

3-18-1998

DDASaccident128

Database of Demining Accidents
DDAS

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DDAS Accident Report

Accident details

| | |
|--|--|
| Report date: 15/05/2006 | Accident number: 128 |
| Accident time: 11:10 | Accident Date: 18/03/1998 |
| Where it occurred: Zakir Sharif village, Dand District, Kandahar Province | Country: Afghanistan |
| Primary cause: Field 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: dry/dusty grass/grazing area hard |
| Date record created: 13/02/2004 | Date last modified: 13/02/2004 |
| 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 (?)
dog missed mine (?)
inadequate training (?)
inadequate medical provision (?)
pressure to work quickly (?)
inadequate training (?)

Accident report

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

The accident occurred on land classed as "agricultural" and described as "medium" hard. A photograph of the site showed hard, dry ground with patches of coarse grass. The victim had been a deminer for two years and had last attended a revision course sixteen months before. It was 41 days since the last time off. The device was identified as an PMN by fragments found at the site.

On the day of the accident the team were delayed by two punctures on the way to the site and arrived late (10:45). The dog-set's task was to check a breaching/boundary lane.

The victim said that the dogs checked a leash length (8m) and both dogs indicated a suspect point. The point was investigated and the fuse of a mortar was found. He was checking the second leash at a distance of 11 metres from the first when he stepped on a mine at 11:10.

The victim was treated at the site, then transferred to ICRC hospital in Kandahar, and from there to hospital in Peshawar, Kandahar.

A preliminary accident report seen in July 1998 stated that the victim "worked one leash then he started for the second leash from the same place, while the procedure is that the second leash should be started one metre back from the cleared area..."

The victim stated that his dog missed the mine, and also that the Team Leader and the Set Leader had walked where the accident occurred before he did. He added that there was a delay in stemming the bleeding from his leg while colleagues went to fetch a camera with film.

The Team Leader stated that he was negotiating to keep a shepherd away from the area when the accident occurred. The group's set Leader had told him that the victim stepped from the safe area [for no obvious reason]. The Team Leader was also the medic and did not mention any delay in treatment.

Two other deminer/surveyors said that the victim caused the accident by his carelessness.

Conclusion

The investigators determined that the accident was caused by either the dog performing badly or its handler performing badly by failing to control and "read" his dog properly. They considered that poor performance by the mine-dog Set Leader was "obvious". They considered that the group might have been rushing in order to make up for lost time caused delays caused by the vehicle problems on the way to the task.

Whether or not the dog was at fault, they found that the handler had ignored safety procedures by following the dog into the area when only one dog had checked it. The Set Leader should have prevented this.

Recommendations

The investigators recommended that dog-handlers only enter the area after it had been checked by a second dog, that the Set Leaders should ensure this, that medical staff should make every effort to provide medical assistance as soon as possible, and that Set Leaders should ensure that cameras with film are on site at all times. They thought that the Set Leader should be disciplined, that all mine-dogs sets should have a revision course on survey procedure as soon as possible and that command groups should ensure that work was not rushed.

Victim Report

| | |
|---|---------------------------------------|
| Victim number: 164 | Name: Name removed |
| Age: | Gender: Male |
| Status: dog-handler | Fit for work: not known |
| Compensation: not made available | Time to hospital: not recorded |
| Protection issued: Not recorded | Protection used: not recorded |

Summary of injuries:

INJURIES

minor Arm

severe Leg

AMPUTATION/LOSS

Leg Below knee

COMMENT

See medical report.

Medical report

A preliminary report listed the victim's injuries as: "right leg amputated, left leg received fragments... left leg broken, right arm got lower injury".

No formal medical report was in the record in September 1999 (it's absence was noted by the accident investigators).

The victim complained that his field treatment was delayed while his colleagues went 1km to another survey team to get a camera with film in it so that his injuries could be photographed prior to treatment. The investigators observed that this (if true) indicated "extremely poor performance of the team medic". [Photographs on injuries were required by the insurance company at that time.]

A photograph in the file showed the victim with his left leg lightly bandaged and his sock saturated with blood while his right leg was raised to show the amputation (perhaps 10cm above the ankle).

No record of compensation was found in June 1998.

Analysis

The primary cause of this accident is listed as a "*Field control inadequacy*" because the victim was working improperly and his error went uncorrected.

If it is true that his supervisors walked over the area prior to him, they set a bad example that may indicate that they were inadequately trained for their jobs. Similarly, if the medic delayed treatment for a photograph to be taken, he demonstrated a lack of the ability to make an appropriate decision about priorities. Both may imply a training need that would be serious management failings. The secondary cause is listed as "*Inadequate training*".

Gathering of medical treatment and compensation details was prevented by the UN programme manager who denied all access to records in September 1999. Access has continued to be denied up to the date of completion of this version of the database.

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 often impossible.