DDAS Accident Report

Accident details

Report date:	19/07/2011	**Accident number:**	771
Accident time:	09:05	**Accident Date:**	29/10/2007
Where it occurred:	AF1208/12494, MF010, Dasht Chinar village, Rostaq district of Takhar province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Management/control inadequacy (?)
Class:	Excavation accident	**Date of main report:**	None
ID original source:	(33)	**Name of source:**	UNMACCA
Organisation:	[Name removed]		
Mine/device:	PMN-2 AP blast	**Ground condition:**	not recorded
Date record created:		**Date last modified:**	19/07/2011
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 training (?)

handtool may have increased injury (?)

use of pick (?)

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 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 ACCIDENT OCCURRED TO [Demining group] DT # 1 ON 29 OCTOBER 2007

INTRODUCTION:

An investigation team was convened by the Area Manager of AMAC Northeast to investigate the demining accident occurred on [the Victim] deminer of [Demining group] DT-1 at Dasht Chinar village, Rostaq district of Takhar province. The mentioned demining accident occurred at 09:05 hours on 29 October 2007 in Minefield # AF1208/12494/MF010. As result of this accident, the deminer received injuries on his eyes, left arm and forehead.

SUMMARY:

MF# AF1208/12494/MF0010 is located within SHA#1 of Community No-1455 which was mined during the period of fighting between the Russian and the Mujahideen.

In this area reportedly 7 accidents happened on locals in the past. Demining operations in the mentioned task was started on 11/09/2007 and during the clearance operations the team found totally 6 PMN2 mines. On 29/10/2007 at 09:05 am an accident happened in Lane number 11 where [the Victim] was working. The deminer did not wear PPE/Visor and as a result of the accident the victim deminer got injuries to his eyes, forehead and left arm. The team medic and a neighbouring MDC team medic applied first aid to casualty and then he was evacuated to Kundoz hospital for more treatments.

CONCLUSIONS:

The following points were found by investigation team:

- The deminer had not worn PPE/visor because there were no signs of damage to the PPE and visor and he got injuries to his eyes, forehead and arm.
- Due to lack of proper training, excavation drill has not been practiced in accordance with the NGO SOP because the deminer was excavating the centre of the signal by bayonet.
- The bayonet handle was broken as the result of the accident.
- Poor command and control was dominated in the team because the team leader and section leader failed to make the deminer to wear his PPE and visor.
- As it was checked in other parts of the area, it was found that the team was working by pick/shovel to excavate the signal.
- The team got two digital cameras, but none of the camera was available while the accident happened, so the team did not took the photos of the accident area and the casualty.
- The team had HF Codan radio, but it did not work properly.

RECOMMENDATIONS:

The following points are to be considered:

- Disciplinary action against involved command group is recommended.
- Refresher training for the team and Special training for the command group of the team is recommended and the training should be monitored by relevant AMAC.
- The command group must avoid the deminers of using folding shovel/pick for excavation.
- The PPE is to be used all the time when the operations are ongoing in the site.
- Internal QA is to be reinforced by relevant field office in order to identify the weak point(s) of team's operations in the field and to take necessary actions to eliminate these weak point(s).
- The relevant field office is to make sure the team is equipped with proper communication means, because while an accident happens, it is essential that the team have proper means to transfer the message to relevant offices and/or take photo etc.
- [Demining group] management is strongly recommended to make sure through internal QA visit that the team has all the necessary equipments with them, because it is the second time within a month that accidents happened, but the team did not have their digital camera with them; once when the accident happened on [Demining group] team # 5 on 23/09/2007 in Ishkamish district of Takhar and the second time in team#1 on 29 October 2007.

Victim Report

Victim number:	957	**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: severe Arm; severe Eyes; severe Head

COMMENT: No Medical report was made available. ". . . eyes, forehead and left arm".

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the Victim was working with his visor raised (and possibly with an unauthorised tool) and his errors were not corrected. The secondary cause is listed as a *Management Control Inadequacy* because the provision of effective field managers and appropriate equipment are management responsibilities.

“Inadequate training” is listed under notes because the investigators found that training of deminers and their managers was necessary.

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, so ignoring the requirements of the IMAS. It is noteworthy that the Afghan national staff have been more responsible about sharing data than those internationals who presume greater responsibility.