6-9-1997

DDASaccident091

Humanitarian Demining Accident and Incident Database

AID

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DDAS Accident Report

Accident details

Report date: 19/04/2006
Accident number: 91
Accident time: not recorded
Accident Date: 09/06/1997
Country: Afghanistan
Where it occurred: Pul-e-Alam Village, Logar Province
Primary cause: Field control inadequacy (?)
Secondary cause: Inadequate training (?)
Class: Handling accident
ID original source: none
Organisation: [Name removed]
Mine/device: Fuze
Ground condition: not recorded
Date record created: 24/01/2004
Date last modified: 24/01/2004
No of victims: 1
No of documents: 1

Map details

Longitude: 
Latitude: 
Alt. coord. system: Coordinates fixed by:
Map east: 
Map north: 
Map scale: not recorded 
Map series: 
Map edition: 
Map sheet: 
Map name: 

Accident Notes

inadequate training (?)
inadequate investigation (?)
request for clearance with explosive charge (?)

Accident report

An investigation on behalf of the UN MAC was carried out and its report made briefly available. The following summarises its content.

The victim had been a deminer for eighteen months (including Battle Area Clearance BAC). The victim was working at BAC in an area described as a "battlefield with scattered ordnance".

The investigators determined that the victim was clearing an area containing numerous fuzes. Instead of destroying the fuze where it was, he carried the fuze to another place where he
"might have" dropped it and caused the accident. The device was identified as a mortar fuze, one among many UXO spread around the area and blast damaged.

**The Team Leader** said that the victim was working properly, and suggested that such accidents could be prevented if fuzes were destroyed on the spot.

**The Section Leader** said that the victim was working properly, and suggested that such accidents could be avoided by working "in accordance with the instruction of the command group".

A **witness** deminer said that the victim was working properly and that the accident was caused by the sensitivity of the fuze.

**The victim** said that he was working properly and moved the fuze because there were many in the area so he could not safety blow it up where it was. He suggested that new method of working in these areas was needed to prevent such accidents – and said that the use of "explosives…by main lane system" was an alternative.

**Conclusion**

The investigators concluded that the accident was caused by the victim's carelessness when carrying the fuze. They said he was "negligent of the demining procedure" because he should not have moved the fuze.

**Recommendations**

The investigators recommended that no deminer should move any fuze without instructions to do so and that the Section Leader should ensure their searchers do not touch any UXO or fuze.

**Victim Report**

<table>
<thead>
<tr>
<th>Victim number: 122</th>
<th>Name: [Name removed]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
<td>Gender: Male</td>
</tr>
<tr>
<td>Status: deminer</td>
<td>Fit for work: yes</td>
</tr>
<tr>
<td>Compensation: none on record</td>
<td>Time to hospital: not recorded</td>
</tr>
<tr>
<td>Protection issued: Not recorded</td>
<td>Protection used: not recorded</td>
</tr>
</tbody>
</table>

**Summary of injuries:**

**INJURIES**

minor Abdomen

**COMMENT**

See medical report.

**Medical report**

The victim's injuries were summarised as a minor injury to the right side of his stomach. No medical report was attached. The victim was treated in the field.

The demining group reported the accident and said that the victim suffered slight abrasions and returned to work on the same day.
Analysis

The primary cause of this accident is listed as a "Field control inadequacy" because the victim was working improperly and was not corrected.

The fact that none of the field supervisors were aware that he was working improperly implies confused (if not inadequate) training, which would be a management failing. The secondary cause is listed as "Inadequate training".

The agency that was used to make investigations for the UN MAC (based in Pakistan) at this time was frequently constrained by lack of funds, staff and transport. At times their movement was constrained by safety concerns. As a result, investigations were frequently delayed by weeks, meaning that an assessment of the site at the time of the accident was impossible.