James Madison University
JMU Scholarly Commons

Global CWD Repository | Center for International Stabilization and Recovery

5-24-2006

DDASaccident551

Humanitarian Demining Accident and Incident Database
AID

Follow this and additional works at: https://commons.lib.jmu.edu/cisr-globalcwd

Part of the Defense and Security Studies Commons, Peace and Conflict Studies Commons, Public Policy Commons, and the Social Policy Commons

Recommended Citation
Database, Humanitarian Demining Accident and Incident, "DDASaccident551" (2006). *Global CWD Repository*. 750.
https://commons.lib.jmu.edu/cisr-globalcwd/750

This Other is brought to you for free and open access by the Center for International Stabilization and Recovery at JMU Scholarly Commons. It has been accepted for inclusion in Global CWD Repository by an authorized administrator of JMU Scholarly Commons. For more information, please contact dc_admin@jmu.edu.

DDAS Accident Report

Accident details

Report date:	04/02/2008	**Accident number:**	551
Accident time:	10:48	**Accident Date:**	24/05/2006
Where it occurred:	Task # 099, Ashrafkhail village. Bagram District, Parwan Province	**Country:**	Afghanistan
Primary cause:	Management/control inadequacy (?)	**Secondary cause:**	Field control inadequacy (?)
Class:	Excavation accident	**Date of main report:**	24/08/2006
ID original source:	OPS-27/290-06	**Name of source:**	UNMACA
Organisation:	[Name removed]		
Mine/device:	PMN-2 AP blast	**Ground condition:**	dry/dusty rocks/stones
Date record created:		**Date last modified:**	04/02/2008
No of victims:	1	**No of documents:**	2

Map details

Longitude:		**Latitude:**	
Alt. coord. system:	WGS 84	**Coordinates fixed by:**	GPS
Map east:	E 069 14 30.5	**Map north:**	N 34 52 15.1
Map scale:		**Map series:**	
Map edition:		**Map sheet:**	
Map name:			

Accident Notes

inadequate investigation (?)

inconsistent statements (?)

long handtool may have reduced injury (?)

mine/device found in "cleared" area (?)

standing to excavate (?)

use of shovel (?)

visor not worn or worn raised (?)

dog missed mine (?)

Accident report

The report of this accident was made available in August 2007 as a PDF file. Its conversion to a text file for editing means that some of the formatting has been lost. The substance of the report is reproduced below, edited for anonymity. The original PDF file is held on record. Text in [ ] is editorial.

Cover letter

File: OPS-27/3006

To: Chief of Operations/DPM, UNMACA

From: Area Manager UNAMAC Kabul

Date: 24 August 2006

Subject: Investigation Report

Attached please find the investigation report along with its supporting documents of the Demining Accident happened on [the Victim] deminer of [Specialist National MDD agency] MDG-18 at MF 099 in Ashrafkhil village, Bagram district of Kabul Province on 24 May 2006. [Name removed] QMA and [Name removed] OPS Assistant for AMAC Kabul have carried out the investigation.

The findings and recommendations are mentioned in the report, forwarded for your info and further action

Demining Investigation Report

Date of report: 23 August 2006

Date of accident: 24.05.06, 1045 hrs

Location: Nr Ashraf Khail, Bagram District, Parwan Province

GR: WGS 84, E 069 14 30.5; N 34 52 15.1; GPS

Device that caused the incident/accident: PMN-2 AP blast

Device was detonated while excavating.

The task was suspended due to existing of a big ditch within MF. Totally 104162.5 sqm of the MF was cleared and 12000 sqm left un-cleared covering the ditch area.

