DDAS Accident Report

Accident details

Report date:	06/03/2011	**Accident number:**	681
Accident time:	10:40	**Accident Date:**	21/07/2009
Where it occurred:	MF 30910965, Kandahar Airport, Daman district, Kandahar province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Inadequate equipment (?)
Class:	Excavation accident	**Date of main report:**	29/09/2009
ID original source:	OPS,14/01-20, Ref: 09/10/326	**Name of source:**	UNMACCA
Organisation:	[Name removed]		
Mine/device:	AP blast (unrecorded)	**Ground condition:**	dry/dusty hard
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 (?)

squatting/kneeling to excavate (?)

handtool may have increased injury (?)

Inadequate detector pinpointing

Accident report

The only report of this accident that has been made available to date was in a “Lessons Learned” summary provided as a PDF file. The 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 as more information becomes available.

The *Lessons Learned* summary is reproduced below, edited for anonymity.

Mine Action Coordination Centre of Afghanistan (MACCA)

File: OPS,14/01-20, Date: September 29, 2009. Ref: 09/10/326

Subject: INVESTIGATION REPORT & LESSONS LEARNED OF [Demining group] DT# 3 DEMINING ACCIDENT

Attached please find the investigation report and lessons learned of [Demining group] DT# 3 demining accident occurred on 21 July 2009 in Kandahar airport, Daman district of Kandahar province.

LESSONS LEARNED SUMMARY OF [Demining group] DT-03 MINING ACCIDENT

INTRODUCTION:

An investigation team was convened by the AMAC South to investigate the demining accident involving [the Victim] the Deminer of [Demining group] DT-03. The accident occurred at 10:40 hours on 21 July 2009 at the minefield number 30910965, located in Kandahar Airport, Daman district of Kandahar province.

SUMMARY:

ME # 309/0965 is an anti-personal mine contaminated site around Kandahar Airbase. During the Russian invasion a big security belt of landmine was established by the government forces to secure the airbase from the attacks of Mujahedeen. This minefield is one of the minefields covered in the above mentioned large size of contaminated area.

As the task is located inside Kandahar Air Field (KAF) and as well as the victim is evacuated to the coalition force military base hospital. Therefore, due to security consideration of coalition forces the investigation team was not allowed to physically observe the accident scene and conduct interview with victim deminer.

According to the statement of team leader, section leader and medical report the findings of investigation team are as follows:

On 21 July 2009 while deminer [the Victim] was working in his clearance lane, investigating a detected signal with his hand trowel, he hit a mine on its top and caused it to go off. The weather was hot and the ground surface was hard and dry, so it seems that the deminer had used his excavation tool by force and carelessly and directly on pinpointed spot so touched the top of mine and caused the accident. As the deminer was dressed with PPE (vest, helmet and visor according to [Demining group] SOPs), so his face, neck and chest remained safe. As he was working in squatting position, so his both legs were injured and also he got fracture to his right hand fingers. The injuries to both legs of deminer were preventable if the apron or lower limbs covering PPE was used.

CONCLUSIONS:

The investigation team concluded that the carelessness of deminer caused the accident. But the main element involved in accidents together with other causes is poor supervision.

RECOMMENDATIONS:

The following points are to be considered:

a. Hard grounds are to be prepared by machines first and then to be dealt manually.

b. [Demining group] is recommended to consider lower limb cover in terms of PPE and amend their SOP accordingly.

c. The deminer should not hurry up during the excavation drill, be careful and do not use the prodding/excavation tools carelessly.

d. The team command group should strictly control the deminers during operation and immediately stop them while practicing in contrary to standard operating procedures.

Victim Report

Victim number:	865	**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:**	Frontal apron, Long visor

Summary of injuries:

INJURIES: severe Hands, severe Legs

COMMENT: No Medical report was made available.

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the investigators found that there was “poor supervision”. The secondary cause is listed as *Inadequate equipment* because the hand tool being used by the deminer was too short and was not blast resistant (as recommended in the IMAS) and so is likely to have contributed to his injury.

It is bizarre that the deminers were permitted to work in this “security” area but that the investigators were not permitted to enter the area to conduct a post-accident investigation.

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 presence of the accident summary implies that a full and comprehensive accident investigation was made, but not made available for others to learn from.