

6-1-1997

# DDASaccident094

Humanitarian Demining Accident and Incident Database  
*AID*

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# DDAS Accident Report

## Accident details

<b>Report date:</b> 19/04/2006	<b>Accident number:</b> 94
<b>Accident time:</b> not recorded	<b>Accident Date:</b> 01/06/1997
<b>Where it occurred:</b> Qala Muslim Village, Ward 7, Kabul city	<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> [No date recorded]
<b>ID original source:</b> none	<b>Name of source:</b> MAPA/UNOCHA
<b>Organisation:</b> [Name removed]	
<b>Mine/device:</b> PMN AP blast	<b>Ground condition:</b> hard rocks/stones
<b>Date record created:</b> 24/01/2004	<b>Date last modified:</b> 24/01/2004
<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>	<b>Coordinates fixed by:</b>
<b>Map east:</b>	<b>Map north:</b>
<b>Map scale:</b> not recorded	<b>Map series:</b>
<b>Map edition:</b>	<b>Map sheet:</b>
<b>Map name:</b>	

## Accident Notes

inadequate metal-detector (?)  
inadequate equipment (?)  
handtool may have increased injury (?)  
partner's failure to "control" (?)  
inadequate investigation (?)  
squatting/kneeling to excavate (?)

## Accident report

At the time of the accident the UN MAC in Afghanistan favoured the use of two-man teams (usually operating a one-man drill). The two would take it in turns for one to work on vegetation cutting, detecting and excavation, while the other both rested and supposedly "controlled" his partner.

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 15 months. It was five months since he last attended a revision course and 45 days since his last leave. The area where the accident occurred was described as a hard hillside. A photograph showed uneven ground and many rocks.

The investigators determined that the victim was working in an area with barbed wire obstacles (that should have been cut and removed). After going around the wire and detecting again he got a reading. He did not mark the reading but squatted and started to prod with his bayonet, and detonated the mine (which was identified as a PMN from "found fragments").

The victim's visor and bayonet were damaged. A photograph showed the bayonet bent (curved) and the visor intact.

**The team Sub-Commander** said the victim used excessive force while prodding so was not working properly.

**The victim's partner** said he was doing his job properly and the hard ground was the cause of the accident. He said that an improved mine detector would help prevent such accidents in future.

## Conclusion

The investigators concluded that the accident was caused by "negligence of the demining procedures" because the barbed wire should have been cut and removed. Also that the command group showed poor performance and should have prevented the victim ignoring proper marking and prodding procedures.

## Recommendations

The investigators recommended that it should be stressed that all teams' command groups have close supervision of their deminers; that no one should be allowed to prod without placing markers properly; that obstacles in the demining lane should be removed, especially when those obstacles interfere with the detecting process; and that the command group should be disciplined for poor control.

## Victim Report

<b>Victim number:</b> 126	<b>Name:</b> [Name removed]
<b>Age:</b>	<b>Gender:</b> Male
<b>Status:</b> deminer	<b>Fit for work:</b> no
<b>Compensation:</b> 500,000 Rs (100%)	<b>Time to hospital:</b> not recorded
<b>Protection issued:</b> Helmet Thin, short visor	<b>Protection used:</b> Helmet, Thin, short visor

## Summary of injuries:

## INJURIES

minor Chest

minor Face

minor Legs

severe Arm

severe Hand

severe Hearing

severe Shoulder

## AMPUTATION/LOSS

Finger

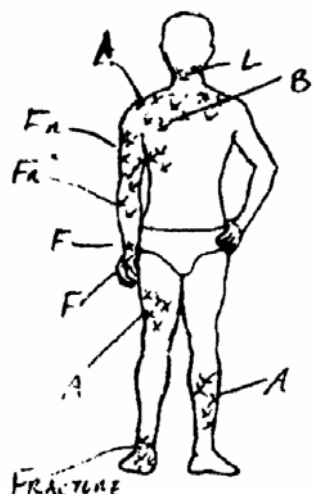
## COMMENT

See medical report.

## Medical report

The victim's injuries were summarised as: fractured fingers on right hand, fragments on right arm, legs, chin, left hand and chest.

A medic's sketch (reproduced below) showed multiple fragments and abrasions to his chest and right arm, right thigh and left shin and a fractured ankle.



The demining group submitted a compensation claim on 22<sup>nd</sup> September 1997 but it was lost by the insurers. It listed his injuries as: loss of hearing both ears, amputation right index finger, stiffness of fingers of right hand. The claim was resubmitted listing the injuries as: loss of hearing in both ears, multiple injuries to right hand, right shoulder and both legs.

Compensation of 500,000 Rs was forwarded on 4<sup>th</sup> December 1997.

## Analysis

The primary cause of this accident is listed as a "*Field control inadequacy*" because the victim was working around an obstacle that the field supervisors should have arranged to be removed.

The inadequacy of the detector and of the short handtool provided may represent serious failings higher in the management chain.

The appropriate tools for "wire-pulling" may not have been available - see the accidents in Afghanistan on 13<sup>th</sup> January 1997 and 29<sup>th</sup> April 1997 in which problems with barbed wire removal also arose.

The secondary cause is listed as "*Inadequate equipment*".

The use of a squatting position to "excavate" was in breach of UN requirements, but not in breach of the demining group's unauthorised variations to those requirements. The failure of the UN MAC to either listen to field feedback and adapt the SOP for local conditions, or enforce their own standards may be seen as a management failing.

The victim's severe deafness is common among Afghan claims at this time, when insurance favoured such injury and testing the validity of claims was difficult.

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.