

8-17-2010

DDASaccident730

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, "DDASaccident730" (2010). *Global CWD Repository*. 929.
<https://commons.lib.jmu.edu/cisr-globalcwd/929>

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: 09/07/2011	Accident number: 730
Accident time: 08:54	Accident Date: 17/08/2010
Where it occurred: AF/3203/00398, MF 081, Dragi Village, Tani District, Khost Province	Country: Afghanistan
Primary cause: Field control inadequacy (?)	Secondary cause: Management/control inadequacy (?)
Class: Excavation accident	Date of main report: 10/10/2010
ID original source: None	Name of source: UNMACCA
Organisation: [Name removed] CBDT	
Mine/device: AP blast (unrecorded)	Ground condition: steep slope
Date record created:	Date last modified: 09/07/2011
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 (?)
handtool may have increased injury (?)
Inadequate detector pinpointing
visor not worn or worn raised (?)
squatting/kneeling to excavate (?)

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] CBDT-23 DEMINING ACCIDENT

INTRODUCTION:

Demining investigation teams were convened by AMAC Gardez and [Demining group] to investigate and find out the cause of the demining accident involving [the Victim] the deminer of [Demining group] CBDT-23. The accident occurred at 8:54 hours, on 17 August 2010 in Task # AF/3203/00398/MF 081 located in Dragi village, Tani district of Khost province.

SUMMARY:

Task # AF/3203/00398/MF 081 is located in a mountainous area contaminated with anti-personnel mines, in Dec 2009 the area polygon surveyed by [Demining group] LIAT-11. Mines planted by Russian forces during the year 1984 to protect their position from the possible attacks of mujahiddin.

Mine clearance operations in Tani district started by [Demining group] as community based demining approach and deminers from the community are engaged in this operation. On 8th July 2010, CBDT-23 started demining operations in mentioned minefield; the progress was around 20% till the demining accident happened. The team found/destroyed 4 anti-personal mines up to the accident time.

On 17 August 2010 Mr. [the Victim] the deminer was working in his clearance lane excavating a detected signal, his excavation tool touched a mine and caused it to explode. According to the investigation report the signal was not pinpointed correctly and the de-miner has used his bayonet directly on the top of anti-personnel mine, so the accident happened. Unfortunately the victim deminer was not fully dressed with PPE, so he got severe injuries on his eyes, whole face and finger of his left hand.

As the majority of minefields in Tani district are located on the hillsides, and the likelihood of mines with changed position due to seasonal flood is high. Therefore, a comprehensive site operations plan was required covering all the predictable scenarios during the clearance operations e.g. changes in direction of mines, mine displacement etc. But this point was missed in the site operations plan.

CONCLUSIONS:

The main contributing factor to this demining accident was the carelessness of deminer himself. In addition, as the deminer was working without having worn his PPE appropriately and had not been controlled by the command group, therefore, the weakness of command and control is also noticeable.

RECOMMENDATIONS:

The following points are to be considered:

[Demining group] operation department is recommended to take necessary action in terms of strengthening command and control element in their teams especially in community based projects.

- A strong discipline should be emplaced in all community based projects as this is the third accident within Tani CBD project of the same scenario.

- As Tani is a tribal area and all the people are strongly following their elders, therefore, the issue of carelessness of deminers should be discussed with elders and the possible consequences of the situation should be detailed to them.
- [Demining group] operations department is recommended to develop a plan for the improvement of supervision, command and control in their teams.

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

Victim Report

Victim number: 923	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: severe Eyes; severe Face; severe Hand

COMMENT: No Medical report was made available. "severe injuries on his eyes, whole face and finger of his left hand".

Analysis

The type of AP blast mine is inferred from other accidents nearby: it is likely to have been a PMN or a PMN-2.

The primary cause of this accident is listed as a *Field Control Inadequacy* because the investigators identified field control failings and the Victim was working improperly (visor raised or not worn) but his error was not corrected. The secondary cause is listed as a *Management Control Inadequacy* because the investigators advised the managers to develop a plan for improved "supervision, command and control".

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.