History of the Minefield: MF # AF10308/01625/099 locates at Ashrafkhil village, Bagram district, Perwan province. This MF is part of impact survey ID 1205 SHA-01, which is reported by ALIS as high impacted community, and then the clearance was requested by locals. It is a mixed AT and AP mine contaminated area. Firstly the mines were planted by the Russians and the then government forces to block the mujahidden entrance way. For the second time mines were planted in this area during the Taleban and the northern alliance conflicts

Survey team No.03 was deployed for conducting technical survey of this area. Survey of the area was completed on 28.11.04. Total surveyed area of the task is 116,162.5 Sqm. Clearance of this area was started by MDG-18 on 19 May 05 to 02 Aug 05 and the MDG cleared 104162.5 sqm out of the surveyed area. The remaining area was suspended because of existence a ditch that requires MDU operation. Due to two AP mine accidents, which was occurred on local tractor in cleared area on 03 Dec 05 the accident was investigated by

AMAC investigation team and as result it was recommended that the cleared area still not used by local people should be rechecked because in some portion the clearance was not conducted from the original ground surface. Then MDG 18 started re-clearance of this task required area on 03 April 2006 and completed on 19 June 2006. Due to gathering sediment soils on a part of the task searching of this part by the dogs were inapplicable; therefore the team leader of the team deployed a manual party of the same team to clear this area on which the accident occurred.

Description of the incident/accident: Note: Only facts of the episode. No guessing, no statements!

On 24 May 2006, at 1045 hrs a PMN-02 detonated on [the Victim] deminer of MDG-18 while he was excavating a located signal. The located signal was a dispositioned PMN--2 mine. The deminer received multiple minor injuries on his face and also soils and smoke entered the eyes of the injured deminer. All steps of medical first aid were applied on the victim by the team medic. His eyes were washed by saline serum in the site as the soils and the dusts were removed from his eyes by the team medic then he was shifted to the Bagram Air base Hospital. According to the team leader, since his injuries were minor the victim was permitted to leave the hospital at the same day. According to the team nurse, the victim condition was good after the accident he has moved by his feet about 10 meters toward safe area; he was able to find his way and distinguish the team members as he laid on stretcher by himself.

The [Specialist National MDD agency] relevant field office firstly reported that the accident happened during demonstration in Khairkhana area, Ward-17 of Kabul city on 29 May 2006 at 2;45 pm. Then [Specialist National MDD agency] field office on 29 June 2006 reported that it was a demining accident happened during demining work at the team worksite on 24 May 2006 at 10:48 am (see attached accident reports). In view of the second report, AMAC took action for investigation this accident.

Casualties: the Victim got slight injuries on his face.

Equipment/property damage: One prodder has been completely damaged (according to TL).

Site conditions: The terrain was open and flat. The soil was soft and dry. The weather was clear, calm and mild. There was no vegetation.

[The accident site.]

Team and task details: Last QA inspection - 13.06.06. Team has been at the site from 03 April 06 to 29 June 2006. Working hours are from 06 hrs in the morning to 12 noon. There were no breaks because the Deminer was working only 30 minutes. The detector is use was the Mil D1. The prodder was a prodder made locally. The PPE was used but the visor of his

helmet was up (based on casualties he received on his face). Last leave was from 21 March to 02 April 2006.

Medical reaction time: Time of accident to Paramedic was on the accident site: 3 minutes. Time of Paramedic starting treatment to the casualty was in the ambulance ready for transport: 10 minutes. Time for ambulance to drive 15 km from site to hospital: 25 minutes. Total CASEVAC time 38 minutes. Last time a CASEVAC drill was done: 20.06.06.

Conclusion

1. The [Specialist National MDD agency] relevant field office firstly reported that the accident happened during demonstration in Khairkhana area Ward-17 of Kabul city on 29 May 2006 at 2:45 pm. Later, on 29 June the same source reported that it was a demining accident happened during demining work at the team worksite on 24 May 2006 at 10:48 am.

2. When the investigation team visited the site the team was already shifted to Logar province. The accident area was cleared and the original shape of the accident point was completely changed due to passing time. All evidences were removed from the site as they had long time for doing so.

