

James Madison University

JMU Scholarly Commons

Global CWD Repository

Center for International Stabilization and
Recovery

9-28-2010

DDASaccident640

HD-AID

Humanitarian Demining Accident and Incident Database

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

HD-AID, "DDASaccident640" (2010). *Global CWD Repository*. 839.
<https://commons.lib.jmu.edu/cisr-globalcwd/839>

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: 07/07/2011	Accident number: 640
Accident time: 11:30	Accident Date: 28/09/2010
Where it occurred: AF/3203/07956, MF0034, Gosha Village, Tani District, Khost Province	Country: Afghanistan
Primary cause: Inadequate training (?)	Secondary cause: Field control inadequacy (?)
Class: Missed-mine accident	Date of main report: 29/11/2010
ID original source: None	Name of source: UNMACCA
Organisation: [Name removed]	
Mine/device: PMN-2 AP blast	Ground condition: not recorded
Date record created:	Date last modified: 07/07/2011
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

protective equipment not worn (?)
visor not worn or worn raised (?)
inadequate investigation (?)
mine/device found in "cleared" area (?)

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] DEMINING ACCIDENT

INTRODUCTION:

The demining investigation team was convened by AMAC Southeast to investigate the causes of demining accident occurred to [Demining group] involving Mr. Rasool Badshah S/O Syal Badshah the de-miner of [Demining group] CDBT-13. The accident occurred on 28 Sep 2010 at 11:30am in task No. AF/3203/07956/MF0034 located in Gosha village, Tani district of Khost province.

SUMMARY:

Task number AF/3203/07956/MF0034 is located on the top of a hill on west side of Gosha village. The area was mined by Russian troops during 1987-1992 to prevent their positions from the attacks of Mujahidin. The area was polygon surveyed by [Demining group] LIAT in November 2009, [Demining group] CDBT-13 started clearance operations there on 10 Dec 2009. 74% of the task was cleared and 53 AP mines destroyed by the team till the accident happened.

According to the witness statements and the physical observation of the accident point, the accident happened while the de-miner was walking from the rest area to his clearance lane. He stepped on missed PMN anti-personnel mine in cleared area. Therefore, this mine was missed during the clearance operation. The exploded mine resulted in below knee amputation of deminer's right leg, multiple injuries on his left leg, left foot heel, right hand palm and some minor injuries on his right arm. The de-miner was sent to Khost hospital after receiving first aids in the site. While accident happened the de-miner did not have PPE on, he was walking in cleared area to proceed to his clearance lane after the break time.

The previous team leader of this team was shifted to other CBD project by [Demining group] and the new team leader was appointed to this team from the community. The QC check had not been conducted by section leader and team leader on the cleared lane where the mine was missed.

CONCLUSIONS:

A missed mine caused this accident.

RECOMMENDATIONS:

The following points are to be considered by [Demining group]:

- [Demining group] operations department should make sure that the command group of the teams are conducting QC checks of the cleared ground as outlined in [Demining group] QM SOP, section 24-1.
- The command group should make sure that the detectors are tested and compensated to the ground on daily basis.
- [Demining group] operations department should develop and implement a capacity development plan for their teams especially the CBD teams as the majority of [Demining group] accidents are relating to CBD projects.
- The deminers should check their detectors prior to start operations after any break. [The detector is use was the Ceia.]

Feedback on any preventive and corrective actions taken by [Demining group] is required to be submitted to the MACCA within 7 days, effective from the issue of this report.

Victim Report

Victim number: 823	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: None

Summary of injuries:

INJURIES: minor Arm, severe Foot, severe Hand, severe Leg

AMPUTATION/LOSS: Leg Below knee

COMMENT: No Medical report was made available. "below knee amputation of deminer's right leg, multiple injuries on his left leg, left foot heel, right hand palm and some minor injuries on his right arm".

Analysis

The primary cause of this accident is listed as *Inadequate training* because the investigators recommended improved metal detector training to avoid missing mines. The secondary cause is listed as a *Field Control Inadequacy* because the area had not been subjected to an internal QA check and should not have been treated as clear until that check had been completed. The failure of the demining group's managers to ensure that appropriate training was conducted and appropriate QA checks took place was a significant *Management Control Inadequacy*.

Metal detector checks and calibration should be conducted regularly throughout the day because battery condition can deteriorate rapidly, and temperature variations can adversely affect ground calibration. The number of problems with this Ceia detector in this theatre raises questions about both the detector model and the training.

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.