

DDAS Accident Report

Accident details

Report date: 15/07/2011	Accident number: 757
Accident time: 10:35	Accident Date: 07/06/2009
Where it occurred: AF/0308/01635, MF1847, Qala-e-Ahmad Khan Village, Bagram District, Parwan Province	Country: Afghanistan
Primary cause: Field control inadequacy (?)	Secondary cause: Inadequate equipment (?)
Class: Excavation accident	Date of main report: None
ID original source: None	Name of source: UNMACCA
Organisation: [Name removed]	
Mine/device: AP blast (unrecorded)	Ground condition: hard
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 training (?)
use of shovel (?)
visor not worn or worn raised (?)
handtool may have increased injury (?)

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] DT-02 DEMINING ACCIDENT

INTRODUCTION:

An investigation team was convened by AMAC Central to investigate the de-mining accident involving [the Victim] the Section Leader of [Demining group] DT-02. The accident occurred at 1035 hours on 07 June 2009 at minefield number AF/0308/01635/MF1847, located in Qala-e-Ahmad Khan village, Bagram district of Parwan province.

SUMMARY:

MF # AF/0308/01635/MF1847 is an anti-personnel mine contaminated task around Bagram Airbase. During Russian invasion on Afghanistan a security belt of landmine was established by the government forces to secure the airbase from the attacks of Mujahedeen. MF 1847 is heavily contaminated minefield covered 57,335 sqm area, [Demining group] DT-02 cleared 12,986 sqm area and found/destroyed 370 AP mines till the accident date.

On 07 June 1035 hours [the Victim] the section leader of mentioned team stopped his deminer [Name removed] and started to work instead of him as the deminer was getting tired. He hit the top of a mine with his prodding tool so the accident occurred. There is a wound with regular edges on the forehead of section leader and some abrasions on his face and left eye. The PPE was used during the operation, but the visor was broken down by a forceful back out of excavation tool possibly the shovel and caused the injury to him. According to the investigation report, the pictures of wound, the view of scene and the picture of broken visor, it seems that the shovel was used during operation. As the ground was hard and required to be prepared by MDU first, but it was not planned and ignored by team command group.

CONCLUSIONS:

It was the fault of team leader for giving permission to section leader to work instead of a deminer. The section leader himself made a big mistake in terms of giving up his own job as a controller and getting involved in detection and investigation of signals. The poor management of the operations in the task was another factor contributed to the accident.

RECOMMENDATIONS:

[Demining group] management is recommended to strengthen the internal QA and strictly control the teams in terms of team/operations management and site operations planning. [Demining group] is also recommended to make sure that the job description is will understood by command group. And to ensure that the safest way of conducting demining operations is being practiced. In order to prevent such cases in future, the [Demining group] Operations department is requested to come up with a management solution to such cases and present it to MACCA OPS department by no later than 2nd July 2009.

Victim Report

Victim number: 946	Name: [Name removed]
Age:	Gender: Male
Status: supervisory	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; Long visor

Summary of injuries:

INJURIES: minor Eye; minor Face

COMMENT: No Medical report was made available. ". . wound with regular edges on the forehead. . and some abrasions on his face and left eye "

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the investigators found that the Victim and his Team Leader had made a "mistake" when the Victim took over excavation from a tired deminer. The secondary cause is listed as *Inadequate equipment* because excavation in hard ground with a shovel is patently dangerous. The fact that the ground should have been mechanically prepared was noted by the investigators, and the fact that it was not was a *Management Control Inadequacy* which they noted as a cause.

In the absence of photographs, it is uncertain whether the Victim was wearing his visor. It seems that the blade of the shovel was thrown back at the Victim and it may have hit the Visor, breaking it's face, or hit his face causing a "wound with regular edges" (which a broken visor is unlikely to do).

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.