DDAS Accident Report

Accident details

Report date:	15/07/2011	**Accident number:**	758
Accident time:	08:30	**Accident Date:**	07/07/2010
Where it occurred:	AF/0701/07772, MF 0351, Zawu village, Paktya Province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Inadequate training (?)
Class:	Other	**Date of main report:**	None
ID original source:	None	**Name of source:**	UNMACCA
Organisation:	[Name removed]		
Mine/device:	P2Mk2 AT blast	**Ground condition:**	dry/dusty
Date record created:		**Date last modified:**	15/07/2011
No of victims:	0	**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 (?)

mechanical detonation (?)

non injurious accident (?)

Accident report

The only report of this accident that has been made available to date is a UNMACA 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 as more information becomes available.

The document is reproduced below, edited for anonymity.

LESSONS LEARNED SUMMARY OF [Demining group] MDU-05 DEMINING INCIDENT

INTRODUCTION:

An investigation team was convened by AMAC Gardiz to investigate the demining incident involving a Front End Loader (FEL) machine of [Demining group] MDU-05. The incident occurred at 08:30 am on 07 July 2010 at minefield # AF/0701/07772/MF 0351, located in Zawu village, centre of Paktya Province.

SUMMARY:

The minefield # 0351 is located in Zawu village around 20Km southern side of Gardiz city, it is an AT mines (P2MK2) contaminated area. The mines have been laid by Mujahidin to block the movement of Russian tanks and their possible attacks.

On 7th July 2010 at 08:30 KAB 174 Rippers FEL of [Demining group] MDU-05 started ground processing operations in MF 0351, supporting MDG-20 in their clearance operations. During this operation a P2MK2 anti-vehicle mine exploded on its right back tyre and caused damages to it and its wheel. Fortunately there is no any casualty involved in this incident. According to the investigation report, this MDU started operations from the safe area and gradually proceeded into the MF, on the way back to safe area, the machine entered in un-cleared area, initiated a mine and caused incident. The machine operator was not able to see his way back because of dust raised by a strong wind, but still he continued to reverse his machine, so entered in un-cleared area. Although the team leader called him in radio to stop driving back, but it was late and the incident happened immediately. The operator maintained 20-30cm of safety margin when he was conducting operation and reversing his machine to start new lane for processing.

CONCLUSIONS:

It is the conclusion of investigation team that the incident happened because of 2 factors:

Carelessness of machine operator as he could not realize the safe ground from the contaminated, but continued to reverse his machine

Short and limited safety margin for the machine operation. This factor is relating to site operations management, command and control.

RECOMMENDATIONS:

[Demining group] is recommended to conduct a one day refresher training focussing on safety measures during the operations.

The safety margin for FEL operation should be reviewed by [Demining group] operations department.

Practical steps should be taken for the improvement of supervision, command and control in the field.

Feedback on any preventive and constrictive 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.

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the machine's external controller gave instructions about the operator's error too late for him to avoid entering the unsafe area. The secondary cause is listed as *Inadequate training* because the problem with dust was predictable and it seems that those involved in the incident had not prepared for it.

It is hard to see how the operator could maintain a safety overlap of 20-30cm during operations when he could not see because of dust raised by the machine. Having good visibility is a problem in many ground-engaging mechanical operations, meaning that effectively the driver is "radio controlled" by an observer.

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. National staff have been more responsible than the internationals with overall responsibility.