

5-27-2009

DDASaccident711

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, "DDASaccident711" (2009). *Global CWD Repository*. 910.
<https://commons.lib.jmu.edu/cisr-globalcwd/910>

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: 711
Accident time: 08:40	Accident Date: 27/05/2009
Where it occurred: AF/2402/21188, MF0322, Navy Deh Village, Daman District, Kandahar Province	Country: Afghanistan
Primary cause: Field control inadequacy (?)	Secondary cause: Management/control inadequacy (?)
Class: Other	Date of main report: 15/06/2009
ID original source: None	Name of source: UNMACCA
Organisation: [Name removed]	
Mine/device: AP blast (unrecorded)	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

inadequate investigation (?)
inadequate training (?)
protective equipment not worn (?)
inadequate survey (?)

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.

File last changed: 14th September 2009

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 Section Leader of [Demining group] DT-16. The accident occurred at 08:40 hours on 27 May 2009 at the minefield number AF/2402/21188/MF 0322, located in Navy Deh village, Daman district of Kandahar province.

SUMMARY:

MF # AF2402/21188/MF322 is an anti-personal mine contaminated task around Kandahar Airbase. During Russian invasion on Afghanistan a security belt of landmine was established by the government forces to secure the airbase from the attacks of Mujahedeen. MF 322 is one of the minefields covered in the above mentioned mine belt.

On 27 May 2009 at 0840 hrs [the Victim] the section leader of [Demining group] DT-16 entered to a mined area which was not covered in current MF, stepped on a mine and caused the accident. According to the investigation report the section leader left the site for admin area in order to bring painted rocks for the marking purpose, on the way back from the admin area he wanted to use the shortest way, entered to unsafe area and the accident occurred. He had taken off his PPE and visor. As a result of accident the victim has lost his left leg from below knee and got multiple injuries on his right leg and both hands.

CONCLUSIONS:

Poor management of the team daily operations caused this accident. As the team leader did not have a complete sight of his team to control his personnel during the operations. Additionally deminers should paint the rocks in the site; there is no need to carry painted rocks from a distance of around 500 meters for the marking of clearance lanes. It is not the job of section leaders to carry painted rocks to the team, but they are assigned to conduct supervision throughout the operations period.

RECOMMENDATIONS:

[Demining group] operation is recommended to review the current capability of command group in the team and take necessary actions. [Demining group] management is also requested to come up with a management solution to this problem and present their plan of action to prevent such accident in the future. MACCA OPS department expects to hear from [Demining group] by no later than 22nd of June 2009 that:

- identifies why the accident occurred
- Puts into place steps designed to prevent the recurrence of this type of accident in the future.

Victim Report

Victim number: 896	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: Frontal apron Long visor	Protection used: None

Summary of injuries:

INJURIES: severe Hands; severe Leg

AMPUTATION/LOSS: Leg Below knee

COMMENT: No Medical report was made available. "the victim has lost his left leg from below knee and got multiple injuries on his right leg and both hands".

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the investigators state that the Victim was engaged in an activity that he should not have been doing – because he should have been supervising deminers. The cause may have been an *Inadequate survey* because it is likely that the Victim thought he was walking across a non hazardous area when the accident occurred. The area may have been a recorded hazardous area, in which case the field supervisors should have been told that there directly adjacent task areas. The failure to tell the demining group that there was a hazardous area alongside, (or for the group managers to tell its field supervisors that there was), is a serious *Management Control Inadequacy*, so this is the secondary cause assigned.

The summary asks the demining group to identify a cause for the accident, and to identify the corrective measures needed. This implies that the investigators were relying on an "internal" investigation rather than making an independent investigation themselves. It is possible that the security situation at the time prevented the investigators from visiting the accident site.

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.