11-22-1997

DDASaccident139

Humanitarian Demining Accident and Incident Database
AID

DDAS Accident Report

Accident details

Report date:	15/05/2006	**Accident number:**	139
Accident time:	not recorded	**Accident Date:**	22/11/1997
Where it occurred:	Tapi Maranjan, Ward 8, Kabul City	**Country:**	Afghanistan
Primary cause:	Management/control inadequacy (?)	**Secondary cause:**	Inadequate equipment (?)
Class:	Victim inattention	**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:**	grass/grazing area hard rocks/stones
Date record created:	13/02/2004	**Date last modified:**	13/02/2004
No of victims:	1	**No of documents:**	1

Map details

Longitude:		**Latitude:**	
Alt. coord. system:		**Coordinates fixed by:**	
Map east:		**Map north:**	
Map scale:	not recorded	**Map series:**	
Map edition:		**Map sheet:**	
Map name:			

Accident Notes

inadequate investigation (?)

victim ill (?)

inadequate metal-detector (?)

inconsistent statements (?)

partner's failure to "control" (?)

pressure to work quickly (?)

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 last attended a revision course four months before and had last been on leave 42 days before the accident. The ground being worked on was described as "medium-hard" grazing land [rocky hillside]. The group involved claim to have found fragments identifying the mine involved as a PMN.

The investigators said that the demining group had moved before the investigation took place and their management would not co-operate to let the investigators see the site. They discovered that the group of deminers involved had worked for 3 months and 12 days without a break before the accident. The victim was feeling ill and had been treated by the medic but was not allowed to take time off. He had asked for a few days leave but his request was rejected.

The investigators checked the Team's detectors and found five to be not "in proper working condition". The victim used one of these detectors. At the end of the working day the victim was taking his equipment to the store and either stepped into an uncleared area or stepped on a missed mine (due to the faulty detectors).

The Team Leader said the victim walked into an uncleared area carelessly and caused the accident. He said that the length of a field mission should not be extended and this would prevent recurrence of the accident.

The Section Leader said the victim was depressed and walked into the uncleared area carelessly. He said deminers should not be pressurised to work quickly, missions should not have duration extended, and that the problems of individual deminers should be considered.

The victim said he walked into an uncleared area and it would not have happened if he were in a normal mood.

A witness deminer said he was behind the victim and saw him step into an uncleared area.

Conclusion

The investigators concluded that the victim was feeling unwell and had requested leave, so he might not have been concentrating when he stepped into an uncleared area. He might also have stepped on a missed mine.

Recommendations

The investigators recommended that the company should recondition all faulty detectors and give instructions to Team Leaders to allow sick deminers to take time off. They further recommended that deminers should always have a break at the end of a two month mission and that command groups should ensure that store and rest areas are positioned "to eliminate possibility" of deminers walking into an uncleared area. Also, the command group should watch the deminers leaving the minefield to ensure that they do not walk into an uncleared area. A final recommendation was that the demining company in questions should be required to co-operate with the accident investigators.

Victim Report

Victim number: 193 **Name: Name removed**

Age:	**Gender:** Male
Status: deminer	**Fit for work:** not known
Compensation: not made available	**Time to hospital:** not recorded
Protection issued: Helmet Thin, short visor	**Protection used:** not recorded

Summary of injuries:

INJURIES

minor Foot

minor Legs

severe Genitals

severe Leg

AMPUTATION/LOSS

Leg Below knee

Genital

COMMENT

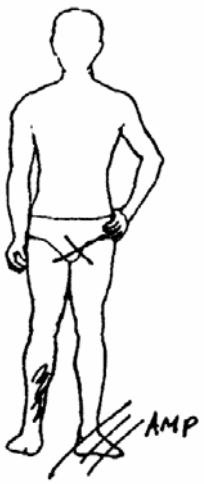
See medical report.

Medical report

The victim's injuries were summarised as a left leg amputation below the knee, wounds above his left knee, deep injuries to his right thigh and scrotum/testicle (left testicle removed), and his right foot severely lacerated.

A photograph showed a misshapen and bandaged right foot (heel and ankle) and an amputated left foot.

A medic's sketch (reproduced below) showed injury to the right shin and genitals, and amputation of the left foot.



The insurers were informed on 25th November 1997 that the victim had suffered amputation of his left leg below the knee, right leg multiple severe injuries, and the partial loss of his left

testicle. They were sent a disability claim on 23rd April 1998 listing the injuries as "amputation of left leg, debridement right leg; left side orchidectomy, DPC of scrotum, SSG right leg, SSG left leg stump. DPC left leg".

The victim was in two hospitals from 22nd November 1997 until 11th January 1998.

No record of compensation was found in June 1998.

Analysis

The primary cause of this accident is listed as a *"Management control inadequacy"* because the victim's group was obliged to work despite having spent an unreasonable period without a break, with inadequate equipment, and the victim himself was obliged to work while sick. The secondary cause is listed as *"Inadequate equipment"*.

The inadequacy of the equipment provided, especially the detectors, was a further serious management failing.

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 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.