

4-25-1999

# DDASaccident334

Humanitarian Demining Accident and Incident Database  
*AID*

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# DDAS Accident Report

## Accident details

<b>Report date:</b> 19/05/2006	<b>Accident number:</b> 334
<b>Accident time:</b> 09:15	<b>Accident Date:</b> 25/04/1999
<b>Where it occurred:</b> Kane, Qaterghai, Rodat District, Nangrahar Province	<b>Country:</b> Afghanistan
<b>Primary cause:</b> Field control inadequacy (?)	<b>Secondary cause:</b> Inadequate equipment (?)
<b>Class:</b> Missed-mine accident	<b>Date of main report:</b> 23/07/1999
<b>ID original source:</b> No: MI 06/99	<b>Name of source:</b> IGM
<b>Organisation:</b> Name removed	
<b>Mine/device:</b> PMN AP blast	<b>Ground condition:</b> hard metal fragments
<b>Date record created:</b> 20/02/2004	<b>Date last modified:</b> 20/02/2004
<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> Task:08-0805-044-024	<b>Map series:</b>
<b>Map edition:</b>	<b>Map sheet:</b>
<b>Map name:</b>	

## Accident Notes

inadequate communications (?)

inadequate investigation (?)

## Accident report

Access to the accident data was denied by the MAC programme manager. A brief summary of the accident was provided by a professional researcher who had access to the original documents. That summary is reconstructed here.

[Map references are not recorded in the MAC records, so the minefield task number (when available) is entered in the Map Ref field at the Incident/Accident tab as an identifying feature.]

The accident occurred on a hillside that was “grazing land” and described as “hard”. The victim had nine years experience, had last attended a revision course in December 1998 and had last been on leave 20 days before. The site was a heavily mined hillside that had also been a battlefield. This made it a difficult task for the deminers because of the number of readings from the detectors.

The Victim was working in a breaching party making a lane to the top of the hill. He had been working for 20 minutes when he registered a detector reading. [There is some confusion over what happened next – presumably he was not observed.] He then either moved to mark the reading and stood on the mine or marked the reading and stepped back, stepping on the mine.

He suffered “Amputation of right leg. Wounds to left leg and chest.” He was treated at the site for fifteen minutes, then died. [Extrapolating from similar accidents in the theatre, a traumatic amputation of the lower right leg is recorded.]

The deminers were getting many detector readings (almost continuously) across the site. The accident occurred in an area away from the known minebelt and the investigators thought it likely that the Victim dismissed a detector reading as a fragment and did not investigate it.

It was suggested that the Victim lost his balance due to the hot conditions and his heavy helmet. However, he did not appear to have stepped outside his breaching lane.

The investigators found that the demining team had no HF radio.

## **Conclusion**

The investigators found that the accident was preventable if the SOPs had been strictly applied. They also found that the Victim had some family problems and that some money had been stolen from him recently. They felt that these problems may have been distracting him.

## **Victim Report**

<b>Victim number:</b> 420	<b>Name:</b> Name removed
<b>Age:</b>	<b>Gender:</b> Male
<b>Status:</b> deminer	<b>Fit for work:</b> DECEASED
<b>Compensation:</b> not made available	<b>Time to hospital:</b> not recorded
<b>Protection issued:</b> Helmet	<b>Protection used:</b> not recorded
Thin, short visor	

### **Summary of injuries:**

INJURIES

severe Leg

AMPUTATION/LOSS

Leg Below knee

FATAL

COMMENT

The victim died 15 minutes after the accident.

No medical report was made available.

## **Analysis**

The primary cause of this accident is listed as a "*Field control inadequacy*" because the investigators decided that the victim was ignoring detector readings, and this error was not corrected. The secondary cause is listed as "*Inadequate equipment*" because the demining group were operating without any communications system in place, and this must have been done with the knowledge of their management.

The failure to conclude a report on this fatal accident for three months may indicate a management failure at the top of the management chain. No criticism of the NGO charged with carrying out accident investigations for the UN MAC is intended. The NGO is frequently not provided with the means to carry out investigations in a timely manner.

The failure of the MAC to allow access to accident reports means that the report made here is acknowledged to be unsatisfactory. It will be revised if access is ever allowed. The failure of the MACC to act with transparency is bound to raise questions over what they have to hide.