DDAS Accident Report

Accident details

Report date:	22/07/2011	**Accident number:**	789
Accident time:	08:10	**Accident Date:**	09/10/2007
Where it occurred:	CDS, Sang Ab Village, Deh Sabz District, Kabul Province	**Country:**	Afghanistan
Primary cause:	Inadequate training (?)	**Secondary cause:**	Victim inattention (?)
Class:	Demolition accident	**Date of main report:**	None
ID original source:	(31)	**Name of source:**	UNMACCA
Organisation:	[Name removed]		
Mine/device:	PMN-2 AP blast	**Ground condition:**	demolition site (explosives)
Date record created:		**Date last modified:**	22/07/2011
No of victims:	2	**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 (?)

pressure to work quickly (?)

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 TO [Demining group] ON 09 OCT 2007

INTRODUCTION:

An investigation team composed of Mr. [Name removed] the QMA and [Name removed] the AMAC OPS Assistant was convened by the Area Manager of AMAC Centre to investigate the demining accident that occurred on [Victim No.1] Asst. Team Leader of [Demining group] EOD-4 at Deh Sabz district of Kabul province. The accident happened at 08:10 hours on 9 Oct 2007 in [Demining group] CDS located at Sang Ab village, Deh Sabz district of Kabul province.

SUMMARY:

The accident happened in [Demining group] CDS which is located at Sang Ab village, Deh Sabz district of Kabul province. The [Demining group] WAD and EOD teams use this CDS for demolition of bulk UXO/Ammunitions. On 9th Oct 2007 at 08:10 Hrs, the accident happened on [Victim No.1] the Asst. Team Leader of [Demining group] EOD-4 while he was shifting UXO to pit. There were three antipersonnel PMN-2 mines near to the UXO and the Asst. Team Leader has stepped on one of these mines which in result the mine exploded and cut off his right leg and he also received some injuries on other parts of his body. Moreover, deminer [Victim No.2] who was working near to the accident point also received some injuries to different parts of his body.

CONCLUSIONS:

The following points were found by investigation team:

- [Demining group] EOD Team-5 was working in BF # 1960 located at Surkh Bullandi village, Shakar Dara district of Kabul province. A villager had hidden some mines in a metallic box near the task. On 8 Oct 2007, the villager informed about these team and request for demolition of these mines. The team opened the box and the team leader and supervisor checked these mines. Totally 8 antipersonnel mines (1 PMN and 7 PMN-2) were inside the box. They specified three PMN-2 mines as safe to move (inactive) and five are unsafe to move. The Supervisor instructed the team leader to dispose the five unsafe mines and deliver the remaining three safe mines to [Demining group] EOD – 4 for disposal at CDS. The [Demining group] EOD-4 had demolition program at [Demining group] CDS in Deh Sabz desert. The team put UXO in the pit for demolition, the team leader was inside the pit and the other members of the team including [Victim No.1] the Asst. Team Leader were carrying UXO to the pit. As at this time the Asst. Team Leader stepped one of these three mines that have been put near the pit and caused it to explode.
- The major non-conformance and/or negligence has been done by the Team Leader of [Demining group] EOD-5 and the Supervisor because from one side they mistakenly has specified these three active mines as safe and from the other side instead of demolishing all these mine in situ have unnecessarily delivered these three mines to the EOD-4.
- The EOD-4 command group was to check these mines to ensure whether or not these mines are really safe; demining is a risky job and the Team Leader of EOD-4 should have checked these mines instead of supposing it safe only because others saying.
- The Assistant Team Leader should have control other members of the team rather than taking part on transportation of UXO.

- It has been the last day the mission and the team would go to mission leave the day next so in such days, normally the deminers are in hurry to finish the work soon and this is why they cannot fully concentrate to their work; one of the contributory factors for the accident can be because of programming the CDS on the last day of OPS mission.

RECOMMENDATIONS:

The following points are to be considered:

- Whenever explosives devices are found in a box/container and some of them found unsafe then all of them should be considered unsafe.
- The teams command group should not suffice on others' saying but they should personally check and confirm the safety of devices that are taken over.
- The team's command group should not directly work in the field but they should control the team's members and ensure they are considering safety precautions and working in accordance with the set procedures.
- Site Supervisors are to strictly control the personnel in the field and prevent them practice unsafe actions.
- The suspected explosives items should not be put in the way of personnel walking.
- The team should undertake refresher training.
- The team members should be very cautious when walking in demining worksite and be alert of the ways that they walk.

Victim Report

Victim number: 979
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: Long visor
Short frontal vest
Protection used: None

Summary of injuries:

COMMENT: No Medical report was made available. ". . . injuries to different parts of his body".

Victim Report

Victim number: 978
Name: [Name removed]
Age:
Gender: Male
Status: supervisory
Fit for work: not known
Compensation: Not made available
Time to hospital: Not made available
Protection issued: Long visor
Protection used: None

Short frontal vest

Summary of injuries:

INJURIES: severe Body

AMPUTATION/LOSS: Leg

COMMENT: No Medical report was made available. ". . . cut off his right leg and he also received some injuries on other parts of his body".

Analysis

The primary cause of this accident is listed as *Inadequate training* because the investigators found that the Team Leader had incorrectly identified live mines as defuzed mines. Generally, with the PMN and the PMN-2, the removal of the booster can be easily seen, so the mistake implies that the man was not adequately trained. The secondary cause is listed as a *Victim inattention* because Victim No.1 accidentally stepped on the mine left outside the pit. The mine would have been visible and in the open, but presumably Victim No.1 was carrying something that meant he did not see it.

The demining group routinely expects all staff to work as a team regardless of their role, so a supervisor standing and watching would have been against their ethos.

The “Inadequate investigation” listed under notes refers to the absence of injury details and the full accident report. The UN supported MACCA has failed to make full reports 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.