMARY:

AF/0112/0042/MF 0340 is located alongside the Kabul-Jalalabad highway, near to Surobi Power station. The area was mined during 1981-1989 by Russian troops and their successor government in order to keep their convoys safe from the attacks of Mujahedeen during their travelling from mentioned highway. This area was surveyed by LIS under the community No-1201, SHA -02 and then was polygoned by LIAT during 2008. Several mine accidents occurred in the area on human and animals during the past years.

[Demining group] DT-26 was tasked to start clearance operation on 21 December 2008. During the period of operations they cleared 17490m2 area and found/destroyed 17 AP mines and 738 different types of ERW.

On 20 January 2009 while de-miner [the Victim] was working in his clearance lane excavating a detected signal, his bayonet stroked the top of a PMN mine and caused it to explode. According to the investigation report the de-miner has not maintained and considered the default clearance depth during the excavation and used his bayonet carelessly, therefore, caused the accident. Unfortunately the victim was not fully dressed with PPE and his visor was up during the accident. Thus he has got several injuries on his face, legs and different parts of his body.

CONCLUSIONS:

The investigation team concluded that the contributing factors to this accident were: poor command and control in the team and Carelessness of de-miner, as he has started operation directly on the top of mine and not used his PPE properly.

RECOMMENDATIONS:

The following points are to be considered:

- Full PPE must be worn correctly at all times in a hazard area while the operation is going on.
- The de-miners should pinpoint the signal properly, mark the point and then to start excavation according to the SOPs.
- The de-miners should not hurry up during operations and be careful during excavation drill and do not use the bayonet forcefully.
- The command group should strengthen their supervision during operation and stop the deminers from conducting drills in contrary to SOPs.
- The team should undergo refresher training with focus on prodding and excavation drill plus team command and control.

- The IPs are recommended to timely inform the AMACs of accident occurring and do not disturb the accident area until arrival of internal and external investigation teams.

Victim Report

Victim number:	967	**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 Body; severe Eyes; severe Face; severe Legs

COMMENT: No Medical report was made available. "…injuries on his face, legs and different parts of his body".

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the Victim was working with his visor raised (and perhaps without frontal body protection) and was excavating on top of the mine, but these errors were not corrected. The secondary cause is listed as a Management Control Inadequacy because the investigators found that the group's management should "strengthen their supervision during operation". Failure to provide effective training is a further significant *Management Control Inadequacy*.

The investigators do not record whether the Victim suffered eye injury, but this is considered highly likely and so is recorded.

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.