DDAS Accident Report

Accident details

Report date:	19/07/2011	**Accident number:**	778
Accident time:	07:15	**Accident Date:**	23/07/2007
Where it occurred:	AF/2008/18355, MF148, Nayeb Ghafoor Village, Kohsan District, Herat Province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Inadequate training (?)
Class:	Excavation accident	**Date of main report:**	None
ID original source:	(18)	**Name of source:**	UNMACCA
Organisation:	[Name removed]		
Mine/device:	AP blast (unrecorded)	**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 detector pinpointing

use of pick (?)

squatting/kneeling to excavate (?)

visor not worn or worn raised (?)

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 ON [Demining group] DT - 06 ON 23 JULY, 2007

INTRODUCTION:

An investigation team was convened by the Area Manager of AMAC West (Herat) to investigate the demining accident involving [the Victim] a deminer from [Demining group] DT-06. The accident occurred at 07:15 hours on 23 July 2007 at task # AF/2008/18355/ MF148 located in Nayeb Ghafoor village, Kohsan district of Herat province. The accident resulted serious injuries to the both eyes of the victim deminer.

SUMMARY:

The mentioned task is part of SHA #1 of impacted community#796 which is contaminated by AT and AP mines. The area had been surveyed partially by [Other demining group], but the survey of the task was not completed, so [Demining group] team was assigned on 02 June 2007 to clear the task based on new concept of operation. [The Victim] deminer was working in a bushy area with MIL-D1 mine detector and after he pinpointed a signal he put the detector away and started excavation of the signal by using a pick, and within a few minutes the pick stroke on the top of an AP mine and the explosion happened. The deminer had worn his PPE and helmet, but as the visor of his helmet was up, he got injuries to his face and both eyes. After receiving first aid the victim was evacuated to the hospital for more treatment.

CONCLUSIONS:

The following points were found by investigation team:

- Poor command and control was dominated during the operation of the team, because the deminer was working by pick with his visor up, but the command group of the team failed to avoid him of doing such wrong practice.
- According to team leader brief the team was working based on new concept of operation, but they did not know what the new concept of operation is.
- The report of LIS and the task order information clearly mention that the area is contaminated by both AT and AP mine but the deminers of the team were not briefed by team leader that which type of mine is expected in the task.
- It is the second accident happened in this team since 13 February 2007 that clearly shows lack of training and weak command and control of the command group.

RECOMMENDATIONS:

The following points are to be considered:

- Retraining of the team is recommended with focusing on the proper excavation drill, and the training is to be monitored by relevant AMAC.
- The command group of the team is to enhance their control on deminers and avoid them of using wrong tools and ignorance of standards.

- The command group of the team must read completely and thoroughly all the documents given by AMAC and make sure themselves of any misunderstanding, then start their work based on a proper clearance plan.
- The relevant supervisor/field officer should advise the command group of the teams to brief their team members about the key information of the task and operation, prior to commencement of actual daily operation.
- A special training is to be conducted for command group of the team with focusing on better control and manage of team activities as well as new concept of operation.

Victim Report

Victim number: 964

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 Eyes; severe Face

COMMENT: No Medical report was made available. ". . serious injuries to the both eyes".

Analysis

The primary cause of this accident is listed as *Inadequate training* because the investigators recommended that training for the deminers and their Field Managers was required. The secondary cause is listed as a *Field Control Inadequacy* because the Victim was working with his visor raised and using the wrong tool but his errors were not corrected. Failure to provide effective training is a significant *Management Control Inadequacy*, as is failure to explain the "new concept of operations" or the threats anticipated at a Task.

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 over sharing data than those internationals who presume greater responsibility.