DDAS Accident Report

Accident details

Report date:	22/07/2011	**Accident number:**	792
Accident time:	07:17	**Accident Date:**	02/07/2007
Where it occurred:	AF/0719/08130, MF0015, Kharzon Village, Laja District, Paktya Province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Management/control inadequacy (?)
Class:	Missed-mine accident	**Date of main report:**	None
ID original source:	(17)	**Name of source:**	UNMACCA
Organisation:	[Name removed]		
Mine/device:	AP blast (unrecorded)	**Ground condition:**	not recorded
Date record created:		**Date last modified:**	22/07/2011
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 (?)

Inadequate detector pinpointing

protective equipment not worn (?)

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 OCCURRED ON [Demining group] ON JULY 02, 2007

INTRODUCTION:

An investigation team was convened by the Area Manager of AMAC Southeast (Gardez) to investigate the demining accident involving [the Victim] a deminer from [Demining group] DT-25. The accident occurred at 07:17 hours on 02 July 2007 at task # AF/0719/08130/MF0015 located in Kharzon village, Laja district of Paktya province. The accident resulted left leg lost to the deminer.

SUMMARY:

The mentioned task is an area, in which the POMZ and PMN mines have been laid by Russians in 1980. The area was surveyed by [another demining group] on 11/04/2006 and the clearance of the task was started by [another demining group] on September 2006, but it was suspended in October 2006 as the weather became cold. On 01 April 2007 the clearance operations was resumed by [Demining group] DT-25, which was being supported by MDU.

[The Victim] deminer was working in his lane and had some advancement on his working lane. After he excavated a signal and found nothing he went to the safe area for rest and when he was coming back on the lane that was cleared by him, suddenly the explosion occurred. It shows that he had missed a mine.

As a result of the accident, the victim deminer lost his left leg. After receiving the first aid he was evacuated to hospital.

CONCLUSIONS:

The following points were found by investigation team:

- The deminer was working carelessly, because he excavated a signal and after he found noting he did not check the area again by detector and that is the main reason for the mentioned missed mine.
- The team leader and section leader of the team were absent and the supervisor of the project ignored the absence of two key personnel in command group.
- Poor command and control is also considered as a contributing factor as the section leader was absent and there was no one to control the victim
- The deminer did not use PPE and this is considered another indicator showing team's poor command and control.

RECOMMENDATIONS:

The following points are to be considered:

- The management of [Demining group] is advised to make sure that the command group of their teams are present or if any member of command group takes leave, a qualified person should be assigned to carry on as his temporary replacement.
- Retraining of the team is recommended with focusing on the use of detector and removal of the signal of the reading points.

- [Demining group] Management is to make sure that the related field offices have nominee(s) for replacement of any of the command group's member in case he is absent or on leave.
- Team command group is to be taught how to conduct some quality check of the lane cleared by deminers.

Victim Report

Victim number:	982	**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:**	None

Summary of injuries:

AMPUTATION/LOSS: Leg

COMMENT: No Medical report was made available. "left leg lost to the deminer".

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the investigators found that there were not adequate field supervisors on site when the accident happened, and that this was proven by the Victim's failure to wear PPE. The secondary cause is listed as a *Management Control Inadequacy* because the management failed to ensure that there were enough field supervisors to control the Victim who was working inappropriately and missed a PMN mine (large metal indication). He was effectively working without supervision and without QA checks.

Inadequate training is listed under Notes because the investigators recommended that field supervisors should have QA training and that the deminers needed retraining in detector use and signal investigation procedures.

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.