3. Since the victim had left the worksite for Peshawar, Pakistan at the accident day and not returned back so far, therefore we could not meet him to see his condition and injuries and hear of him the actual history of the accident.

4. After passing many days of the accident, the witnesses had shared their points and opinions regarding the accident as they reflected the same points in their statements so that we could not extract actual history of the accident from the witnesses' statements.

5. The victim instead of admitting to hospital and providing the required medical report, at first day of the accident informally had left the site and had moved toward Peshawar, Pakistan.

6. From the accident date till now which becomes more than two months the victim has not returned to his job, it shows that may his injuries be critical.

7. From statements of the witnesses we could extract the following points:

The type of the detonated mine was PMN-02 and its depth was more that 30 cm.

Based on our experience we can say that the deminer was not prodding, but he was working by shovel when the mine detonated.

The deminer was dressed with PPE, but his visor was up (from the injuries in his face and the dust and smoke entered in his eyes).

Due to lack of proper command and control of the team leader and the relevant section leader and carelessness of the deminer this accident occurred.

The team has changed the clearance methodology from searching by dog to manual clearance by themselves without reporting the matter to the AMAC

Recommendations

1. All deminers while working on a located signal must pay full attention and concentrate his mind on his work, observe 30 to 35 degree angle between the prodder and the surface of the ground and consider the distance between the reading markers.

2. The IPs must report the correct and exact history of the accidents/incidents and do not convert it intentionally to a wrong history.

3. The team command group should strictly control the team and ensure that the team members are working correctly, with appropriate equipments and in accordance with the set procedure and all the team members are busy in the worksite are fully dressed with PPE.

4. Whenever any accident happens in the worksite, the team members should keep the accident point in its original shape and do not change original shape of the accident points till arrival of the investigation team.

5. The accidents report must be based on facts and reported to the AMAC office at the same day of the accident.

6. Whenever the teams want to change the task order specified clearance methodology, they should urgently report through the relevant field office to AMAC. After getting permission of AMAC the teams are authorized to change the clearance methodology.

7. The team member should reflect the facts in their statements. This can help the investigation team to easily find the facts and reflect the exact faults to the demining program till the teams do not repeat such faults in future.

Original incident report

File:OPS-27/ 2- &14/06

To: Chief of OPS/DPM UNMACA

From: Area Manager UNAMAC Kabul

Date: 30 May 2006

Subject: Non-demining Incident Report

Attached please find a copy of non-demining incident report submitted by [Specialist National MDD agency] sub- officer regarding the incident happened on [the Victim] deminer of [Specialist National MDD agency] MDG-18 who has got injuries on his eye while he was busy with shopping in Khairkhana area of Kabul city on 29 May 2006. The incident took place as result of stone throwing by demonstrators to the shop where the deminer was located.

[National MDD specialist agency]
Date: May,29,2006

File No: [Specialist National MDD agency]/KBL/Sub Office/OPS-082-006

To: Area Manager, UNAMAC Kabul

From: Sub Officer, [Specialist National MDD agency] Central Area

Subject: NON-DEMINING INCIDENT REPORT

a. Agency / Team No: [Specialist National MDD agency]/1V1DG#18

b. Date & time of report: 29,05,2006 at 2:45 PM

c. Location (Province/District): Kabul City khair khana

d. Date/Time of Injury/incident: 29,05,2006 at 02:00 PM

e. Name & F/Name of injured person: [Name removed] Emp# 1498

f. Description: Eye Injury

g. Treatment given: First aid given by local doctor then shifted to [Specialist National MDD agency] Poly clinic Kabul.

h. How incident occurred: While he was shopping in Khair Khana suburb of Khabul city the people who are on strike threw stone to the shop for which the glass of the shop was broken and multiple particle of the glass went to his eye.

g. Current condition: Good

Any other information: Full document well be submitted later on.

