6-6-1998

DDASaccident119

Database of Demining Accidents
DDAS

DDAS Accident Report

Accident details

Report date:	15/05/2006	**Accident number:**	119
Accident time:	11:10	**Accident Date:**	06/06/1998
Where it occurred:	Tapa Tajbig, Ward 7, Kabul City	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Inadequate training (?)
Class:	Demolition 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:**	agricultural (abandoned) hard
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 metal-detector (?)

inadequate training (?)

inconsistent statements (?)

inadequate area marking (?)

Accident report

At the time of the accident the demining group were working with a one man drill in two man teams (changing about every 30 minutes).

An accident report was made on behalf of the UN MAC and made available in September 1999. The following summarises its content.

The accident occurred on agricultural land described as "medium hard". The victim had been a deminer for 18 months and had last attended a revision course six months before. The mine was identified as a PMN from fragments found at the site.

The deminer and his partner were unable to use detectors (because they were "reading continuously" and so were prodding and excavating the area. Photographs of the area showed flat, dry, agricultural land. The victim located a PMN and reported it to his Section Leader" who told him to prepare a charge for its destruction. He lit the safety fuse and "rushed towards the safe area". As he did so he stepped into an uncleared area. A mine detonated and "the victim lost his right foot and got serious injuries to his left foot" at 11:10.

The investigators found that victim and his "command group" had ignored technical and safety procedures. They cut the safety fuse to 50cm (rather than 100-120cm). The victim then waited 20 seconds to ensure that the fuse was burning normally. The investigators felt that this wasted time and further obliged the victim to hurry as he left the area. He ran, which was against "procedures". Further, the investigators thought it possible that the safety lane was poorly marked, so confusing the victim about where it was safe to tread.

The Team Leader stated that the land was heavily contaminated with old food tins and so the detectors were reading continuously. He reported that 50cm of fuse was cut and that 250g of demolition charge was used, and that the charge detonated 30 seconds after the accident occurred. [If the victim waited 20 seconds after lighting the fuse, and it was 30 second burn, the charge could not have gone off 30 seconds after the accident]. He thought the victim was careless.

The Section Leader stated that the victim lost his left leg below the knee and had minor injuries to his left foot when he "stepped over the mine in uncleared area and caused the explosion".

The victim's partner reported that the placed charge detonated 25 seconds after the accident.

Conclusion

The investigators concluded that the accident was caused by ignoring technical and safety procedures. The Section Leader either cut the fuse too short himself or allowed the victim to do so. This left the deminer with 50 seconds instead of the minimum of 100 seconds needed to reach a safe area without haste.

Recommendations

The investigators recommended that marking of safe lanes should be clear, fuses should be cut long enough to avoid a need for haste and that disciplinary action should be taken against the Team and Section leaders.

A sketch map of the site seemed to show that the victim deliberately crossed a 10m strip of uncleared land and the accident occurred within three metres of the mine he was destroying.

Victim Report

Victim number:	155	**Name:**	**Name removed**
Age:		**Gender:**	Male
Status:	deminer	**Fit for work:**	not known
Compensation:	not made available	**Time to hospital:**	20 minutes
Protection issued:	Helmet Thin, short visor	**Protection used:**	not recorded

Summary of injuries:

INJURIES

minor Hand

minor Leg

AMPUTATION/LOSS

Leg Below knee

COMMENT

See medical report.

Medical report

No formal medical report was made available.

The accident report stated that the victim received first aid at the site and was taken to the ICRC hospital in Kabul. After one day there he was flown to Peshawar, Pakistan to another hospital. The investigators reported that the victim later "became mute". A letter to the demining group's director dated 24th June 1998 reported that the victim had been in a coma since he arrived at hospital.

The initial field treatment was listed as:

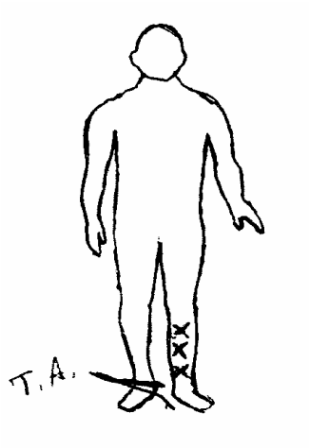
infusion Ringer Lactate 1000ml

analgesic inj-sosagen 30mg given I.M. at 11:20

Amp. Ampicillin 1gr I.V.

ATS 3000 units I.M.

The medic controlled bleeding with a tourniquet and pressure bandage, and also irrigated and dressed the wounds. His sketch is reproduced below.



The victim left for hospital at 11.23 when his pulse was recorded as 100/min, BP 135/90 "mmHg" and Respiration 20/min.

The victim arrived at hospital at 11:30 when his pulse was recorded at 100/min, BP at 130/90 and Respiration at 28/min.

He was given a general anaesthetic (ketamine IV) and a below knee amputation of his right leg was performed along with debridment "of all other wounds". The hospital report concluded with the line "he became unconscious after 14 hours" at the hospital.

Photographs in the file showed the victim during first treatment. His right foot was missing just above the ankle. Lacerations to the left lower leg appeared minor and did not appear to affect the victim's foot. There were also lacerations on the palm of his left hand.

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because the Team Leader allowed safety procedures to be breached by using a short fuse.

The open admission of this breach in his statement implies that he may not have been aware that he was breaking rules, and so may have been inadequately trained which would be a serious 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.