DDAS Accident Report

Accident details

Report date:	08/02/2011	**Accident number:**	593
Accident time:	11:27	**Accident Date:**	22/02/2010
Where it occurred:	Task # AF103081007671 MF 211, Galache village, Bagram district, Parwan province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Inadequate equipment (?)
Class:	Excavation accident	**Date of main report:**	17/03/2010
ID original source:	056/Rao	**Name of source:**	UNMACCA
Organisation:	**[Name removed]**		
Mine/device:	MUV fuze	**Ground condition:**	not recorded
Date record created:		**Date last modified:**	08/02/2011
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 (?)

inadequate equipment (?)

visor not worn or worn raised (?)

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 cover letter and *Lessons Learned* summary are reproduced below, edited for anonymity.

Mine Action Coordinaton Centre of Afghanistan (MACCA)

Ref 056/Rao

Subject: INVESTIGATION REPORT & LESSONS LEARNED OF [Demining group]/JMAS CS-11 DEMINING ACCIDENT

Attached please find the investigation report and lessons learned of [Demining group]/JMAS CS-11 demining accident occurred at 11:27 hours, 22 Feb 2010, in Qalacha village, Bagram district of Parwar province.

Best regards,

Distribution list:

Complete investigation: [Demining group]

Lessons learned:

[All demining groups active in Afghanistan at the time.]

MCPA, RONCO, MDC, OMAR, DAFA, JMAS, ATC, PMNVRA, HDI, HT, AGMA, EODT, ACL, CMCC, MTI, NDSS, PSS, UXB, ADC, UADC, DAO, TDC, G4S, AMACs (7).

For information:

MACCA, Chief of Staff DMC, Director Operations Staff

File: OPS. 14/01/01

To: See Distribution list

From: [Name removed], Chief of Operations, MACCA, Kabul

Date: 17th March 2010

Mine Action Coordination Centre of Afghanistan (MACCA)

LESSONS LEARNED SUMMARY OF [Demining group] CS-11 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] JMAS CS-11. The accident occurred at 11:27 hours, 22 Feb 2010 in Task # AF103081007671MF 211, located in galache village, Bagram district of Parwan province.

SUMMARY:

MF # 211 is a historical place which was contaminated with anti-personnel mines laid by Russian troops during the period of 1981-1984.

Also during armed conflicts between Taliban and Northern Alliance in 1997-2000, this area was re-contaminated

Demining group] JMAS clearance section # 11 started clearance operation of the task on 6th October 2009, and so far out of 112,000m2 size of the task 160,00m2 has been cleared and during the clearance the team found/destroyed 38 anti personnel mines & 30 different types of UXO.

On 22 Feb 2010 at 11:27 hrs while [the Victim] deminer was busy excavating a detected signal, suddenly the accident happened.

According to the investigation report the de-miner was using the scraper direct on the top of the detected signal causing it to go off. It was then found that the exploded item was a MUV fuse.

As a result of the explosion, [MUV fuze] sustained injuries on his eyes, right side ear, arm and head; the injuries indicate that the de-miner was not using his visor properly.

After receiving first aid at the field the victim was transferred to Kabul emergency hospital for further treatment.

CONCLUSIONS:

Poor supervision by the command group to control the deminer during the operations and carelessness of the de-miner are considered the main contributing factors for this accident.

Using the scraper directly on the centre of pinpointed signal and also working with visor in up position are both contrary to the approved working procedure, but the team command group failed to avoid these wrong practice.

RECOMMENDATIONS:

However as per [Demining group]'s internal investigation report they managed to conduct refresher training for their teams, but the following points are also to be considered by all concerned:

1) 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.

2) Inappropriate use of visor resulted in injuries to the eyes and face of de-miner, therefore, all the command groups are strongly recommended to strengthen their focus on this point and never allow their de-miners to work without proper use of PPE and visor.

3) The findings of internal and external investigation reports and lessons learned are to be further circulated to the field staff and make sure that the main contributing factors are well understood by all the de-miners.

4) Feedback on any preventive and corrective actions taken by [Demining group]/JMAS 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: 777 **Name:** [Name removed]

Age: **Gender:** Male

Status: deminer **Fit for work:** not known

Compensation: Not made available **Time to hospital:** Not recorded

Protection issued: **Protection used:** Not recorded

Summary of injuries:

INJURIES: severe Arm, severe Eyes, severe Face

COMMENT: No Medical report was made available

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the Victim was working with a visor raised (or not worn) and the field supervisors failed to correct this. The secondary cause is listed as *Inadequate equipment* because the Victim was working with a short scraper that fails to meet the recommendations of IMAS 10.30 covering PPE at the time of the event. This widely used tool appears to have been approved by the UNMACCA, which implies that it is ignoring that IMAS.

The “Inadequate investigation” listed under notes refers to the absence of a full accident report. The UNMACCA has failed to make these widely available for some years, also in contravention of the requirements of the IMAS which they are required to apply. The summary of the accident is good, and its presence implies that full and comprehensive accident investigation was made.