

2-24-2009

DDASaccident716

Humanitarian Demining Accident and Incident Database
AID

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DDAS Accident Report

Accident details

Report date: 07/07/2011	Accident number: 716
Accident time: 10:00	Accident Date: 24/02/2009
Where it occurred: AF/1614/147, MF0018, Mullah Sultan Village, Khulam District, Balkh Province	Country: Afghanistan
Primary cause: Field control inadequacy (?)	Secondary cause: Inadequate survey (?)
Class: Other	Date of main report: 08/06/2009
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 survey (?)

inadequate area marking (?)

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 date: 8th June 2009

LESSONS LEARNED SUMMARY OF [Demining group] DT-30 DMINING ACCIDENT

INTRODUCTION:

An investigation team was convened by AMAC North to investigate the de-mining accident involving [the Victim] the De-miner from [Demining group] DT-30. The accident occurred at 10:00 hours on 24 February 2009 at minefield number AF/1614/147/MF0018, located in Mullah Sultan village, Khulam district of Balkh province.

SUMMARY:

Minefield # AF/1614/147/MF0018 is an anti-personnel contaminated site which was mined by Russian backed government during the war period 1980-1989 and then during internal war period 1992-1995. This task is located on the top of a hill near to Khulm district HQ. Around 11 accidents happened in this SHA so far.

On 18 November 2008, [Demining group] DT-30 started de-mining operation in the area which was suspended by [Demining group] demining team. On 24 February 2009 at 10:00 MDU was busy in preparation operation in mentioned task and get closed to the manual parties, thus the manual parties were instructed by command group to stop the work and keep safety distance with Machine.

[The Victim] was working in one of the closest lanes to MDU, therefore, he also stopped the operations and wanted to keep safety distance with operating machine, he crossed the boundary of minefield and entered to a suspected area, he stepped on a mine there, and the accident happened. The consequences of this accident were traumatic amputation of left leg plus some superficial injuries on right leg and right hand fingers of deminer.

CONCLUSIONS:

It is concluded that although elements of poor task reconnaissance and an inadequate technical survey both contributed towards the accident occurring, the biggest contributing factors were the failure of the command group to maintain control of their operation and lack of professional discipline displayed on the part of the deminer.

RECOMMENDATIONS:

The director of [Demining group] is requested to respond to the MACCA with a management solution that; identifies why the accident occurred and, puts into place steps designed to prevent the reoccurrence of this type of accident.

[Demining group] is requested to respond no later than COB 7 Jun 09.

The request should be addressed to the MACCA CoO.

Victim Report

Victim number: 905	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	Protection used: Not recorded

Long visor

Summary of injuries:

INJURIES: minor Hand; minor Leg

AMPUTATION/LOSS: Leg

COMMENT: No Medical report was made available. "traumatic amputation of left leg plus some superficial injuries on right leg and right hand fingers.

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the investigators found a "failure of the command group to maintain control of their operation". They should have ensured that their deminers knew where it was safe to walk. It seems likely that the area marking was inadequate. The secondary cause is listed as *Inadequate survey* because the investigators found that "poor task reconnaissance and an inadequate technical survey both contributed towards the accident occurring".

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.