Follow-up letter

File: OPS/03/01-15

Date: 16 November 2006

To: See distribution list

From: Chief of Operations, UNMACA, Kabul

Subject: Follow up action on demining accident happened to the deminer of [Specialist National MDD agency] in task # 099 in Ashrafkhail village. Bagram District of Parwan Province.

Reference: Demining investigation report File: OPS-27/290-06 dated: August 24, 2006, of UN-AMAC Kabul.

A demining accident happened on May 24 2006 in clearance lane of [the Victim] the deminer of MSG-18 of [Specialist National MDD agency] in task # 099 of Ashrafkhail village, Bagram district of Parwan province, causing multiple injuries to the deminers' face and also soil and smoke entered to his eyes.

The investigation report concluded that, the accident occurred on May 24, 2006 but the [Specialist National MDD agency] relevant field office reported firstly that the accident happened during demonstrations in Khairkhana area, Ward # '17 of Kabul city, then later on 29 June the [Specialist National MDD agency] field office reported that it was a demining accident happened during operations in minefield # 099 of Bagram district of Parwan province and when the investigation team went to the site of accident for investigation, the team was relocated to Lagar province and the accident point was found changed as natural land and not any evidence of accident was seen. The investigation report further added that, the victim deminer left the Afghanistan and went to Pakistan after the accident and not returned back up to the time of investigation carried out and also the witnesses from mentioned team were counted their words and answered the same sentences for each question; but what we have derived from the statements of witnesses are as follows:

I. The type of the mine exploded was PMN-2.

II. The deminer was dressed with PPE but his visor was up i.e. the injuries in face and eyes of deminer.

III. Due to poor supervision by command group the accident occurred.

IV The team had changed the clearance methodology from searching by dog to manual clearance without reporting the matter to the AMAC.

Recommendations:

i. As the objective of investigation is lessons and learns the facts should not be hidden and relevant area office should be advised and warned.

ii. The IPs are report the immediate, correct and exact history of the accident.

iii. The team command group should strictly control the deminers during operation in order to make sure that they are using correct methodology and proper tools.

iv, Disciplinary action to be taken against command group.

Distribution List With attachment: AMACs (5), Sub AMAC Gardez and Director [Specialist National MDD agency]

Less attachment: [All demining groups in country.]

Victim Report

Victim number:	725	**Name:**	[Name removed]
Age:		**Gender:**	Male
Status:	deminer	**Fit for work:**	not known
Compensation:	Not made available	**Time to hospital:**	38 minutes
Protection issued:	Frontal apron Long visor	**Protection used:**	Frontal apron, Long visor worn raised

Summary of injuries:

minor Eyes

minor Face

minor Hearing

COMMENT: No Medical report was made available. Injuries may have been more severe.

STATEMENTS

Statement and Witness Report 1: Team Leader

Date: 1st August 2006

Q1. As we know, your team was busy in re-clearance of this task. Please express, which team had worked before you in this task, how long they worked and why the task was re-cleared?

A1. The task was firstly cleared by [Specialist National MDD agency] MDG-18 under supervision of team leader [Name removed] after completion of clearance two mines detonated under the a villager’s tractor, then the AMAC ordered for re-clearance of this task as the same team started to re clearance of this task.

Q2. On which date you commenced and ended your clearance activities in this task, whether you have found any mine or UXO in this task or not, if yes pleased described how many and which type?

A2. Re-clearance of the task was started on 03-04-06 and completed on 19-06-06.

Q3. Please explain how the accident occurred?

A3. Sediment soils had been gathered on original surface of the ground, we wanted to clear and remove this soils by manual parties based on manual clearance procedure, as the mine detonated during prodding in this area.

Q4. Previously you had reported that the victim was slightly injured during demonstration in Sarai Shamali, Ward-I 7, Kabul city, but latter you changed your opinion and reported to UNMACA saying that the victim was injured in the result of a PMN-02 mine incident occurred in the MF-084 of Ashrafkhil village, Bagram. Please explain why you did so?

A4. Yes, after the incident I prepared report of the incident for preparation of the victim insurance report.

