

7-2-2000

# DDASaccident339

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> 339
<b>Accident time:</b> 09:40	<b>Accident Date:</b> 02/07/2000
<b>Where it occurred:</b> Qula-e-Muslim Village, Ward 7, Kabul Province	<b>Country:</b> Afghanistan
<b>Primary cause:</b> Inadequate survey (?)	<b>Secondary cause:</b> Field control inadequacy (?)
<b>Class:</b> Missed-mine accident (survey)	<b>Date of main report:</b> 14/08/2000
<b>ID original source:</b> MI 05/2000	<b>Name of source:</b> IGM
<b>Organisation:</b> Name removed	
<b>Mine/device:</b> PMN AP blast	<b>Ground condition:</b> bushes/scrub grass/grazing area metal fragments rocks/stones
<b>Date record created:</b> 21/02/2004	<b>Date last modified:</b> 21/02/2004
<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> Task01-0101-007-660	<b>Map series:</b>
<b>Map edition:</b>	<b>Map sheet:</b>
<b>Map name:</b>	

## Accident Notes

inadequate medical provision (?)  
inadequate metal-detector (?)  
mine/device found in "cleared" area (?)  
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 Victim [whose name was not recorded] had been employed in demining for six years. He had last attended a revision course on 25-27<sup>th</sup> June, 2000, and had last been on leave 26 days before the accident. The area had previously been surveyed by the same team carrying out another survey at the time of the accident. The ground was described as “grazing land”, some normal and some hard with bushes, grass and stones. The weather was described as being “a bit hot”. The mines in the area had been laid by the Soviet occupying forces. The mines were laid in a “very dense” pattern to protect military posts and ammunition stores.

The Survey Team was divided into two and the group that had the accident began making a survey lane at the bottom of the hill. The Victim marked a detector reading and when he investigated it, found some fragments. He put the detector aside and moved to collect stones to construct a Turning Point and mark the cleared survey lane. While walking in the survey lane (within the safety margin or “overlap”) he stepped on a PMN mine.

The accident occurred at 09:40. The Victim was extracted and taken to a safe site at 09:45, when a tourniquet was applied. Further removed to safer site by 10:00. He was taken to an ambulance by 10:30 and to ICRC hospital at 10:45. An air CASEVAC occurred at 14:10 and he was admitted in CMH hospital Peshawar at 15:30.

The Team leader said that the accident occurred 1.4 meters beyond the cleared-area markings, so suggesting that the Victim had overstepped the safe zone. However the Victim stated that he had just cleared to this location.

The investigating team found several detector indications in “cleared areas”.

The investigators reported that readings on the mine detectors were almost continuous in this area, and it is likely that the victim interpreted these as fragments. Because of the false alarm rate, all indications were not being investigated. They remarked that it was not possible to use dogs in this area because of the terrain.

The investigators observed that the Victim’s detector had no handle, so may have been operated too high above the ground.

## Conclusion

The investigators identified poor quality control by the Team Leader. They said that the Team Leader must have known about the surveyors ignoring detector indications. They concluded that the accident was preventable.

## Victim Report

<b>Victim number:</b> 427	<b>Name:</b> Name removed
<b>Age:</b>	<b>Gender:</b> Male
<b>Status:</b> surveyor	<b>Fit for work:</b> not known
<b>Compensation:</b> not made available	<b>Time to hospital:</b> 5 hours 50 minutes
<b>Protection issued:</b> Not recorded	<b>Protection used:</b> not recorded

**Summary of injuries:**

## INJURIES

minor Leg

## AMPUTATION/LOSS

Leg Below knee

## COMMENT

No medical report was made available.

**Analysis**

The primary cause of this accident is listed as “inadequate survey” because it seems likely that the mine had been missed by the Victim and in the previous survey of the area. The Secondary cause is listed as a “*Field control inadequacy*” because the field supervisors were apparently allowing the surveyors to leave metal fragments in the ground.

The inadequate medical provision referenced in the notes relates to the unacceptable length of time it took for the Victim to reach a surgical facility.

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.