

# DDAS Accident Report

## Accident details

<b>Report date:</b> 22/07/2011	<b>Accident number:</b> 787
<b>Accident time:</b> 09:25	<b>Accident Date:</b> 09/09/2007
<b>Where it occurred:</b> AF/0308/01637, MF0154, Gojur khel Village, Bagram District, Parwan Province	<b>Country:</b> Afghanistan
<b>Primary cause:</b> Field control inadequacy (?)	<b>Secondary cause:</b> Field control inadequacy (?)
<b>Class:</b> Missed-mine accident	<b>Date of main report:</b> None
<b>ID original source:</b> (29)	<b>Name of source:</b> UNMACCA
<b>Organisation:</b> [Name removed]	
<b>Mine/device:</b> PTAB submunition	<b>Ground condition:</b> not recorded
<b>Date record created:</b>	<b>Date last modified:</b> 22/07/2011
<b>No of victims:</b> 2	<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 (?)  
inadequate training (?)  
mechanical follow-up (?)  
visor not worn or worn raised (?)  
safety distances ignored (?)

## 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 ATC ON SEPTEMBER 09, 2007**

### **INTRODUCTION:**

An investigation team was convened by the Area Manager of AMAC Central (Kabul) to investigate the demining accident involving [Victim No.1] and [Victim No.2] deminers from ATC Good Neighbourhood Project, DT- 31. The accident occurred on 09 September 2007 at 09:25 hours in task # AF/0308/01637/MF0154 located in Gojur khel village, Bagram district of Parwan province.

### **SUMMARY:**

This area is part of Bagram airbase security mine belt. The area is heavily contaminated by UXO and anti personnel mines laid by Russian forces on 1985 to protect Bagram airbase.

The team has found and destroyed 476 PMN/PMN-2 mines and 1100 different types of UXO since commencement of clearance operations in the mentioned minefield. On 09 Sep 2007, at 09:25, while [Victim No.1] deminer was collecting the igniters of Russian made PTAB bomblets from a portion of the minefield, which was prepared (but not cleared) by excavator, he stepped on a PTAB bomblets which caused it to explode. The explosion made a crater by approx 50 cm depth and 70 cm diameter.

As a result of the explosion, [Victim No.1] lost his left leg of lower knee and received multiple injuries on his face while the second deminer [Victim No.2] who was working 5 metres away from the accident point received some injuries on his face. The two did not have helmets on their heads while the accident happened.

After receiving first aid at the site the victims were shifted to Bagram Airbase American Military Hospital. The first victim is under treatment at the hospital and the second victim [Victim No.2] was discharged from hospital.

### **CONCLUSIONS:**

The following points were found by investigation team:

- The accident area and its surrounding have been prepared by the excavator with 15 cm depth. However extra soil existed there and needed to be removed from the original ground surface but the team ignored removal of the extra soil and has deemed it as original ground surface.
- The relevant section leader claimed that before the accident, at 09:15 hrs he had some quality checks in the lane where the accident happened. But as the investigation team deployed another party for finding any evidence of the item that caused the accident, there were three missed signals which shows poor internal QC check of the section leader.
- During investigation of the accident point a fragment, looked like residue of Russians made PTAB Bomblet was found at crater of the explosion which shows that the exploded device was Russian made PTAB bomblet.

- The two deminers of the party were working at the same lane with about 5 metres distance from each other and were collecting some igniters which show direct safety breach.
- The two victim deminers were dressed with PPE but their helmets were not on their heads while the accident happened.
- The investigation team could not see all demining tools of victim deminers at the accident site; the demining tools and PPE of the victim deminers were already shifted to the base camp and original shape of the accident point was also changed.
- It is the third accident that happened in this team during one year; other teams working in this project do not have any accident during their work in this project which shows poor command and control of the team leader.
- The team members were not happy with their helmets and bayonets. They said that our helmet is too heavy and the bayonet is too long and its shield is big.
- The teams working in this project do not have mission leave while other clearance teams are granted 10 days mission leave after each 50 working days.

### **RECOMMENDATIONS:**

The following points are to be considered:

- Refresher training is to be conducted for the team, focusing on safety precautions and proper use of hand tools during excavation and soil removal. Internal and External QA should be carried out on the process of refresher training.
- On completion of the refresher training, special QA should be accomplished and subject to satisfaction on the result of the refresher training, the team can be deployed back to work.
- The team command group should strictly control and make sure that all members of the team are fully dressed with PPE/visor and at least 25 meters safety distance are maintained between the working lanes.
- The relevant supervisor/field officer should reinforce internal quality control visit to make sure the team is working according to approved standards and procedures.
- The command group should strictly control the deminers not to enter and walk into unclear areas.
- The team command group should ensure that all extra soils are removed from original ground surface and consider the 13 cm clearance depth from original ground surface.
- The team command group is to secure the accident point and keep site and tools in its original shape until UNMACA/AMAC investigation team arrives to the accident site.
- The project field office is to consider the teams' mission leave and provide opportunity for the teams to go for mission leave after each 50 days work as other demining teams.

## Victim Report

**Victim number:** 975 **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 **Protection used:** Frontal apron  
Long visor

### Summary of injuries:

INJURIES: severe Face

AMPUTATION/LOSS: Leg Below knee

COMMENT: No Medical report was made available. ". . . lost his left leg of lower knee and received multiple injuries on his face".

## Victim Report

**Victim number:** 976 **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 **Protection used:** Frontal apron  
Long visor

### Summary of injuries:

INJURIES: severe Face

COMMENT: No Medical report was made available. ". . . injuries on his face".

## Analysis

The primary and secondary causes of this accident are listed as *Field Control Inadequacy* because the Victims were working without wearing their visors and at a distance from each other that was in breach of their SOPs but these errors were not corrected. Also, the field controllers claimed to have conducted a QA check of the area, but the investigators found metal in the area so showing that the QA check with a metal-detector had been inadequate. Failure to supply appropriate field controls is, of course, a significant management failing.

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.