

7-8-2008

# DDASaccident631

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, "DDASaccident631" (2008). *Global CWD Repository*. 830.  
<https://commons.lib.jmu.edu/cisr-globalcwd/830>

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](mailto:dc_admin@jmu.edu).

# DDAS Accident Report

## Accident details

<b>Report date:</b> 05/03/2011	<b>Accident number:</b> 631
<b>Accident time:</b> 09:19	<b>Accident Date:</b> 08/07/2008
<b>Where it occurred:</b> Pusht-e- Band (Burma) village, Khoram Saharbagh district, Samangan Province	<b>Country:</b> Afghanistan
<b>Primary cause:</b> Victim inattention (?)	<b>Secondary cause:</b> Field control inadequacy (?)
<b>Class:</b> Excavation accident	<b>Date of main report:</b> Not recorded
<b>ID original source:</b> OPS/14101-17	<b>Name of source:</b> UNMACCA
<b>Organisation:</b> [Name removed]	
<b>Mine/device:</b> PMN AP blast	<b>Ground condition:</b> not recorded
<b>Date record created:</b>	<b>Date last modified:</b> 05/03/2011
<b>No of victims:</b> 1	<b>No of documents:</b> 1

## Map details

<b>Longitude:</b>	<b>Latitude:</b>
<b>Alt. coord. system:</b> Not recorded	<b>Coordinates fixed by:</b>
<b>Map east:</b>	<b>Map north:</b>
<b>Map scale:</b>	<b>Map series:</b>
<b>Map edition:</b>	<b>Map sheet:</b>
<b>Map name:</b>	

## Accident Notes

inadequate investigation (?)  
visor not worn or worn raised (?)  
squatting/kneeling to excavate (?)

## Accident report

The only report of this accident that has been made available to date was in a UNMACCA accident summary. 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 summary is reproduced below, edited for anonymity.

## **Mine Action Coordination Centre of Afghanistan (MACCA)**

File: OPS/14101-17

Date: August 12, 2009

Subject: INVESTIGATION REPORT LESSONS LEARNED OF [Demining group] MU-16  
DEMINE ACCIDENT IN SAMANGAN PROVINCE

Attached please find the investigation report and Lessons Learned from the demining accident, occurred to one of deminer of [Demining group] MU-16 on 08 July 2009 at 09:19 hours in Pusht-t-Band (Burma) Village, Saharhagh district of Samangan Province.

### **LESSONS LEARNED SUMMARY OF [Demining group] MU-16 DEMINE ACCIDENT**

#### **INTRODUCTION:**

An investigation team was convened by AMAC North to investigate the demining accident involving [the Victim] the deminer of [Demining group] MU-16. The accident occurred at 09:19hrs on 08 July 2009 at minefield number AF/1506/13176/H- 5157, located in Pusht-e-Band (Burma) village, Khoram Saharbagh district of Samangan Province.

#### **SUMMARY:**

Minefield # AF/1506/1317611-1- 5157 is located on a hill about 500 metres away from the village of Burma, which was front line between belligerent groups during internal war. From the military point of view this area was important for both sides of the conflict factions; therefore, the AP mines were laid there in 1991 by Sayed Kayan militia to stop the attacks of their opposition. Four accidents occurred on animal from 1996 to 1998. However, the area is mined but it is partially cultivated by villagers.

On 1st July 2009 MU-16 of [Demining group] started clearance operation on mentioned task, On 08 July 2009 at 0919hrs while [the Victim] was investigating a signal in his clearance lane, he found two bullets. He re-checked the spot and found the same signal, this process repeated for three times. Finally he found a root stump in the excavation trench with a thickness of around 2.5 cm and started to remove it, because it was blocking further excavation there. However the deminer had proper tool in his toolkit to cut such obstacles, but he tried to cut it with his scraper. After a few chops of the root stump with a scraper, a PMN mine was initiated and caused the accident. As it seems from the investigation report, the root was located on the pressure plate of mine, so it went off because of applying pressure on it. Fortunately as the deminer was fully dressed with PPE, he got some non-critical injuries. The visor was scratched by accident so he got some injuries on his face, but none of the injuries were severe.

#### **CONCLUSIONS:**

The accident occurred because of carelessness of deminer, as he wanted to remove the root stump for further investigation of a detected signal, but used the scraper instead of secateurs available in his toolkit. The command group did not pay attention to see and stop him from such action.

#### **RECOMMENDATIONS:**

However, the [Demining group] has taken disciplinary actions against the command group, but as a lessons learned the following points are to be considered by all demining teams:

- A. The command group should strictly control the deminers during the operations and stop them when practicing in contrary to the organization SOP.
- B. The deminers should not hurry up during the excavation, be careful and seek guidance from their command group when facing such obstacles during the operations.
- C. Demining organizations should make sure that their team deminers know the approved safe working procedures and if needed refresher training is to be conducted.

### Victim Report

<b>Victim number:</b> 813	<b>Name:</b> [Name removed]
<b>Age:</b>	<b>Gender:</b> Male
<b>Status:</b> deminer	<b>Fit for work:</b> not known
<b>Compensation:</b> Not made available	<b>Time to hospital:</b> Not made available
<b>Protection issued:</b> Frontal apron Long visor	<b>Protection used:</b> Frontal apron, Long visor

**Summary of injuries:**

INJURIES: minor Face

COMMENT: No Medical report was made available.

### Analysis

The primary cause of this accident is listed as *Victim Inattention* because it seems that the Victim worked incautiously despite having appropriate tools to hand. The secondary cause is listed as a *Field Control Inadequacy* because the Victim’s errors – which probably included wearing a raised visor) were not corrected. The demining group’s senior management apparently acted to correct field supervision errors, so are to be commended.

This demining group wear a frontal vest that does not have a collar interfacing with the visor (so does not meet the minimum IMAS requirement) so it is possible that ejecta from the blast could have struck the Victim’s lower face and throat without the visor being raised.

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 in contravention of the requirements of the IMAS. The existence of a good summary implies that the Afghan investigators carried out a professional investigation and generated a detailed report that should be shared.