

10-10-2009

# DDASaccident641

Humanitarian Demining Accident and Incident Database  
*AID*

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# DDAS Accident Report

## Accident details

<b>Report date:</b> 05/03/2011	<b>Accident number:</b> 641
<b>Accident time:</b> 11:20	<b>Accident Date:</b> 10/10/2009
<b>Where it occurred:</b> MF 322, Navy Deh village, Daman district, Kandahar Province	<b>Country:</b> Afghanistan
<b>Primary cause:</b> Field control inadequacy (?)	<b>Secondary cause:</b> Management/control inadequacy (?)
<b>Class:</b> Excavation accident	<b>Date of main report:</b> Not recorded
<b>ID original source:</b> OPS, 14/01-27	<b>Name of source:</b> UNMACCA
<b>Organisation:</b> [Name removed]	
<b>Mine/device:</b> PMN AP blast	<b>Ground condition:</b> hard rocks/stones
<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 (?)  
use of pick (?)  
squatting/kneeling to excavate (?)  
inadequate training (?)  
non injurious accident (?)

## Accident report

The only report of this accident that has been made available to date is a UNMACCA Lessons Learned Summary supplied as a PDF file. Its conversion into a DDAS file has led to some

formatting being lost. Text in square brackets [ ] is editorial. This record will be revised as more information becomes available.

The accident summary is reproduced below, edited for anonymity.

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

File: OPS, 14/01-27

Date: 1<sup>st</sup> December 2009

Subject: INVESTIGATION REPORT & LESSONS LEARNED OF [Demining group]-DT-16 DEMINING ACCIDENT

Attached please find the investigation report and lessons learned of [Demining group] -DT-16 demining accident occurred on 10 October 2009 in Navy Deh village, Daman district of Kandahar Province.

### **LESSONS LEARNED SUMMARY OF [Demining group] DT-16 DEMINING ACCIDENT**

#### **INTRODUCTION:**

An investigation team was convened by the AMAC South to investigate the demining accident involving [the Victim] the Deminer of [Demining group] DT-16. The accident occurred at 11:20 hours on 10 Oct 2009 at the minefield number AF/2402/211881MF 322, located in Navy Deh village, Daman district of Kandahar province.

#### **SUMMARY:**

MF # 322 is an anti-personal mine contaminated area, part of a big mine belt around Kandahar Airfield (KAF). The area was of great importance from the military point of view, so the Russian troops planted mines there to protect their positions from the attacks of Mujahedeen and secure the KAF.

On 10 Oct 2009 at 11:20 hrs when [the Victim] deminer was working in his clearance lane with a pickaxe that suddenly an explosion happened. As per investigation report the deminer was using pickaxe instead of bayonet because the ground surface was hard. He started to prepare a trench by pickaxe from second reading marker for further investigation of the signal, but there was a stone in close vicinity of pinpointed spot and the deminer wanted to remove it, so his pickaxe might touched the PMN mine or the stone put extra pressure on the mine and the explosion happened. Fortunately the deminer was fully dressed with PPE while the accident happened; therefore, he did not receive any injuries, but the visor broken down.

#### **CONCLUSIONS:**

Almost all the accidents of [Demining group] in Southern area and some of them in central area are because of the improper use of pickaxe during the clearance operations. It is also concluded that the carelessness of deminers, lack of proper training on where and how to use the pickaxe and poor supervision the main are contributing factors to all these accidents.

#### **RECOMMENDATIONS:**

As the use of pickaxe and its relation with demining accidents is an issue now in [Demining group] teams, therefore, it is strongly recommended to [Demining group] operations and QA cell to review the use of pickaxe on whether to use the pickaxe in future operations or

completely remove it. If [Demining group] is going to continue with pickaxe, so they shall make sure that it is used according to the standard operating procedures.

As the visor was broken down with the blast of a PMN mine, so it is also recommended to [Demining group] to conduct a trail on new visors and make sure that it can resist against blast mines from a specific distance i.e. between deminer's face and a hazard item during demining operations.

MACCA OPS department is waiting to receive a written report from [Demining group] after 10 days of distribution of this report.

### Victim Report

<b>Victim number:</b> 824	<b>Name:</b> [Name removed]
<b>Age:</b>	<b>Gender:</b> Male
<b>Status:</b> deminer	<b>Fit for work:</b> yes
<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:

COMMENT: No injuries recorded. No Medical report was made available.

#### Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the Victim was using a pickaxe to investigate a metal detector reading and his error was not corrected. The secondary cause is listed as a *Management Control Inadequacy* because the investigators imply that the use of the pickaxe is approved by the management when they recommend that its use be changed.

The use of a pickaxe on hard ground in Afghanistan has been common since the early 1990s despite UN edicts intended to stop its use. The hard ground can make the bayonet (a common and inappropriate alternative) intolerably slow.

Details of the broken visor were not provided, but 5mm polycarbonate visors are not able to survive a PMN mine blast without damage. If the visor protected the Victim's face, it performed appropriately.

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 the accident summary implies that the Afghan investigators did make a comprehensive report and the failure of the UN to share it with others is regrettable.