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Humanitarian Demining Accident and Incident Database

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Recommended Citation

HD-AID, "DDASaccident737" (2010). *Global CWD Repository*. 936.
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DDAS Accident Report

Accident details

Report date: 11/07/2011	Accident number: 737
Accident time: 07:15	Accident Date: 14/07/2010
Where it occurred: AF/0802/09333, MF 0333, Fatehabad Village, Surkhrod District, Nangarhar Province	Country: Afghanistan
Primary cause: Field control inadequacy (?)	Secondary cause: Management/control inadequacy (?)
Class: Missed-mine accident	Date of main report: 27/06/2010
ID original source: None	Name of source: UNMACCA
Organisation: [Name removed]	
Mine/device: AT (unrecorded)	Ground condition: not recorded
Date record created:	Date last modified: 11/07/2011
No of victims: 0	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 (?)
mechanical detonation (?)
non injurious accident (?)

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] MDU-04 DEMINING INCIDENT

[MDU – Mechanical Demining Unit]

INTRODUCTION:

An investigation team was convened by AMAC Jalalabad to investigate the demining incident involving a Front End Loader (FEL) machine of [Demining group] MDU-04. The incident occurred at 07:15 am on 14 July 2010 at minefield # AF/0802/09333/MF 0333, located in Fatehabad village, Surkhrod district of Nangarhar province.

SUMMARY:

The minefield # 0333 is located in Fatehabad desert around 25Km away from Jalalabad city. This area is intended to be used as a residential township for the returnees from Pakistan. Prior to commencement of clearance operations two anti-vehicle mines exploded there on a local truck and a loader. Then the local people requested clearance of the area and [Other demining group] emergency response team was tasked to start clearance operation there. Considering ground condition, [Demining group] MDU-04 (FEL) was also tasked to support mentioned demining team.

It was 07:10 AM on 14 July 2010 while an anti-vehicle mine exploded under the back tyre of [Demining group] MDU-04 FEL machine during the ground processing operation. Fortunately no casualty is involved in this incident; only one tyre and a wheel were destroyed by the explosion. The main objective of MDU support to [Other demining group] DT was the possibility of deeper mines due to extra soil and gravel brought by seasonal floods in the site. Therefore, the depth of mines should have been expected more than default. This was the main issue which had not been considered by the team command group and MDU operator. So, the team was failed to consider required depth during the ground processing operation. The bucket was used shallow in the ground, but the command group did not pay attention to it. The operator was also careless and ignored that the MDU was planned to this task because of possibility of deeper mines there.

CONCLUSIONS:

Poor command and control, poor task management and poor site operations plan are the main contributing factors. However lack of cooperation and carelessness of MDU operator can also be counted as contributing factors.

RECOMMENDATIONS:

The depth for MDU processing operation should be clearly mentioned in site operations plan and maintained throughout the operations.

- More internal QA visits should be planned and conducted on MDUs by [Demining group], as this is the fourth incident of FEL machines during the two months.
- Practical steps should be taken by [Other demining group] and [Demining group] for the improvement of supervision, documentation, command and control in the field.

Feedback on any preventive and constrictive 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.

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the investigators found that the machine operator was working inappropriately and his error was not corrected. The secondary cause is listed as a *Management Control Inadequacy* because the investigators found that the planning of the machine's deployment required improved, "supervision, documentation, command and control in the field", all of which are management issues that the group's senior management should have addressed before four similar accidents had occurred in two months.

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.