DDAS Accident Report

Accident details

Report date:	15/05/2006	**Accident number:**	104
Accident time:	not recorded	**Accident Date:**	06/04/1997
Where it occurred:	Kock Kin Village, Kabul Province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Victim inattention (?)
Class:	Other	**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:**	agricultural (abandoned) clay grass/grazing area soft
Date record created:	12/02/2004	**Date last modified:**	12/02/2004
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 (?)

inconsistent statements (?)

partner's failure to "control" (?)

inadequate area marking (?)

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 been a deminer for seven years. He had last attended a revision course six months before and had last been on leave 33 days before the accident. The ground in the area was described as soft agricultural land. A photograph showed flat land with clay soil and scattered grass.

The investigators determined that the victim returned to his breaching lane after the short break and accidentally walked beyond the area he had cleared before the break, where he stepped on a mine. He may have not marked the end of his work properly. The device was identified as a PMN (from "found fragments").

The original accident report indicated that the deminer was using a detector when the accident occurred.

The Team Leader said that the deminer was marking in order to start a new two metre lane beside the one he had cleared when the accident occurred. "He might have made some mistake in this time".

The Section Leader said that the victim was marking the cleared area when the accident occurred and must have been careless.

The victim's partner said that he was starting the marking for a new lane when the accident occurred and he must have been careless.

The victim said that during his break a shepherd told him that there were visible mines near to where he was working. He went to see the place with the shepherd, and stepped on a mine.

Conclusion

The investigators concluded that the victim crossed the "cleared path" and that the Section Leader should have checked the victim's marking because the correct marking procedures were not carried out

Recommendations

The investigators recommended that all Section Leaders should have proper control over their breaching parties and that deminers must not move unnecessarily into uncleared areas.

Victim Report

Victim number:	137	**Name:**	**Name removed**
Age:		**Gender:**	Male
Status:	deminer	**Fit for work:**	no
Compensation:	500,000 Rs (100%)	**Time to hospital:**	not recorded
Protection issued:	Helmet Thin, short visor	**Protection used:**	not recorded

Summary of injuries:

AMPUTATION/LOSS

Leg Below knee

Leg Below knee

COMMENT

Other unspecific "body" injury is referenced. See medical report.

Medical report

The victim's injuries were summarised as amputation of both legs and injuries to other parts of his body. A medical report recorded that "both legs of the victim have been cut from the tibia", and that there were deep injuries to the tibia on the right leg.

A photograph showed the deminer with both legs amputated just above the ankle.

A medic's sketch is reproduced below.

The insurers were informed on 7th April 1997 that the victim had lost both feet and suffered multiple injuries. A disability claim was submitted on May 29th 1997 in which the injuries were summarised as traumatic amputation of both legs below knee. A hospital bill for 16,519 Rs in respect of treatment for the victim was presented on 27th May 1997.

Compensation of 500,000 Rs (100% disability) was forwarded on 23rd December 1997.

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because the victim appears to have either deliberately gone into an uncleared area or been working inadequately and his errors went uncorrected. His supervisors should have stopped both, and should have undertaken any "excursions" that were necessary.

The secondary cause is listed as *"Victim inattention"* because it seems likely that the victim acted thoughtlessly without thinking of the possible consequences of his action.

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.