Q5. In which date and time the accident occurred and specified the injuries that the victim received during of the incident?

A5. The incident happened on 24 May 2006 at 10:48 am. Since the deminer did not receive any injury, I did not report our office as it was my mistake.

Q6. As soon as the accident occurred you should reported through your field office to AMAC office and kept the incident point in its original shape till coming the AMAC investigation team, but you didn't so, please explain the reason?

A6. Since the deminer on whom the accident happened did not receive any injury and the accident was too small, the accident was not reported.

Q7. What was the deminer doing when the accident occurred and whether was he dressed with complete PPE or not?

A7. The deminer was prodding while the incident occurred and was fully dressed with PPE. Since the mine was deep and the deminer was properly dressed with PPE, the deminer was not injured.

Q8. Please specify how mach was the depth of the detonated mine?

A8. Depth of the mine was around 35 cm.

Q9. In accordance to the procedure the area should be searched by dog, but as it was seen the area in which the incident occurred was cleared by manual party, what was the reason?

A9. Due to gathering sediment soils on original ground surface of the incident area we just had marked the area, after some days one of the QMITs come and advised us to work this area by manual parties so we started clearance of this area manually.

Q10. Where is and what is doing the deminer on whom the accident happened nowadays?

A10. The deminer on whom the accident occurred nowadays is on without pay leave.

Statement and Witness Report 2: Assistant Group Leader

Date: 02.08.06

Q1. Please write us your observation from the accident scene so the cause of the accident is clear?

A1. To answer the above question I would like to add I was busy with dog set in A party of the above team section to control the dog set and also, ten minutes prior to the accident I checked the party whom the accident occurred by my self. The operation was going smooth and they were observing the operation with the procedure of SOP. I returned to a party to restart my checking over there. After 10 minutes I heard the explosion. The accident resulted to the injury of a Deminer. I reported the team leader by VHF radio. Then together with doctor of the team came to the patient to help him. On cause of the accident I want to add there was much soil on the ground the team leader had asked them to work manually due to much soil on the ground after our investigation we realized they have used the prodder and the prodder is touched the mine so, it is caused the accident.

Q2. Would you please clear what steps should we take to avoid such accident in the future?

A2. It would be better to not task MDG to the area where it is much extra soil on the ground and it is not a suitable task for MDG. It is better to task MCTs on such areas. If the area is small we should suspend it till MCT is available then we should task MCTs because they are much experienced on such tasks.

Q3. You have mentioned in Q.No.2 that the area was not suitable for MDG. Prior to start the clearance of the task. If it is like that then why did not reject the task prior to the clearance?

A3. Minefield No. AF/0308/01625/099 was a suitable task for MDG as a small part of the area which was near to a well a part of it was a dry valley had some extra soil also, it was located near the deep well and where the land owner wanted to start the construction and cultivation work on this area so, we our head office asked us to clear the area.

Statement and Witness Report 3: Section Leader

Date: 2nd August 2006

Q1. Please explain how the accident occurred?

A1. The party was working manually. Plenty of soils were gathered at the workplace of the party. I was busy with Party F as I suddenly heard the voice of explosion.

Q2. Which mistake of the de-miner caused the accident?

A2. I do not know what mistake of the de-miner caused the accident.

Q3. Was the deminer dressed with PPE while the accident occurred?

A3. Yes, the deminer was fully dressed with PPE.

Q4. Which parts of the victim body was injured in the accident?

A4. Since the deminer was dressed with PPE, he did not get any injury; just soils were interred in his ayes as the team nurse applied medical first aid on him.

Q5. Where the victim is and what is doing know?

A5. I do not know where he is, he is absent.

Q6. Wither you were given leave regarding this accident or not, if yes how many days?

A6. When the accident occurred, leave was announced for the team and we were on leave for one day.

Q7. If you have information, please express wither insurance has been issued to the victim or not, if yes. how much?

