DDAS Accident Report

Accident details

Report date:	15/07/2011	**Accident number:**	759
Accident time:	09:50	**Accident Date:**	06/09/2010
Where it occurred:	Task: 339-3960, KMTC Range, Pul-i-Charkhi, Ward 9, Kabul	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Inadequate training (?)
Class:	Excavation accident	**Date of main report:**	08/11/2010
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:**	15/07/2011
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

visor not worn or worn raised (?)

squatting/kneeling to excavate (?)

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] DEMINING ACCIDENT

INTRODUCTION:

The demining investigation teams were convened by AMAC Kabul and [Demining group] to investigate and find out the causes of demining accident involving Mr. [the Victim] the de-miner of [Demining group] DT-03. The accident occurred on 06 Sep 2010 at 09:50am in task No. 339-3960 of KMTC Range Poli Charkhi, Ward No. 09 of Kabul city.

SUMMARY:

[Demining group] is subcontracted by USACE for mine/ERW clearance in Pul-i-Charkhi-Kabul, as this task was designated by USACE as a BAC; however the information management system of mine actions marked around 16,800sqm as mine contaminated area in mentioned site. An AP mine was found and destroyed by [Acronym removed] using a burn technique. After discovering the mine [Demining group] team checked the area with MDDs, then the team conducted BAC operations there for the whole task.

On 06 Sep 2010, when Mr. [the Victim] was working in his clearance lane and excavated a detected signal, during the excavation drill his excavation tool touched the mine and caused it to go off. According to investigation report the cause of the accident was the wrong excavation technique, as he started excavation drill close to the pinpointing target. He had gone down and did not expand the trench to allow entry from the side, which caused to stroke his excavation tool on the top of the mine. Due to the injuries sustained on his eyes, it seems that the deminer had moved his visor up during the excavation. He also got some injuries on his right hand and left leg.

CONCLUSIONS:

Using wrong procedure for the investigation of deep target by the deminer was the main contributing factor to this accident.

RECOMMENDATIONS:

However, the [Demining group] has already taken appropriate actions, but as a lessons learned the following points are to be considered by all demining teams:

- A comprehensive assessment, technical survey and planning for the clearance of each single task should be conducted prior to commencement of clearance operations.
- Excavation drill on deep signals should begin on the home side with a wide trench and reasonable distance from the target to allow the deminer to conduct excavation getting deeper to the target properly. The de-miners/searchers should not work in hurry during the operations and be careful while conducting investigation on any detected signal.
- Full level of protection should be considered during the clearance operations both in BAC sub-surface clearance and mine clearance activities.

Victim Report

Victim number:	947	**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

Summary of injuries:

INJURIES: minor Hand; minor Leg; severe Eyes

COMMENT: No Medical report was made available. ". .some injuries on his right hand and left leg."

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because it seems that Victim was working with his visor raised (or not worn) and his error was not corrected. The secondary cause is listed as *Inadequate training* because the investigators determined that the Victim did not pinpoint a detector reading properly and so dug onto the top of the mine. Both these causes are effectively *Management control inadequacies* because the group’s management has responsibility for the training of deminers and field supervisors.

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.