

DDAS Accident Report

Accident details

Report date: 19/04/2006	Accident number: 98
Accident time: not recorded	Accident Date: 26/05/1997
Where it occurred: Chilston, Ward 7, Kabul city	Country: Afghanistan
Primary cause: Field control inadequacy (?)	Secondary cause: Inadequate training (?)
Class: Handling accident	Date of main report: [No date recorded]
ID original source: none	Name of source: MAPA/UNOCHA
Organisation: [Name removed]	
Mine/device: Fuze	Ground condition: bushes/scrub residential/urban
Date record created: 24/01/2004	Date last modified: 24/01/2004
No of victims: 2	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

partner's failure to "control" (?)
inadequate investigation (?)
safety distances ignored (?)
vegetation clearance problem (?)
inadequate training (?)

Accident report

An investigation on behalf of the UN MAC was carried out and its report made briefly available. The following summarises its content.

Both victims had worked in a Battle Area Clearance (BAC) team for 18 months. BAC teams did not have revision courses. The time since their last leave was not recorded. The ground where the accident occurred was described simply as a "battlefield". A photograph showed a low ruined wall with a derelict building behind.

The investigators determined that the two victims found a "UXO" fuze while working in a bushy area.

The Team Leader stated that "the victim was busy searching inside the grass and collapsed bricks of a wall but was careless. He recommended no one should touch fuzes and that safety distances should be maintained.

The Section Leader said the searcher was working properly and was careless by searching in a standing position.

Victim No.2 said that Victim No.1 was working properly but that the accident might not have occurred if they had been more careful.

Victim No.1 said that the accident occurred as he was removing bushes and that fuze might have been booby trapped. He said he should have taken more care when moving the bushes.

Conclusion

The investigators concluded that the victims were careless and probably caused the accident by investigating the fuze unnecessarily. They were not maintaining correct safety distance (or both would not have been injured) and the Section leader had poor command and control of the victims.

Recommendations

The investigators recommended that no deminers should be allowed to move UXO with instruction from the command group, and that Section Leaders should supervise carefully to ensure safety procedures are observed.

Victim Report

Victim number: 130	Name: [Name removed]
Age:	Gender: Male
Status: deminer	Fit for work: yes
Compensation: 7,500 Rs	Time to hospital: not recorded
Protection issued: Helmet	Protection used: not recorded
Thin, short visor	

Summary of injuries:

INJURIES

minor Arms

minor Feet

minor Hand

minor Legs

COMMENT

See medical report.

Victim Report

Victim number: 130	Name: [Name removed]
Age:	Gender: Male
Status: deminer	Fit for work: yes
Compensation: 7,500 Rs	Time to hospital: not recorded
Protection issued: Helmet	Protection used: not recorded
Thin, short visor	

Summary of injuries:

INJURIES

minor Arms

minor Feet

minor Hand

minor Legs

COMMENT

See medical report.

Victim Report

Victim number: 131	Name: [Name removed]
Age:	Gender: Male
Status: deminer	Fit for work: presumed
Compensation: none on record	Time to hospital: not recorded
Protection issued: Helmet	Protection used: not recorded
Thin, short visor	

Summary of injuries:

INJURIES

minor Chest

minor Leg

COMMENT

See medical report.

Medical report

Victim No.2's injuries were summarised as minor injuries to right leg and chest. The victim said he had injuries to his right foot and chest. A medical report recorded injury to his left foot and chest. A photograph showed injuries to his right foot, right leg and chest.

The medic's sketch is reproduced below.



The demining group informed the insurers on 28th May 1997 that the victim had sustained fragments to right leg and chest. A compensation claim was made on behalf of the victim on 15th January 1998 stating that he sustained wounds to his chest and right leg and was away from duty until 15th June 1997.

No record of an insurance payment was on file.

Analysis

The primary cause of this accident is listed as a "*Field control inadequacy*" because the victims were working inappropriately and their errors were not corrected.

The activity of the victims is unclear but the injuries imply that the device was in (or close to) Victim No.1's hand, and that Victim No.2 was beside him. No mention is made of protective equipment but the lack of facial injury implies that visors were worn.

There is some indication that correct procedures were not known (were they allowed to handle fuzes or not?) and if this was so it would represent a significant failure of training and so of management systems. The secondary cause is listed as "*Inadequate training*".

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.