A7. I do not know any thing about his insurance, as I know his insurance has not been paid yet.

Q8. How much deep was the detonated mine and what type it was?

A8. The mine which caused the accident was about 30 cm depth.

Q9. Firstly you have reported that accident occurred during demonstration in Sarai Shamali, ward-17, Kabul city, but then you reported that the accident occurred in the result of demining accident in the field, please explain the reason?

A9. I do not have information about the reports you said.

Q10. How many mines your section has discovered in this task, specify with their types?

A10. The type of the mines found in this site was PMN-02, the exploded mine may also be of that type.

Q11. What was your work procedure in the accident area, wither you were searching the area by dog or reading signals by detectors.

A11. The party was working manually in accident area.

Q12. Why in the accident area instead of searching by dogs you were working by manual parties?

A12. Due to being a lot of soils on ground surface of the accident area, searching by dogs was inapplicable so the area was cleared manually.

Statement and Witness Report 4: Paramedic

Date: 02.08.06

Q1. Did you see the accident by your eyes?

A1. Yes, while the accident happened I was setting between two sections under my paramedic tent.

Q2. Please clarify how the accident happened?

A2. While I heard the explosion suddenly I took all medical equipment, which were in need and then rushed to the accident point, it had 10 M distance to cleared area. I checked the casualty step by step. I checked the general condition of the casualty I could not see any major problem. At that time as smoke and dust had affect the patient, by the way he could find the way and could recognize his friends. He got in to the stretcher himself and we did all the first Aid. He lay down on the stretcher. I started the second step I washed his eyes completely by serum. I washed all the dust from his eyes and there were no injuries in his eyes. There were some slight injuries on his face. Finally we took the patient to Bagram Hospital.

Statement and Witness Report 5: Deminer partner of Victim

Date: 02 July 2006

1. Please explain how the accident occurred?

2. Was the deminer, on whom incident happened, dressed with PPE or not?

3. The deminer which mistake caused the incident?

4. How long he has worked as deminer wither you are satisfy of his practical experience?

5. How much was the depth of the mine which caused the incident and what type was it?

6. Have you found any mine before or after of the incident in this task?

7. Which places of the victim body, during the accident, got injured?

8. Where is the victim now and why he does not present in his work.

9. Why your team firstly reported it demonstration accident and then demining accident?

Answers:

1. Finishing my work period, I went to the rest area located 50 meters away from our party workplace and my partner started to work, while he was prodding the accident happened.

2. Yes he was dressed with PPE.

3. Since he was prodding and I was resting, I did not see his mistake.

4. He has been appointed as deminer in the year 2003 and have sufficient experienced in demining.

5. The mine was too deep; mass of soils was collected on it had about 40 cm depth. I could specify type of the mine.

6. After clearance while the villagers' tractor was ploughing, two mines were detonated, as MDG-18 started re-clearance of the task.

7. I could not see any serous injuries on the body of victim; just spot injuries were seen on face of the victim as the team treated his injuries.

8. After the accident I could not met him.

9. I do not have any information in this regard.

Analysis

The primary cause of this accident is listed as a "Management control inadequacy" because the management of the demining agency initially lied in order to conceal the true nature of the accident. This was irresponsible and set all their employees a very bad example. It implies that they did not want the true cause to be known, or to have to take corrective actions that they knew would be required. The fact that the Victim subsequently disappeared is a matter of concern.

The secondary cause is listed as a "Field control inadequacy" because the Victim was working with his visor raised and his error was not corrected.

It is not clear why the agency reported the accident later. Perhaps it was to ensure that the Victim received compensation from the insurers? But that conflicts with the consistent claims of the Field supervisors that his injuries were not serious.

This accident is listed as an "Inadequate investigation (?)" under Notes because the investigators did not find out what had happened. Given the time lapse between the accident and the investigation, it may have been impossible for them to do so.

It seems that MDDs may have missed this mine during the previous clearance of the area.