

8-12-1997

DDASaccident154

Humanitarian Demining Accident and Incident Database
AID

Follow this and additional works at: <https://commons.lib.jmu.edu/cisr-globalcwd>

 Part of the [Defense and Security Studies Commons](#), [Peace and Conflict Studies Commons](#), [Public Policy Commons](#), and the [Social Policy Commons](#)

Recommended Citation

Database, Humanitarian Demining Accident and Incident, "DDASaccident154" (1997). *Global CWD Repository*. 354.
<https://commons.lib.jmu.edu/cisr-globalcwd/354>

This Other is brought to you for free and open access by the Center for International Stabilization and Recovery at JMU Scholarly Commons. It has been accepted for inclusion in Global CWD Repository by an authorized administrator of JMU Scholarly Commons. For more information, please contact dc_admin@jmu.edu.

DDAS Accident Report

Accident details

Report date: 17/05/2006	Accident number: 154
Accident time: not recorded	Accident Date: 12/08/1997
Where it occurred: Qalai Muslim, Ward 7, Kabul	Country: Afghanistan
Primary cause: Field control inadequacy (?)	Secondary cause: Field control inadequacy (?)
Class: Excavation 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: soft
Date record created: 13/02/2004	Date last modified: 13/02/2004
No of victims: 2	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 (?)
inconsistent statements (?)
partner's failure to "control" (?)
safety distances ignored (?)
squatting/kneeling to excavate (?)
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.

Both victims had been deminers for seven years. They had last attended a revision course seven months before, and had been on leave 39 days before. The ground where the accident occurred was described as soft. The device involved was identified as a PMN from "found fragments".

The investigators decided that the two victims were assigned a breaching lane to clear. Victim No.1 was eager to finish investigating a signal when a rest period was announced, so hurried and used excessive force. Victim No.2: was not maintaining the safety distance required and was also injured.

The Team Leader stated that the deminers were eager to change over roles (not to rest). Victim No.2 was standing behind while Victim No.1 finished prodding.

Victim No.1 stated that he was holding a block of cement up with one hand while he exposed the mine he had found when the block slipped and struck the mine.

Victim No.2 stated that he was working correctly ten metres behind his partner when the mine went off a meter away from their working area. He stated that it may have been a booby trap or tripwire detonated, or that the large cement block could have been attached to it in some way.

Conclusion

The investigators concluded that the accident occurred because of the victim's negligence. Victim No.1 was too eager to start his rest period and Victim No.2 was negligent because he was too close.

Recommendations

The investigators recommended that the command group be told to have close supervision of their deminers. They said that deminers should be reminded to maintain a 35 degree angle when prodding and to avoid excessive force. Also, the resting deminer should control, guide and correct his partner during prodding, and must maintain recommended safety distances. They added that the Section Leader should be disciplined for poor control and that rest periods should not be announced while a deminer is busy investigating a signal.

Victim Report

Victim number: 197	Name: Name removed
Age:	Gender: Male
Status: deminer	Fit for work: not known
Compensation: 150,000 Rs	Time to hospital: not recorded
Protection issued: Helmet	Protection used: not recorded
Thin, short visor	

Summary of injuries:

INJURIES

minor Chest

minor Hand

minor Neck

severe Eyes

COMMENT

See medical report.

Medical report

Victim No.1's injuries were summarised as: injuries to neck, loss of sight, and left hand.

A photograph showed the victim with eye injuries.

A disability claim was submitted on 23rd December 1997 for the victim describing his injuries as a lacerated wound to his right eyelid and fragments to both eyes resulting in a 60% vision loss in his right eye and "left eye partial loss of vision".

A disability payment for the victim of 150,000 Rs was made on 23rd April 1998.

Victim Report

Victim number: 198	Name: Name removed
Age:	Gender: Male
Status: deminer	Fit for work: presumed
Compensation: not made available	Time to hospital: not recorded
Protection issued: Helmet	Protection used: not recorded
Thin, short visor	

Summary of injuries:

INJURIES

minor Arm

minor Face

minor Neck

minor Shoulder

severe Hand

severe Hearing

severe Leg

COMMENT

See medical report.

Medical report

Victim No.2's injuries were summarised as: injuries to face, and to right leg.

A photograph showed Victim No.2 with injuries to his right hand, left leg, face, neck and shoulder.

The demining group reported that Victim No.2 had sustained injuries to his chin, left elbow, shoulder, arm and left leg.

The demining group forwarded a claim on 11th March 1998 for Victim No.2 describing his injuries as multiple injuries including loss of hearing in both ears. The claim was rejected pending an ENT (hearing) report.

No record on a compensation payment to Victim No.2 was found in June 1998.

Analysis

The primary cause of this accident is listed as a "*Field control inadequacy*" because the victims were working improperly and their errors were not corrected.

Some information can be inferred from the injuries suffered. Victim No.1's eye injury shows that he was working with his visor raised (or not worn), while Victim No.2 appears to have been standing behind and to the side of his squatting partner (so explaining the range of his injuries). He was breaching safety distance SOPs. The blast and fragments may have been deflected by the concrete, and the concrete/cement may have struck Victim No.1 so explaining the "blunt trauma" claim.

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 further management failing.

Victim No.2's severe deafness is common of Afghan claims from this period, when insurance favoured such injury and testing the validity of the claims was hard.

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.

Gathering of further accident and medical treatment detail for Victim No.2 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.