

James Madison University

## JMU Scholarly Commons

---

Global CWD Repository

Center for International Stabilization and  
Recovery

---

7-8-2009

### DDASaccident752

HD-AID

*Humanitarian Demining Accident and Incident Database*

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

HD-AID, "DDASaccident752" (2009). *Global CWD Repository*. 951.  
<https://commons.lib.jmu.edu/cisr-globalcwd/951>

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](mailto:dc_admin@jmu.edu).

# DDAS Accident Report

## Accident details

<b>Report date:</b> 14/07/2011	<b>Accident number:</b> 752
<b>Accident time:</b> 09:19	<b>Accident Date:</b> 08/07/2009
<b>Where it occurred:</b> AF/1506/13176, H-5157, Pusht-e- Band Village, Khoram Saharbagh District, Samangan Province	<b>Country:</b> Afghanistan
<b>Primary cause:</b> Field control inadequacy (?)	<b>Secondary cause:</b> Inadequate equipment (?)
<b>Class:</b> Excavation accident	<b>Date of main report:</b> 11/08/2009
<b>ID original source:</b> None	<b>Name of source:</b> UNMACCA
<b>Organisation:</b> [Name removed]	
<b>Mine/device:</b> PMN AP blast	<b>Ground condition:</b> hidden root mat steep slope
<b>Date record created:</b>	<b>Date last modified:</b> 14/07/2011
<b>No of victims:</b> 1	<b>No of documents:</b> 1

## Map details

<b>Longitude:</b>	<b>Latitude:</b>
<b>Alt. coord. system:</b> Not recorded	<b>Coordinates fixed by:</b>
<b>Map east:</b>	<b>Map north:</b>
<b>Map scale:</b>	<b>Map series:</b>
<b>Map edition:</b>	<b>Map sheet:</b>
<b>Map name:</b>	

## Accident Notes

inadequate investigation (?)  
vegetation clearance problem (?)  
visor not worn or worn raised (?)  
squatting/kneeling to excavate (?)  
handtool may have increased injury (?)

## **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: 11th August 2009

### **LESSONS LEARNED SUMMARY OF [Demining group] MU-16 DEMINING ACCIDENT**

#### **INTRODUCTION:**

An investigation team was convened by AMAC North to investigate the demining accident involving [the Victim] the de-miner of [Demining group] MU-16. The accident occurred at 0919hrs on 08 July 2009 at minefield number AF/1506/13176/H- 5157, located in Pusht-e-Band (Burma) village, Khoram & Saharbagh district of Samangan Province.

#### **SUMMARY:**

Minefield # AF/1506/13176/H- 5157 is located on a hill about 500 metres away from the village of Burma, which was front line between belligerent groups during internal war. From the military point of view this area was important for both sides of the conflict factions; therefore, the AP mines were laid there in 1991 by Sayed Kayan militia to stop the attacks of their opposition. Four accidents occurred on animal from 1996 to 1998. However, the area is mined but it is partially cultivated by villagers.

On 1st July 2009 MU-16 of [Demining group] started clearance operation on mentioned task. On 08 July 2009 at 0919hrs while [the Victim] was investigating a signal in his clearance lane, he found two bullets. He re-checked the spot and found the same signal, this process repeated for three times. Finally he found a root stump in the excavation trench with a thickness of around 2.5 cm and started to remove it, because it was blocking further excavation there. However the deminer had proper tool in his toolkit to cut such obstacles, but he tried to cut it with his scraper. After a few chops of the root stump with a scraper, a PMN mine was initiated and caused the accident. As it seems from the investigation report, the root was located on the pressure palate of mine, so it went off because of applying pressure on it. Fortunately as the deminer was fully dressed with PPE, he got some non-critical injuries. The visor was scratched by accident so he got some injuries on his face, but none of the injuries were severe.

#### **CONCLUSIONS:**

The accident occurred because of carelessness of deminer, as he wanted to remove the root stump for further investigation of a detected signal, but used the scraper instead of secateurs available in his toolkit. The command group did not pay attention to see and stop him from such action.

#### **RECOMMENDATIONS:**

However, the [Demining group] has taken disciplinary actions against the command group, but as a lessons learned the following points are to be considered by all demining teams:

- The command group should strictly control the de-miners during the operations and stop them when practicing in contrary to the organization SOP.

- The de-miners should not hurry up during the excavation, be careful and seek guidance from their command group when facing such obstacles during the operations.
- Demining organizations should make sure that their team deminers know the approved safe working procedures and if needed refresher training is to be conducted.

## Victim Report

<b>Victim number:</b> 942	<b>Name:</b> [Name removed]
<b>Age:</b>	<b>Gender:</b> Male
<b>Status:</b> deminer	<b>Fit for work:</b> presumed
<b>Compensation:</b> Not made available	<b>Time to hospital:</b> Not made available
<b>Protection issued:</b> Frontal apron Long visor	<b>Protection used:</b> Frontal apron; Long visor worn raised

### Summary of injuries:

INJURIES: minor Face

COMMENT: No Medical report was made available. "non-critical injuries. . . he got some injuries on his face . . . none of the injuries were severe.

### Analysis

The primary cause of this accident is listed as *a Field Control Inadequacy* because the victim was working with the wrong tool and with his visor raised and these errors were not corrected. The secondary cause is listed as *Inadequate equipment* because the tool and visor were not fit for purpose, which is a significant *Management Control Inadequacy*.

The “scraper” was used to chop, so probably refers to the mattock excavation tool favoured by this demining group (with which there have been many accidents).

The investigators report that the accidentally scratched visor led to facial injuries – so presumably it was not possible to see through, and so worn raised.

The “Inadequate investigation” listed under notes refers to the absence of a full accident report: the summary provided does not list the injuries, MEDEVAC details, or the corrective measures taken, and so is inadequate. The UN supported MACCA has failed to make Board of Inquiry reports widely available for some years, so ignoring the requirements of the IMAS. It is noteworthy that the Afghan national staff have been more responsible over this than those internationals who presume greater responsibility.