

# DDAS Accident Report

## Accident details

<b>Report date:</b> 19/07/2011	<b>Accident number:</b> 785
<b>Accident time:</b> 11:05	<b>Accident Date:</b> 10/12/2007
<b>Where it occurred:</b> AF/0105/01632, MF018, Barikab Village, Qarabagh District, Kabul Province	<b>Country:</b> Afghanistan
<b>Primary cause:</b> Field control inadequacy (?)	<b>Secondary cause:</b> Inadequate training (?)
<b>Class:</b> Excavation accident	<b>Date of main report:</b> None
<b>ID original source:</b> (40)	<b>Name of source:</b> UNMACCA
<b>Organisation:</b> [Name removed]	
<b>Mine/device:</b> YM-1 AP blast	<b>Ground condition:</b> not recorded
<b>Date record created:</b>	<b>Date last modified:</b> 19/07/2011
<b>No of victims:</b> 1	<b>No of documents:</b> 1

## Map details

<b>Longitude:</b>	<b>Latitude:</b>
<b>Alt. coord. system:</b> Not recorded	<b>Coordinates fixed by:</b>
<b>Map east:</b>	<b>Map north:</b>
<b>Map scale:</b>	<b>Map series:</b>
<b>Map edition:</b>	<b>Map sheet:</b>
<b>Map name:</b>	

## Accident Notes

inadequate investigation (?)  
use of pick (?)  
Inadequate detector pinpointing  
handtool may have increased injury (?)  
squatting/kneeling to excavate (?)  
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 involving [Demining group] DT# 12 ON 10 DECEMBER 2007**

### **INTRODUCTION:**

An investigation team was convened by Area Manager of AMAC Centre (Kabul) to investigate the demining accident involving [the Victim] a deminer from [Demining group] DT # 12. The accident occurred at 11:05 hours on 13 [sic] December 2007 at task # AF/0105/01632/MF018 located in Barikab Village, Qarabagh District of Kabul Province.

### **SUMMARY:**

Task # AF/0105/01632/MF018 is located at the east side of Bagram new road which have been recorded by LIAT as SHA#1 of newly identified IS# CA 15. During the year 1998 to 2001 the area was a front line between northern alliance and the Taliban, and mines have been planted by both parties. The area is a high priority task because a new township will be constructed in the area for the returnees. [Demining group] DT#12 was tasked to conduct mine clearance operation of the mentioned area.

On 13/12/2007 at 11:05hrs a demining accident happened on a deminer named [the Victim] as he was working on a detected signal using a pick; suddenly his pick hit top of an YM1 Iranian AP mine and caused it to explode. As a result of the explosion the victim deminer got injuries to his face, eyes and fingers of his right hand.

During the accident the deminer had his apron on, but the visor of his helmet was up or may did not wear the helmet at all, and that is why he got injuries to his face and eyes.

Medical first aid was applied to the deminer by team medic at the site and then the casualty was evacuated to Charikar hospital for treatments.

### **CONCLUSIONS:**

The investigation team found the followings:

- The deminer failed to identify the centre of the single while detecting the ground using mine detector.
- The deminer was working carelessly as he was working with the pick and stroke top of the mine which is an inappropriate practice.
- Working of deminer with his visor up or not wearing the helmet reveals poor command and control of relevant section leader as he failed to prevent the deminer of doing such safety breach, as the investigation team did not find any sign of explosion effect on the helmet of the deminer, so there is much possibility that the deminer did not had the helmet on his head.

### **RECOMMENDATIONS:**

The following points are to be considered:

- Refresher training with much focus on detecting of the signal and excavation drill for the team and special training for command group focusing on better controlling of team activities and quality check of deminer out put is recommended.
- The internal quality control is to be reinforced by relevant organization to make sure the teams are working according to approved procedure.
- All team command groups are to strictly control the team operation and make sure the deminers are well dressed with PPE.

## Victim Report

<b>Victim number:</b> 971	<b>Name:</b> [Name removed]
<b>Age:</b>	<b>Gender:</b> Male
<b>Status:</b> deminer	<b>Fit for work:</b> not known
<b>Compensation:</b> Not made available	<b>Time to hospital:</b> Not made available
<b>Protection issued:</b> Frontal apron Long visor	<b>Protection used:</b> Frontal apron

### Summary of injuries:

INJURIES: severe Eyes; severe Face; severe Hand

COMMENT: No Medical report was made available. ". . . got injuries to his face, eyes and fingers of his right hand".

### Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the victim was working with his visor raised (or removed) and with an inappropriate tool and his errors were not corrected. The secondary cause is listed as *Inadequate training* because the investigators found that training in metal-detector pinpointing and safe excavation was required.

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.