

8-5-1997

# DDASaccident156

Humanitarian Demining Accident and Incident Database  
*AID*

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# DDAS Accident Report

## Accident details

<b>Report date:</b> 17/05/2006	<b>Accident number:</b> 156
<b>Accident time:</b> not recorded	<b>Accident Date:</b> 05/08/1997
<b>Where it occurred:</b> Qala Bahadar, Ward 6, Kabul	<b>Country:</b> Afghanistan
<b>Primary cause:</b> Unavoidable (?)	<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> grass/grazing area hard metal scrap
<b>Date record created:</b> 14/02/2004	<b>Date last modified:</b> 14/02/2004
<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 investigation (?)  
handtool may have increased injury (?)  
pressure to work quickly (?)  
request for machine to assist (?)  
visor not worn or worn raised (?)  
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 two years. It was two months since his last revision course and 17 days since his last leave. The ground where the accident occurred was described as hard, grass covered and littered with tin cans.

The investigators determined that the victim used his detector over the two meter clearance lane he was working. He then put on an anti-fragment jacket and a helmet to start prodding. During the prodding he "made mistake by inserting excessive pressure on the top of the mine..."

**The Team Leader** said that the deminer prodded negligently.

**The Section Leader** said that the deminer put on the fragmentation jacket and helmet before using the detector, and worked well except to wrongly assume that the reading was from one of the many bits of tin can in the area. He thought the use of back-hoe machines would prevent such accidents in future.

**The victim's partner** said that the hard ground made the work difficult but that the victim made a mistake. He added that pressure to work hard and quickly was a factor. He thought that mission duration should be shorter and work time reduced.

## Conclusion

The investigators concluded that the accident occurred because the deminer was working in a fragment strewn area, so presumed that the reading was a fragment. He was careless and prodded using excessive force.

## Recommendations

The investigators recommended that "all deminers must properly sweep the area, accurately investigate all readings and exactly mark the reading points; if any part of the minefield has a continuous reading, the surface must be excavated completely from one side – or a dog set could be asked to check the area. Section Leaders must not allow deminers to ignore safety procedures. They should pay more attention to deminers working in areas with continuous reading from detectors".

## Victim Report

<b>Victim number:</b> 200	<b>Name:</b> Name removed
<b>Age:</b>	<b>Gender:</b> Male
<b>Status:</b> deminer	<b>Fit for work:</b> not known
<b>Compensation:</b> 350,000 Rs	<b>Time to hospital:</b> not recorded
<b>Protection issued:</b> Frag jacket Helmet Thin, short visor	<b>Protection used:</b> Frag jacket, Helmet

### **Summary of injuries:**

minor Face

minor Genitals

minor Hand

minor Legs

severe Hand

severe Hearing

AMPUTATION/LOSS

Finger

COMMENT

See medical report.

### **Medical report**

The victim's injuries were summarised as to his lips, nose, right leg, arm, shoulder and fractured fingers of the right hand.

A photograph showed both hands bandaged and bloody.

A medic's sketch showed injury to both lower legs, face, upper right arm and hand.

The demining group reported that the victim suffered lacerations to both legs, right hand (index and middle fingers fractured), and superficial scrotal injuries (scrotal haematoma).

A compensation claim was forwarded on 28<sup>th</sup> October 1997 claiming he had multiple lacerations to both hands and both legs, multiple fractures to right hand, and loss of hearing in both ears. This had resulted in deformation of his right hand, amputation of part of his right index finger, a left ear total hearing loss, and a partial hearing loss in his right ear. His hearing loss was assessed at 50% on 20<sup>th</sup> July 1997. The damage to his right hand was assessed at 30% on 8<sup>th</sup> October 1997.

Compensation of 350,000 Rs was forwarded on 23<sup>rd</sup> December 1997.

### **Analysis**

The primary cause of this accident is listed as "*Unavoidable*" because it seems that the deminer was working appropriately within his SOPs when the accident occurred.

The use of a detector technique in a heavily contaminated area is highly questionable, but the victim did not choose the technique to use and any failing on that score was one of the command group. The secondary cause is listed as "*Inadequate equipment*".

The wearing of a frag-jacket in this accident is rare among the Afghan accidents recorded, but the victim's facial injuries indicate that the visor was worn raised (at least partly). The use of a squatting position to "excavate" was, in this instance, in line with UN MAC requirements because the frag-jacket was worn.

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.