

DDAS Accident Report

Accident details

Report date: 06/03/2011	Accident number: 658
Accident time: 07:55	Accident Date: 15/08/2010
Where it occurred: MF 078, Dragi village, Tani district, Khost, Province	Country: Afghanistan
Primary cause: Inadequate training (?)	Secondary cause: Management/control inadequacy (?)
Class: Excavation accident	Date of main report: Not recorded
ID original source: Ref.213	Name of source: UNMACCA
Organisation: [Name removed]	
Mine/device: AP blast (unrecorded)	Ground condition: not recorded
Date record created:	Date last modified: 06/03/2011
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
squatting/kneeling to excavate (?)
handtool may have increased injury (?)

Accident report

The only report of this accident that has been made available to date is a UNMACCA Lessons Learned Summary supplied as a PDF file. Its conversion into a DDAS file has led to some formatting being lost. Text in square brackets [] is editorial. This record will be revised as more information becomes available.

The accident summary is reproduced below, edited for anonymity.

Mine Action Coordination Centre of Afghanistan (MACCA)

Ref # 213: File: OPS/14/16 14 /October /2010

Attached please find the investigation report and lessons learned of demining accident happened on 15 August 2010 at 07:55 hrs, in Dragi village Tani district of Khost province.

LESSONS LEARNED SUMMARY OF [Demining group] CBDT-21 DEMINING ACCIDENT

INTRODUCTION:

Demining investigation teams were convened by AMAC Gardez and [Demining group] to investigate and find out the causes of the Demining accident involving [the Victim] the deminer of [Demining group] CBDT-21. The accident occurred at 07:55 hours, on 15 August 2010 in Task # AF/3203/07852/MF 078 located in Dragi village, Tani district of Khost province.

SUMMARY:

Task # AF/3203/07852/MF 078 is located in a mountainous area contaminated with anti-personnel mines. During Dec 2009 the area was polygon surveyed by [Demining group] LIAT-11. Mines planted by Russian forces planted landmines there in late 1984 to protect their position from the possible attacks of Mujahiddin.

Mine clearance operations in Tani district started by [Demining group] as community based demining approach and deminers from the community are engaged in this operation. On 06 th March 2010, CBDT-21 started demining operations in mentioned minefield, the progress was around 60% till accident happened. The team found/destroyed 470 anti-personal mines up to the accident time.

On 15 August 2010 while [the Victim] deminer was busy in his clearance lane excavating a detected signal, his excavation tool touched a mine and caused it to explode. According to the investigation report the signal was not pinpointed correctly and the deminer has used his excavation tool directly on the top of anti-personnel mine and the accident happened. Fortunately the victim deminer was fully dressed with PPE, so he got a superficial injury between the thumb & index finger of his right hand.

As the majority of minefields in Tani district are located on the hillsides and the likelihood of mines with changed positions due to seasonal flood is high. Therefore, a comprehensive and well communicated site operations plan, covering all the predictable scenarios was required e.g. changes in direction of mines, their displacement etc. But this point was not considered in the site operation plan.

CONCLUSIONS:

This is the conclusion of investigation team that this accident was not preventable. However the deminer requires refresher training in pinpointing signals and excavation procedure.

RECOMMENDATIONS:

The following points are to be considered:

A. [Demining group] operations department is recommended to develop a plan for the continual improvement of the technical skills of their community based deminers along with supervision skills of their command group through revision and refresher courses.

B. Feedback on any preventive and corrective actions taken by [Demining group] is required to be submitted to the MACCA office by no later than 7 days, effective to the issue date of this letter.

Victim Report

Victim number: 841	Name: [Name removed]
Age:	Gender: Male
Status: deminer	Fit for work: presumed
Compensation: Not made available	Time to hospital: Not made available
Protection issued: Frontal apron Long visor	Protection used: Frontal apron. Long visor

Summary of injuries:

INJURIES: minor Hand

COMMENT: No Medical report was made available.

Analysis

The primary cause of this accident is listed as Inadequate training because the investigators concluded that the Victim had not been training to pinpoint metal-detector readings appropriately. The secondary cause is listed as a Management Control Inadequacy because the demining group's management is responsible for ensuring that appropriate and effective training is given before a deminer is allowed to work in the field.

There were several accidents with this group in this area at this time. The deminers were all "community" deminers and in each there was a recorded failure to train appropriately.

Although the injury was light, the use of a short handtool that did not comply with IMAS recommendations may have contributed to the hand injury.

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 in contravention of the requirements of the IMAS. The existence of the accident summary implies that the Afghan investigators did make a comprehensive report and the failure of the UN to share it with others is regrettable.