

12-6-2007

DDASaccident790

Humanitarian Demining Accident and Incident Database
AID

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DDAS Accident Report

Accident details

Report date: 22/07/2011	Accident number: 790
Accident time: 11:55	Accident Date: 06/12/2007
Where it occurred: AF/0112/00168, MF 0231, Shinwari Village, Sorobi District, Kabul Province	Country: Afghanistan
Primary cause: Field control inadequacy (?)	Secondary cause: Victim inattention (?)
Class: Missed-mine accident	Date of main report: None
ID original source: (37)	Name of source: UNMACCA
Organisation: [Name removed]	
Mine/device: AP blast (unrecorded)	Ground condition: metal fragments rocks/stones steep slope
Date record created:	Date last modified: 22/07/2011
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 area marking (?)
mine/device found in "cleared" area (?)
visor not worn or worn raised (?)
victim squatting and stepped on mine (?)

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 ACCIDENT involving [Demining group] DT# 01 ON 06 DECEMBER 2007

INTRODUCTION:

A Board of Inquiry (BOI) was convened by Program Director of UNMACA to investigate the fatal demining accident involving [the Victim] a deminer from [Demining group] DT # 01. The accident occurred at 11:55 hours on 06 December 2007 at task # AF/0112/00168/MF 0231 located in Shinwari Village, Sorobi District of Kabul Province.

SUMMARY:

The area was mined in 1997 by the Russians whose convoys were being attacked by Mujahideen as they travelled through Sorobi Pass. The clearance task is confirmed by LIAT as a High mine impacted area. A total of 21 mine accidents have been recorded in this area of which 4 accidents have occurred during the current year.

The deminer was working on a steep, sloping area of a mountain that was known to contain anti-personnel mines. The clearance was made difficult due to the gradient of the slope (approx 45 degrees), the loose nature of the rock and the number of metal fragments in the area.

After the routine break at 1140 – 1150 hrs, the deminer was advised by his Section Leader (SL) to mark his lane clearly so that the SL could conduct his own QC checks. Just prior to the detonation the deminer was observed by the SL and another deminer to be preparing paint for the painting of rocks (for the next week). At 1155 the deminer stepped onto an anti-personnel mine with his left foot while in the squatting position. The deminer then rolled down the steep slope to his final resting place in a previously cleared area. On the way down the slope the deminer lost his helmet and woollen hat and sustained some facial injuries.

The team reacted as per SOPs and the CASEVAC procedure was performed, treatment was given and the victim was then moved to the ambulance and transported to the hospital in Kabul. Unfortunately in spite of extensive surgery and treatment the deminer died at the hospital the following day at 8:00 am.

Some of the stones used for marking the clearance lane had migrated down the slope from the accident site during the blast and were visible to the BOI during their inspection.

CONCLUSIONS:

It is the BOI conclusion that the deminer had missed a mine during the morning's clearance. He was not clearly marking his lane progressively throughout the course of the day and he inadvertently stepped on this mine, receiving extensive blast injuries that resulted in his death.

RECOMMENDATIONS:

The following points are to be considered by all clearance organisations in the MAPA:

- A more rigorous permanent marking system should be employed in clearance operations that are located on steep sloping ground where there is a danger that the marking could move i.e. steel pegs/stakes and ropes should be used not rocks.
- Full PPE shall be worn correctly at all times in a hazard area.
- All organisations are reminded that they shall inform UNMACA when making any variations to the organisations SOPs. This is so that an assessment can be made of the proposed changes before permission is granted to change SOPs.
- The team leader and section leader should both be given formal warnings for not ensuring their team members were adhering to SOPs by clearly marking the lane as they progressed into the hazard.

Victim Report

Victim number: 980	Name: [Name removed]
Age:	Gender: Male
Status: deminer	Fit for work: DECEASED
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 Face

AMPUTATION/LOSS: Leg Below knee

COMMENT: No Medical report was made available. ". . . extensive blast injuries that resulted in his death . . . the deminer died at the hospital the following day at 8:00 am".

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the Victim was working improperly having missed a mine and failed to mark his working area appropriately and the errors were not corrected in a timely manner. It also seems likely that the Victim was working without wearing a visor because the investigators' recommendations include "Full PPE shall be worn correctly at all times in a hazard area". The secondary cause is listed as *Victim inattention* because the Victim stepped on a mine he had failed to locate during his work (unless the marking was so inadequate that he was actually outside the area he had cleared without knowing that he was).

The Victim stepped on a mine while squatting and may have suffered severe thigh, buttock or groin injury as well because the point of initiation would have been behind his blast armour. If he did, it is likely that the facial injuries were caused by the subsequent fall down the hillside rather than the blast.

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 over sharing data than those internationals who presume greater responsibility.