1-19-2000

DDASaccident335

Humanitarian Demining Accident and Incident Database
AID

DDAS Accident Report

Accident details

Report date:	19/05/2006	**Accident number:**	335
Accident time:	11:00	**Accident Date:**	19/01/2000
Where it occurred:	Haji Basher Village, Toor Kotal, Dand District, Kandahar	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Inadequate equipment (?)
Class:	Missed-mine accident (survey)	**Date of main report:**	31/03/2000
ID original source:	No: MI 01/2000	**Name of source:**	IGM
Organisation:	Name removed		
Mine/device:	PMN AP blast	**Ground condition:**	agricultural (abandoned) soft
Date record created:	20/02/2004	**Date last modified:**	21/02/2004
No of victims:	1	**No of documents:**	1

Map details

Longitude:		**Latitude:**	
Alt. coord. system:		**Coordinates fixed by:**	
Map east:		**Map north:**	
Map scale:	Task 2404-081-171	**Map series:**	
Map edition:		**Map sheet:**	
Map name:			

Accident Notes

inadequate metal-detector (?)

mine/device found in "cleared" area (?)

inadequate area marking (?)

inadequate medical provision (?)

inadequate equipment (?)

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 Victim had been employed in demining since 1994. His last revision course was in March 1999 and the time list his last leave was two days. The accident occurred on land described as “agricultural, soft ground”. Mines found in the area were recorded as POMZ, PMN and PMN-2. The demining group was engaged in Surveys (Levels 1 and 2).

The team arrived at the site at 07:30 but did not begin work until 10:00 because of rain the previous day. The Victim was tasked with establishing a start point. After doing so, he started a boundary clearance using a manual search until he reached a belt of PMN mines 22 meters from the start point. He found mines one on each side of the boundary lane and showed these to the supervisor. He was told to move the markers indicating the safe lane. As he turned, he stepped on a missed mine that was between the other two.

The Victim suffered a right leg amputation below the knee and severe lower left leg injuries. The time it took for hospitalisation was not recorded. First aid at the site was given by the Supervisor because the Victim doubled as the site medic. The Victim was then moved to the ICRC hospital in Kandahar before an air MEDEVAC to CMH hospital in Peshawar.

The investigators thought it possible that the Victim had assumed there would be no mine between the two found mines. They observed that the detector is use was “very old”.

The investigators recorded a disagreement between the Victim and supervisor over who was at fault. They found that the Supervisor appeared to have issued an inappropriate instruction to move the markers prior to the discovered mines being dealt with. The Victim was described by the supervisor as being disagreeable, stubborn and difficult to manage. A formal complaint describing this problem had been lodged at the group’s Head Office.

Conclusion

The investigators concluded that the Victim appeared to be moving too quickly in his clearance procedures. They determined that the accident was “preventable”.

Victim Report

Victim number: 421 **Name:** **Name removed**

Age: **Gender:** Male

Status: medic **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

severe Leg

AMPUTATION/LOSS

Leg Below knee

COMMENT

No medical report was made available.

Analysis

The primary cause of this accident is listed as a *"Field Control inadequacy"* because the Victim appears to have been working carelessly and his error was not corrected. The provision of a very old detector (Schiebel AN 19/12) may imply that the tools supplied could not find the threat device, so the secondary cause is listed as *"Inadequate equipment".*

The use of the medic on site as an active deminer engaged in boundary marking was a breach of SOPs and a significant *"Management/control inadequacy"*. The investigator's failure to comment on this may imply that it is common practice for the group. It should be noted that the investigators worked for the same NGO that was carrying out the survey - and still took ten weeks to complete their investigation. 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.