

12-15-2009

DDASaccident661

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, "DDASaccident661" (2009). *Global CWD Repository*. 860.
<https://commons.lib.jmu.edu/cisr-globalcwd/860>

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: 06/03/2011	Accident number: 661
Accident time: 11:30	Accident Date: 15/12/2009
Where it occurred: MF 015, Choni Village, Khanabad District, Kunduz Province	Country: Afghanistan
Primary cause: Field control inadequacy (?)	Secondary cause: Management/control inadequacy (?)
Class: Excavation accident	Date of main report: 11/01/2010
ID original source: OPS/14/01- 03	Name of source: UNMACCA
Organisation: [Name removed]	
Mine/device: AP blast (unrecorded)	Ground condition: not recorded
Date record created:	Date last modified: 06/03/2011
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 (?)
visor not worn or worn raised (?)
protective equipment not worn (?)
standing to excavate (?)
use of pick (?)
Inadequate detector pinpointing (?)
inadequate training (?)

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.

United Nations Mine Action Centre for Afghanistan

File: OPS/14/01- 03

Date: 11th January 2010

Subject: Investigation Report & Lessons Learned of [Demining group]/E0D-01 Demining Accident

Attached please find the investigation report and Lessons Learned of Demining Accident, which occurred on 15 December 2009 in Choni Village, Khanabad District of Kunduz Province.

LESSONS LEARNED SUMMARY OF [Demining group] E0D-01 DMINING ACCIDENT

INTRODUCTION:

An investigation team was convened by the AMAC-NE to investigate the circumstances involved in the demining accident occurred to [the Victim] the Team Leader of [Demining group] EOD-01. The accident happened at 11:30 hrs, 15 Dec 2009 at Task # AF/1405/00000/MF 015 located in Choni Village, Khanabad District of Kunduz Province.

SUMMARY:

MF: AF/1405/00000/MF015 is agricultural land located in Choni village of Khan Abad district and has been recorded by LIS under the community No 1600 then polygoned by MCPA in 2008. It is an area contaminated by anti-personnel mines. Mines were laid to this area by different belligerent militias during the civil war time 1993-2000, specifically during the armed conflicts between the Taliban and northern alliance's forces. The northern alliance planted mines around their military posts to protect them from being attacked by the Taliban

According to the request received from locals on 15th Dec 2009, [Demining group] EOD-01 was tasked by the MACCA/AMAC to clear this area. The size of minefield is 875 m2 and the accident happened on the first day of demining operations at this minefield.

At 11:30 hrs on 15th Dec 2009, [the Victim] the Team Leader of the EOD -01 was working as a deminer and trying to identify the actual mined area. While he was excavating on a signal by a pick, he hit the mine and it caused to the accident. As [the Victim] was not well prepared and fully dressed with PPE, he has got severe injures to face, eyes and forehead.

CONCLUSIONS:

The investigation report indicates that [the Victim] has used the pick which is not a standard excavation tool for excavating a detected signal. In addition to that, he started excavation from the centre of signal while as per the standard prodding/excavation drill, it should be started 15 centimetres back from the signal.

Poor supervision has been recognized as a contributing factor to this accident as the team leader who normally has a controlling role has worked as deminer without observing the safety procedures. He has failed to wear PPE and also used the pick which is not a correct tool for excavation.

RECOMMENDATIONS:

To prevent recurrence of similar accidents in the future, the following points are recommended to [Demining group] management:

- 1) Full PPE and visors should be worn correctly at all time by demining personnel during the course of demining operations in the fields.
- 2) The [Demining group] management should take practical steps to ensure demining operations are carried out in accordance to the organization's SOP and unnecessary and incorrect practices are avoided by ail [Demining group] personnel,
- 3) Picks shall be removed entirely from all [Demining group] deminer's tool kits and/or held centrally at the administration area. The pick shall only be removed from the administration area for use on the clearance site with the direct authority of the Team Leader. [Demining group] shall amend its SOPs to reflect this practice and forward the amendment to MACCA QA Section.
- 4) [Demining group] management shall provide MACCA HQ with feedback on all preventive and corrective actions taken by [Demining group] within 7 days, effective to the issue date of this letter.

Victim Report

Victim number: 844	Name: [Name removed]
Age:	Gender: Male
Status: supervisory	Fit for work: not known
Compensation: Not made available	Time to hospital: Not made available
Protection issued: Not recorded	Protection used: Not recorded

Summary of injuries:

INJURIES: severe Eyes, severe Face, severe Head

COMMENT: No Medical report was made available.

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the Victim was a field supervisor working in breach of basic safety rules including failing to use PPE. The secondary cause is listed as a *Management Control Inadequacy* because the selection and training of field supervisors is a management responsibility.

The *Inadequate training* listed under Notes refers to the excavation beginning directly on top of a mine while using an inappropriate tool. If a field supervisor would do this, it is likelky that the deminers would also.

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.