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DDASaccident093

Humanitarian Demining Accident and Incident Database
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DDAS Accident Report

Accident details

Report date:	19/04/2006	**Accident number:**	93
Accident time:	not recorded	**Accident Date:**	03/06/1997
Where it occurred:	Ward 7, Kabul city	**Country:**	Afghanistan
Primary cause:	Management/control inadequacy (?)	**Secondary cause:**	Inadequate training (?)
Class:	Missed-mine accident	**Date of main report:**	[No date recorded]
ID original source:	none	**Name of source:**	MAPA/UNOCHA
Organisation:	[Name removed]		
Mine/device:	PMN AP blast	**Ground condition:**	hard
Date record created:	24/01/2004	**Date last modified:**	24/01/2004
No of victims:	2	**No of documents:**	2

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 (?)

safety distances ignored (?)

inadequate investigation (?)

visor not worn or worn raised (?)

disciplinary action against victim (?)

Accident report

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

Both victims had been deminers for six and a half years. They had attended a revision course five months before and had last been on leave 46 days before the accident. The ground in the working area was described as a "hard" hillside. A photograph was annotated indicating that

the accident occurred outside the cleared area and that the marking stones were moved after the accident occurred.

The Investigators determined that the accident occurred when the Assistant Team Leader and the Section Leader went to inspect the site of another accident that had occurred the day before [believed to be 1st June]. They did this without the permission of the Team Leader, and without his being aware of it.

The Assistant Team Leader stepped on a mine that had been missed by the victim of the previous accident. He did not check the area prior to walking on it. The device was identified as a PMN (from "found fragments") and the antenna of a VHF radio was reported damaged.

The Acting Team Leader (covering for the Team Leader while he was on leave) said that the victims were not working properly because they went without instruction to examine the accident site.

A deminer witness said that the victims were careless because they did not recheck the accident area as they went.

Conclusion

The investigators concluded that the accident was caused by lack of proper command and control. The victims did not follow the chain of command, and the Acting Team Leader was an unqualified person who was unaware of the whereabouts of the victims. The victims did not observe correct safety procedures by checking around the accident point before walking on it.

Recommendations

The investigators recommended that the Acting Team Leader should be demoted to the position of Section Leader immediately and that a "proper chain of command must be maintained within all demining teams". They also said that no one should decide to leave their post with permission from the Team Leader, and that demining agencies and site offices should be more careful in appointing Acting command personnel.

Victim Report

Victim number: 124

Name: [Name removed]

Age:

Gender: Male

Status: supervisory

Fit for work: not known

Compensation: 250,000 Rs

Time to hospital: not recorded

Protection issued: Helmet

Thin, short visor

Protection used: not recorded

Summary of injuries:

INJURIES

minor Face

minor Hand

severe Arm

AMPUTATION/LOSS

Leg Below knee

COMMENT

See medical report.

Medical report

Victim No.1's injuries were summarised as: amputation of left leg below knee, left hand injury, facial lacerations.

A medic's sketch (reproduced above) showed serious facial injury, left hand and forearm lacerations and below knee lacerations to a traumatic amputation above the ankle. The medical report did not mention eyes.

The demining group reported that the victim suffered a below knee amputation of his left leg, loss of soft tissue on his left forearm and lacerations on his left hand. His injuries were assessed as a 50% disability.

Compensation of 250,000 Rs (50% disability) was paid to the victim on 6th November 1997.

Victim Report

Victim number: 125

Name: [Name removed]

Age:

Gender: Male

Status: supervisory

Fit for work: not known

Compensation: 225,000 Rs

Time to hospital: not recorded

Protection issued: Helmet
Thin, short visor

Protection used: not recorded

Summary of injuries:

INJURIES

minor Leg

minor Neck

severe Eyes

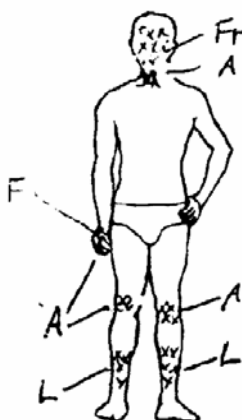
severe Hand

severe Leg

COMMENT

See medical report.

Medical report



Victim No.2's injuries were summarised as: eye injuries, fractures of right hand fingers, laceration on neck and both legs. A medic's sketch (reproduced above) showed finger fracture, face and neck fragments and abrasions, knee abrasions on both legs, and shin lacerations on both legs.

The demining group reported that the victim suffered injuries to both eyes and fracture of right tibia and lacerated wounds to right hand and right thigh – compound fracture to the shaft of right tibia.

His partial loss of vision in both eyes was assessed as a 55% disability on 18th July 1997. The stiffness of four fingers on his right hand was assessed as a 20% disability.

Compensation of 225,000 Rs was paid to the victim on 24th September 1997.

Analysis

The primary cause of this accident is listed as a *"Management/control inadequacy"* because the victims were field supervisors who were inadequately trained and were either ignorant of or ignored basic rules. This inadequacy was recognised by the management group. The secondary cause is listed as *“Inadequate training”*.

The victims' injuries were unusually diverse, affecting eyes, hands and the initiating foot. It is likely that the pair were very close together and that both victims may have been stooping to examine something that Victim No.1 stepped on when the accident occurred.

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.

Related papers

A letter from the UN MAC said that the demining group must demote the Acting Team Leader because he was not qualified. They added that the group must ensure that all Section and Assistant Team leaders hold Team Leader qualifications.