DDAS Accident Report

Accident details

Report date:	07/07/2011	**Accident number:**	710
Accident time:	10:40	**Accident Date:**	28/12/2010
Where it occurred:	AF/3203/00398, MF0081, Dragi Village, Tani district, Khost Province	**Country:**	Afghanistan
Primary cause:	Inadequate training (?)	**Secondary cause:**	Field control inadequacy (?)
Class:	Other	**Date of main report:**	07/02/2011
ID original source:	None	**Name of source:**	UNMACCA
Organisation:	[Name removed] CBDT		
Mine/device:	PMN-2 AP blast	**Ground condition:**	not recorded
Date record created:		**Date last modified:**	07/07/2011
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 (?)

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] DEMINING ACCIDENT

INTRODUCTION:

Investigation team was convened by AMAC Southeast to investigate the demining accident occurred to [Demining group] on 28 December 2011 [sic] at 10:40 am in Task No: AF/3203/00398/MF0081 of Dragi village, Tani district of Khost province. The accident caused the amputation of right leg and left foot toes of [the Victim], deminer of [Demining group], CBDT-23.

SUMMARY:

MF 0081 is located on the top of a hill east side of Sre Kalay of Dragi village, Tani district of Khost province. The mines were laid by Russian troops to prevent Mujahidin's attacks during 1987-1992. Around 15 accidents occurred on animals in this minefield. Mine clearance operations in Tani district started by [Demining group] as community based demining approach and deminers from the community are engaged in this operation. [Demining group] CBDT-23 started clearance operation in mentioned task on 08 Jul 2010. The size of area is 23,549 sqm and the team has cleared 17,597 sqm (75%) and destroyed 28 AP mines till the accident time. This is the second de mining accident in this minefield.

According to investigation report and the observation of accident point, the accident occurred in un-cleared area within the minefield. The deminer was returning back from the rest area to resume the work in his clearance lane, he entered into the minefield, stepped on PMN2 anti-personnel mine and accident happened. The worksite was well prepared and the area was clearly marked in accordance to the [Demining group] SOPs. The deminer did not consider and use the clear access lane to proceed to his working area while he was well aware about the cleared/un-cleared parts of the minefield. He was not stopped by command group when he crossed the marking and entered to the minefield.

The accident caused his right leg traumatic amputation above ankle and left foot toes amputation. The de-miner was evacuated to Khost hospital after receiving of first aids in the operation site.

CONCLUSIONS:

The main contributing factor to this accident is carelessness and negligence of deminer from the organization SOPs. The command group has also failed to stop the deminer from such an action.

RECOMMENDATIONS:

The following points are to be considered:

- [Demining group] is recommended to identify, analyze the situation involved with frequent accidents in Tani CB project and come up with a comprehensive plan of actions to resolve the problem.
- Both the deminers and command group require specific trainings based on the shortfalls identified during the internal and external investigations. The traditional refresher training may not solve the problem.
- [Demining group] operations department is recommended to develop a plan for the improvement of supervision, command and control in their teams.

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:	895	**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:**	Not recorded

Summary of injuries:

AMPUTATION/LOSS: Leg Below knee; Toes

COMMENT: No Medical report was made available. "amputation of right leg and left foot toes".

Analysis

The primary cause of this accident is listed as *Inadequate training* because the investigators recommend that “specific trainings” were required. The secondary cause is listed as a *Field Control Inadequacy* because the Victim walked over an uncleared area and his error was not corrected. It seems likely that he was unaware of the risks he was taking, which implies either a fundamental absence of training, or an absence of willingness for the command group to fail trainees who do not learn the basics. Failure to provide effective training is 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, so ignoring the requirements of the IMAS. It is noteworthy that the Afghan national staff have been more responsible than those internationals who presume greater responsibility.