1-16-1997

DDASaccident109

Humanitarian Demining Accident and Incident Database
AID

DDAS Accident Report

Accident details

Report date:	15/05/2006	**Accident number:**	109
Accident time:	not recorded	**Accident Date:**	16/01/1997
Where it occurred:	Hood Khail Village, Sorobi District, Kabul Province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Inadequate equipment (?)
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 residential/urban rocks/stones
Date record created:	12/02/2004	**Date last modified:**	12/02/2004
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 investigation (?)

inadequate equipment (?)

partner's failure to "control" (?)

pressure to work quickly (?)

visor not worn or worn raised (?)

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 three years. The ground in the area was described as a medium hard rocky hillside and village. A photograph showed that the accident occurred close to (within 50cm of) a rock filled wall on very stony ground.

The investigators determined that the victim was walking in an area that had been cleared three days previously by his own party as he made his way from the minefield at the end of the working day. He trod on a PMN mine that had been missed [presumably identified by inference]. A photograph showed a visor, which had been held in the victim's hand and had shattered. The remnants of the victim's boot were also shown.

The Team Leader said that the deminer was working properly before the accident occurred but must have failed in his duty on the day before. He said that either the victim or his partner missed the mine, and both were responsible because deminers should work as good Moslems to prevent these accidents recurring.

The Section Leader said that the accident was the fault of the victim's partner for missing the mine – but also of the victim for not "controlling" his partner properly.

The victim said that the accident occurred because they were being pushed to work too quickly "Team Leaders should not force the deminers to work faster".

Conclusion

The investigators concluded that "the accident occurred because [the victim] did not carry out his duties properly especially during the clearance of the mentioned area where he missed the mine because he had been forced by command group to work faster which resulted in the accident."

Recommendations

The investigators recommended that Section Leaders must check that deminers have cleared the area properly – especially those deminers they do not have confidence in. Also that deminers should not be forced to work so fast that they miss mines, and that each deminer's partner should control him properly when he is searching and detecting, and should correct his mistakes. They suggest that if the working deminer ignores his controlling partner, the partner should inform the Section Leader who much take disciplinary action. Section leaders must be mobile and check the activities throughout the day, especially checking those who are careless.

The UN MAC recorded that the Section Leader should be disciplined for poor performance of his duty.

Victim Report

Victim number: 142 **Name:** **Name removed**

Age: **Gender:** Male

Status: deminer **Fit for work:** not known

Compensation: 250,000 Rs (50%) **Time to hospital:** not recorded

Protection issued: Helmet

Thin, short visor

Protection used: none

Summary of injuries:

INJURIES

minor Eye

minor Genitals

minor Hand

minor Legs

AMPUTATION/LOSS

Leg Below knee

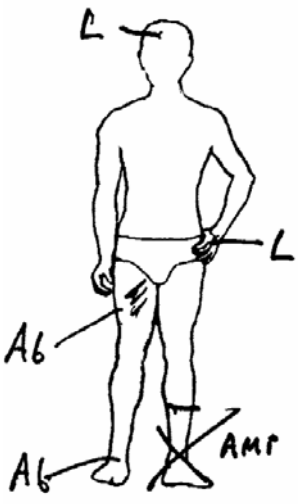
COMMENT

See medical report.

Medical report

The victim's injuries were summarised as a left leg amputated and minor injuries to thighs and testicles.

A medical report stated the victim suffered a below the knee amputation to his left leg, laceration of his scrotum, testes and index finger, abrasion of his right leg, thigh and a fragment in his right eye. A photograph showed the traumatic amputation of the left leg.



The medic's sketch (reproduced above) recorded no genital injury.

The demining group reported that the victim had suffered amputation of his left leg below knee and superficial injuries to his face, groin and right leg.

Compensation of 250,000 Rs (50% disability) was paid (date not known).

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because the victim and his partner were working in such a way that they missed the mine and their error went uncorrected.

If it was true that the victims were pushed to work too quickly to be thorough, that would represent a serious failure of management.

The shattering of the visor implies that it was of inadequate quality, possibly due to age and UV exposure but also because the visor issued was only 3mm thick. The secondary cause is listed as “Inadequate equipment”.

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.