

# DDAS Accident Report

## Accident details

<b>Report date:</b> 19/07/2011	<b>Accident number:</b> 784
<b>Accident time:</b> 09:45	<b>Accident Date:</b> 14/09/2008
<b>Where it occurred:</b> AF/2201/22726/0105, Ghughula City, Bamyan province	<b>Country:</b> Afghanistan
<b>Primary cause:</b> Field control inadequacy (?)	<b>Secondary cause:</b> Victim inattention (?)
<b>Class:</b> Missed-mine accident	<b>Date of main report:</b> None
<b>ID original source:</b> (36)	<b>Name of source:</b> UNMACCA
<b>Organisation:</b> [Name removed]	
<b>Mine/device:</b> AP blast (unrecorded)	<b>Ground condition:</b> not recorded
<b>Date record created:</b>	<b>Date last modified:</b> 19/07/2011
<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 (?)  
inadequate area marking (?)  
protective equipment not worn (?)  
visor not worn or worn raised (?)  
mine/device found in "cleared" area (?)

## 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 # 23 DEMINING ACCIDENT**

### **INTRODUCTION:**

A BOI investigation team was convened by UNMACA to investigate the fatal demining accident involving [the Victim] the deminer from [Demining group] DT-23. The accident occurred at 09:45 am on 14 September 2008 at minefield # AF/2201/22726/0105, located in Ghughula city, centre of Bamyan province.

### **SUMMARY:**

It is the view of the BOI team that after removing his PPE and helmet the deminer has moved back into his lane to place marking in cleared area that he believed to be safe and free of any mines. He may have done this as he was aware that a "delegation" was about to visit the site and he wanted to make sure that his marking was correct. He did receive a large chest wound and several facial wounds that suggest the deminer was struck by rocks thrown up from the mine detonation. There was also some minor blast related injuries to his lower legs. There were no wounds to the deminer's hands or feet so he did not initiate the mine by standing on or touching it.

The BOI team believes this detonation may have occurred as a result of the deminer having leant forward from a safe point and thrown a marking stone down onto the ground. His aim may have been off and he may have inadvertently thrown the stone onto a mine that had not previously been found in the lane. The mine has detonated, propelling the marking stone and other stones back at him with the marking stone striking him in the chest and the remaining stones having caused the injuries around the forehead and eyes. Unfortunately these injuries have resulted in his death at the scene before he could receive any medical treatment for his injuries.

### **CONCLUSIONS:**

It is the BOI conclusion that the deminer, [the Victim], was not clearly marking his lane progressively throughout the course of the day. He has moved back into his clearance lane during a break period, without wearing his PPE and helmet, to place a marking stone. He has not wanted to get too close to the unsafe area and has leant forward and thrown the marking stone forward to mark the lane. This stone has landed on a mine with the detonation causing the stones to be thrown up from the blast and inflicting the injuries that have resulted in his death. It seems that the poor supervision and carelessness of deminer himself are the contributing factors to the accident.

### **RECOMMENDATIONS:**

The BOI recommend that all organisations are reminded the following;

- a. Full PPE and helmet must be worn correctly at all times in a hazardous area.
- b. If PPE and/or the helmets are removed whilst undertaking rest breaks then individuals are not to move from their position in the safe area until they have re-dressed in the PPE and helmet.
- c. Under no circumstances are deminers to carry out any work during the rest period.
- d. The marking of lanes shall take place progressively and in accordance with the procedure. If a deminer has not had the opportunity to complete his marking at the sounding of a break then he is to complete the marking procedure before moving out of his lane to take the break.

e. The command group of all demining teams are to strengthen their supervision and do not let the deminers to work without PPE.

### Victim Report

<b>Victim number:</b> 970	<b>Name:</b> [Name removed]
<b>Age:</b>	<b>Gender:</b> Male
<b>Status:</b> deminer	<b>Fit for work:</b> DECEASED
<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> None

#### Summary of injuries:

INJURIES: minor Legs; severe Chest; severe Eyes; severe Face

FATAL

COMMENT: No Medical report was made available. ". . . injuries around the forehead and eyes . . . large chest wound and several facial wounds. . . minor blast related injuries to his lower legs".

#### Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the Victim was working in the minefield without PPE and his error was not corrected. The secondary cause is listed as *Victim Inattention* because the investigators found that the Victim had inadvertently thrown a rock onto a mine "that had not previously been found in the lane".

It is likely that the rock was not thrown far. Stones tend to break up in a blast and the parts lose their momentum quickly, so the fatal chest wound was probably caused by a mine detonating at a distance of less than two metres.

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 than those internationals who presume greater responsibility.