DDAS Accident Report

Accident details

Report date: 09/07/2011  Accident number: 728
Accident time: 11:00  Accident Date: 17/06/2010

Where it occurred: AF/2802/00362, MF0055, Quryak Village, Shiber district Bamyan Province
Country: Afghanistan

Primary cause: Field control inadequacy (?)  Secondary cause: Field control inadequacy (?)
Class: Other  Date of main report: None
ID original source: None  Name of source: UNMACCA
Organisation: [Name removed]  Ground condition: steep slope
Mine/device: YM-1 AP blast  Date last modified: 09/07/2011
Date record created:  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 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.

LESSONS LEARNED SUMMARY OF [Demining group] DT-21 DEMINING ACCIDENT
INTRODUCTION:
An investigation team was convened by AMAC Central to investigate the de-mining accident involving [the Victim] the deminer of [Demining group] DT-21. The accident occurred at 11:00 hours on 17 June 2010 at minefield number AF/2802/00362/MF 0055, located in Quryak village, Shiber district of Bamyan Province.

SUMMARY:
Minefield (MF) 0055 is located in a mountainous area which was frontline between belligerent groups during the internal war in 1998. From the military point of view the area was important for both sides of the conflict factions. Therefore, the AP mines were laid there by Hizb-e-Wahdat militias to stop the attacks of their opposition (Taliban). So far two mine accidents occurred there on local people.

[Demining group] cleared around 1 sq km highly contaminated area since last year in Shiber district of Bamyan province. During the clearance operations they found/destroyed 174 Iranian YM I AP mines there.

On 17 June 2010 at 11:00 [the Victim] was busy in his clearance lane in a steep sloping area, he lost his balance, got out from his clearance lane to unclear ground, stepped on a YM-I mine and the accident happened. According to the investigation report the team is walking around one and half hours from the base comp to the MF on daily basis which makes the deminers tired. The marking signs in clearance lane were weak and even not distinguishable; the gritty and sliding nature of the ground is another risk factor in this specific minefield. Extra safety measures are required in such areas, for example creating feet steps in order for deminers to be stable during the operations, close supervision and control of the deminers. The consequences of this accident were traumatic amputation of left leg below knee plus some superficial injuries on right leg and right hand fingers of deminer.

CONCLUSIONS:
Poor marking and lack of preparation in such steep sloping area are the main contributing factors to this accident. These factors return back to poor supervision and poor site operations plan.

RECOMMENDATIONS:
The following points are to be considered:

- Strengthening supervision should be the main focus of operations departments of all mine action organizations.
- Internal QA system should be improved and frequent monitoring should be conducted in such problematic areas.
- A comprehensive operations plan should be developed by the team command group considering all risk factors of the working site.
- The team command group should make sure that the marking system is as per SOPs and maintained properly throughout the operations.

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: 920
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 Below knee
COMMENT: No Medical report was made available. "traumatic amputation of left leg below knee plus some superficial injuries on right leg and right hand fingers of deminer".

Analysis

The primary and secondary cause of this accident are listed as Field Control inadequacy because the investigators found that the demining procedures and marking system in use were inappropriate and caused the accident. The demining group’s inability to plan and control a task appropriately was a significant 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. National staff have been more responsible than the internationals with overall responsibility.