DDAS Accident Report

Accident details

Report date:	11/07/2011	**Accident number:**	750
Accident time:	09:15	**Accident Date:**	10/07/2010
Where it occurred:	Task # AF/0101/00096, MF 0868, Waisal abad village, Ward-07, Kabul City	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Inadequate training (?)
Class:	Excavation accident	**Date of main report:**	None
ID original source:	None	**Name of source:**	UNMACCA
Organisation:	[Name removed]		
Mine/device:	AP blast (unrecorded)	**Ground condition:**	not recorded
Date record created:		**Date last modified:**	11/07/2011
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 detector pinpointing

use of pick (?)

squatting/kneeling to excavate (?)

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 group] DT-07 DEMINING ACCIDENT

INTRODUCTION:

An investigation team was convened by AMAC Kabul to investigate the demining accident involving [the Victim] the de-miner of [Demining group] DT-07. The accident occurred at 09:15 hours, 10 July 2010 in Task # AF/0101/00096/MF 0868 located in Waisal abad village, Ward-07 of Kabul City.

SUMMARY:

Task # AF/0101/00096/MF 0868 is located in a hillside area contaminated with anti-personnel mines planted by Russian forces in 1983. The area is mined several times after the Russian withdrawal up to the end of internal conflict in Kabul city. It is recorded by LIS under the community No. 096 then confirmed by LIAT in 2008. Around 6 accidents have been occurred on locals in mentioned area.

As per the request of local people, AMAC Central tasked [Demining group] to start clearance operation there. DT-07 of [Demining group] started clearance of this task on 01 April 2010. Total size of the task is 141618 m2 out of which 58470 m2 has been cleared so far, 16 AP PMN2 mines and 1301 different types of ERW found/destroyed by DT-07 up to the accident time.

On 10 July 2010 at 09:15 AM Mr. [the Victim] the de-miner of mentioned team was working in his clearance lane, excavating a detected signal, his pick touched on the top of a PMN 2 anti-personnel mine and caused it to go off. According to the investigation report the de-miner has used the pickaxe to investigate the signal instead of the bayonet and it seems as he used the pick directly on the top of signal, so caused the accident. Luckily the deminer was fully dressed with PPE, so he got a superficial injury on hand. Then the victim de-miner evacuated to Ebni Sina hospital for the treatment and further checking up, after one hour he discharged from the hospital in normal condition. He is able to continue his activities as a deminer in the field. It is worth to be mentioned that the deminer remained safe due to appropriate use of the PPE.

CONCLUSIONS:

Although the consequence of this accident is acceptable, but the accident could had been avoided if the deminer was not further proceeding from 2nd reading marker with pickaxe.

So carelessness of deminer in terms of using pickaxe in contrary to SOP and lack of control by command group are the contributing factors to this accident.

RECOMMENDATIONS:

The following points are to be considered:

- Standard and appropriate tools of prodding and excavation should be used during the operations.
- The command group should strengthen their supervision during operation and stop the de-miners from conducting drills in contrary to SOPs.
- The de-miners should pinpoint the signal properly, mark it and then start excavation according to the procedure.

- It is the responsibilities of respective IP's operations department to make sure that a proper system of command and control exists in the field.

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:	941	**Name:**	[Name removed]
Age:		**Gender:**	Male
Status:	deminer	**Fit for work:**	yes
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. The Victim was discharged from hospital in one hour in "normal" condition.

Analysis

The primary cause of this accident is listed as a *Field Control inadequacy* because the Victim was working in breach of SOPs and his error was not corrected. The secondary cause is listed as *Inadequate training* because the Victim either did not pinpoint the detector reading appropriately or deliberately excavated onto the top of a mine, which implies that he was not aware of the risks he was running. Because training and field supervision are management responsibilities, both failings imply a significant *Management Control Inadequacy*.

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, ignoring the requirements of the IMAS. National staff have been more responsible than the internationals with overall responsibility.