

10-11-2009

DDASaccident646

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, "DDASaccident646" (2009). *Global CWD Repository*. 845.
<https://commons.lib.jmu.edu/cisr-globalcwd/845>

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: 05/03/2011	Accident number: 646
Accident time: 12:15	Accident Date: 11/10/2009
Where it occurred: MF 5274, Kar Kar village, Baghlan district, Baghlan, Province	Country: Afghanistan
Primary cause: Field control inadequacy (?)	Secondary cause: Management/control inadequacy (?)
Class: Excavation accident	Date of main report: Not recorded
ID original source: OPS, 14/01-28	Name of source: UNMACCA
Organisation: [Name removed]	
Mine/device: AP blast (unrecorded)	Ground condition: not recorded
Date record created:	Date last modified: 05/03/2011
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

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

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, 14/01-28

Date: December 1st 2009

Subject: INVESTIGATION REPORT & LESSONS LEARNED OF [Demining group] - MDG -13
DEMINE ACCIDENT

Attached please find the investigation report and lessons learned of [Demining group] -MDG-13 demining accident occurred on 11 October 2009 in Kar Kar village, Baghlan district of Baghlan Province.

LESSONS LEARNED SUMMARY OF [Demining group]- DG-13 DEMINE ACCIDENT

INTRODUCTION:

An investigation team was convened by AMAC NE to investigate the demining accident involving [the Victim] the deminer of [Demining group] MDG-13. The accident occurred at 12:15 hours, 11 Oct 2009 in Task # AF/13/1312/32114/MF 5274 located in Kar Kar village, Baghlan district of Baghlan Province.

SUMMARY:

Task # AF/13/1312/32114/MF 5274 is an anti-personnel mine contaminated area which was recorded by LIS under the community No. 1473 SHA 01 then polygon by [another demining group]. This area was mined during the internal war from 1996-2001 because of its location from the military point of view. As the area was of military importance for both side of conflict faction, so was hand to hand between them and they put mines to prevent their positions from the attacks of each other. So far 2 accidents on human and 3 on animal have been reported in this area. Size of the area is 39150sqm. During the clearance operation, 33770sqm area cleared and 34 anti-personnel mines were found/destroyed by MDG-13.

On 11 Oct 2009 at 12:15 am while [the Victim] deminer was excavating a detected signal in his clearance lane, his bayonet hit top of an anti-personnel mine and caused it to go off. According to the investigation report, it seems that the deminer started the excavation drill directly from the centre of the detected signal by his bayonet and caused the mine to be exploded. The deminer had the PPE and visor but as the visor was not properly used so he got some superficial injuries on his face, eyes.

CONCLUSIONS:

However the victim was a trained and experienced deminer and there was no any obvious point of concern with him, but he was careless during the investigation of detected signal. The other important point outlined in investigation report was: "the assistant team leader was unable to control and supervise the deminers under his supervision", and he is lack of basic knowledge of reading and writing.

RECOMMENDATIONS:

The following points are to be considered:

A. It is the responsibilities of respective IP's operations department to make sure that a proper system of command and control exists in the field,

B. Inappropriate use of visor resulted in injuries to the eyes and face of involved deminer, therefore, all the command groups are strongly recommended to strengthen their focus on this point and never allow their deminers to use the PPE inappropriately.

C. The [Demining group] Operations department is to take more professional steps to build up and develop a strong capacity of command and control mechanism within their teams and assign qualified people as Team Leader, Asst Team Leader and Section Leaders.

D. Feedback on any preventive and corrective actions taken by [Demining group] is required to be submitted to the MACCA OPS department by no later than 7 days, effective to the issue date of this letter.

Victim Report

Victim number: 829	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: Frontal apron

Summary of injuries:

INJURIES: minor Eyes, minor Face

COMMENT: No Medical report was made available.

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the investigators found that the Victim was working inappropriately with his visor raised and his error was not corrected. The Investigators criticised the quality of the field supervision, which had no effective control. The provision of appropriately qualified, experienced and effective field supervision is a management responsibility so the secondary cause is listed as a *Management Control Inadequacy*.

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.