6-9-2009

DDASaccident633

Humanitarian Demining Accident and Incident Database

AID

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## DDAS Accident Report

### Accident details

<table>
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<th>Report date:</th>
<th>05/03/2011</th>
<th>Accident number:</th>
<th>633</th>
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<tbody>
<tr>
<td>Accident time:</td>
<td>07:55</td>
<td>Accident Date:</td>
<td>09/06/2009</td>
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<tr>
<td>Where it occurred:</td>
<td>AF12008/003241H453 3-8, Kandak-e-921 Sarhadi area, Kohsan District, Herat Province</td>
<td>Country:</td>
<td>Afghanistan</td>
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<tr>
<td>Primary cause:</td>
<td>Field control inadequacy (?)</td>
<td>Secondary cause:</td>
<td>Management/control inadequacy (?)</td>
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<tr>
<td>Class:</td>
<td>Excavation accident</td>
<td>Date of main report:</td>
<td>30/06/2009</td>
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<td>ID original source:</td>
<td>OPS/14/01-11: Ref: 09,06,199</td>
<td>Name of source:</td>
<td>UMACCA</td>
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<td>Organisation:</td>
<td>[Name removed]</td>
<td>Ground condition:</td>
<td>not recorded</td>
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<tr>
<td>Mine/device:</td>
<td>AP blast (unrecorded)</td>
<td>Date record created:</td>
<td></td>
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<tr>
<td>Date record created:</td>
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<td>Date last modified:</td>
<td>05/03/2011</td>
</tr>
<tr>
<td>No of victims:</td>
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<td>No of documents:</td>
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### Map details

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<td>Alt. coord. system:</td>
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### Accident Notes

- inadequate investigation (?)
- Inadequate detector pinpointing
- safety distances ignored (?)
- 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 UMACA accident summary. The conversion into a DDAS file has led to some of the original formatting
INVESTIGATION REPORT & LESSONS LEARNED OF [Demining group] DT-18 DEMINING ACCIDENT IN KANDAK-E- 921 SARHADI AREA, KOSAN DISTRICT OF HERAT PROVINCE

Attached please find the investigation report and Lessons Learned from the demining accident, occurred to [Demining group] DT-18 on 09 June 2009 at 07.55 hours in Kosan district of Herat Province.

LESSONS LEARNED SUMMARY OF [Demining group] DT- 18 DEMINING ACCIDENT

INTRODUCTION:

An investigation team was convened by AMAC West to investigate the demining accident involving [Victim No.1] and [Victim No.2] the Deminers from [Demining group] DT-18. The accident occurred at 7:55 hours on 09 June 2009 at minefield number AF12008/003241H4533-8, located in Kandak-e-921 Sarhadi area, Kohsan district of Herat province.

SUMMARY:

AF/2008/00324/H4533-13 is an anti-personnel mine contaminated area laid by the government forces during the Russian invasion in Afghanistan. The mines are laid in 2 rows as a belt surrounding Kandak-e-921 Sarhadi in order to secure their positions from the attacks of Mujahedeen. [Demining group] DT-18 was tasked for the clearance of mentioned area, on 9th of June 2009 at 07:55 am deminer [Victim No.1] was working in his clearance lane excavating a detected signal, his prodder touched a mine and caused it to explode. According to the investigation report the signal was not pinpointed correctly and the deminer has used his prodder directly on the top of mine, so the accident happened. As a result of accident [Victim No.1] got severe injures on his both eyes and face and lost his right eye completely, because his visor was up during the operation. Another deminer named [Victim No.2] was also injured in this accident, because of being in a close proximity to [Victim No.1]. [Victim No.2] was carrying some painted rocks for marking purpose. He has also got injuries on his face. The command group was failed to control and stop them.

CONCLUSIONS:

As it seems, the carelessness of victim deminer and poor supervision are the contributing factors to this accident, but it is a management problem that a demining team is working on a mine belt, without considering safety procedures at all i.e. not using PPEs, not considering safety distance and lack of command and control. It means the performance of team has not been evaluated by the operations department.

RECOMMENDATIONS:

The following points are to be considered:
Demining group operations department is requested to present their management solution for such accidents in the future and provide MACCA OPS department with written documents by no later than 5th of July 09.

Victim Report

Victim number: 815
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
Protection used: Frontal apron
Long visor

Summary of injuries:
INJURIES: severe Eye, severe Face
AMPUTATION/LOSS, Eye Right
COMMENT: No Medical report was made available.

Victim Report

Victim number: 816
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
Protection used: Not recorded
Long visor

Summary of injuries:
INJURIES: severe Face
COMMENT: Facial injuries. No Medical report was made available.

Analysis

The primary cause of this accident is listed as a Field Control Inadequacy because Victim No.1 was working with his visor raised and his error was not corrected. Victim No.2 was close by (with no visor) and so breaching IMAS recommended working distances (10m in an AP blast mine area). The secondary cause is listed as a Management Control Inadequacy because the investigators identified “poor supervision” as a main cause and it is the senior management’s responsibility to ensure that appropriately trained, experienced and responsible field managers are in place.

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.