

DDAS Accident Report

Accident details

Report date: 15/05/2006	Accident number: 124
Accident time: 09:30	Accident Date: 20/05/1998
Where it occurred: Esa khel, Tani, Khost, Paktia	Country: Afghanistan
Primary cause: Field control inadequacy (?)	Secondary cause: Field control inadequacy (?)
Class: Missed-mine accident	Date of main report: [No date recorded]
ID original source: none	Name of source: MAPA/UNOCHA
Organisation: Name removed	
Mine/device: PMN-2 AP blast	Ground condition: grass/grazing area hard
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 (?)

inadequate training (?)

pressure to work quickly (?)

Accident report

At the time of the accident the demining group were working with a "new" one-man drill in six man teams (changing about every 15 minutes).

An accident report was made on behalf of the UN MAC and made available in September 1999. The investigators were unable to visit the area and made their assessment based on witness statements. The following summarises its content.

The accident occurred on land described as "medium hard" grazing. The victim had been a Section Leader for nine months and had last attended a revision course four months before. It was eight days since his last time off. The mine was identified as a PMN-2 from fragments found at the site.

The victim was going to inspect the work of a breaching party when at 09:30 he stepped on a mine that the deminers had missed during clearance.

He was treated on site, then evacuated to hospital and later to another hospital in Pakistan.

The Team Leader pointed out that he was in charge of all the sections because his assistant was in hospital. He reported that the victim had ignored instructions about checking clearance in the past, had received a formal warning and said he was at fault because he did not supervise the deminers well enough.

Another Section Leader gave a statement confirming that the victim had ignored previous instructions.

The Victim said that he was working properly and that the accident was caused by the negligence of the deminers. He also stated that "it should not be stressed on deminers to complete the target" clearance figures.

Conclusion

The investigators concluded that the accident occurred because the victim had "allowed the deminers to ignore the proper procedure which led to the missed mine". Examples of prior command and control failings by the victim were cited.

Recommendations

The investigators recommended that the command group have close supervision of their deminers and that Section Leaders check lanes to ensure that "no readings are left". They also recommended that the deminers who missed the mine should be disciplined.

The investigators notified the UN MAC on 14th July 1998 that the accident was caused by the detector man missing a mine.

Victim Report

Victim number: 160	Name: Name removed
Age:	Gender: Male
Status: supervisory	Fit for work: not known
Compensation: not made available	Time to hospital: not recorded
Protection issued: Helmet	Protection used: not recorded
Thin, short visor	

Summary of injuries:

severe Leg

AMPUTATION/LOSS

Leg Below knee

COMMENT

See medical report.

Medical report

The insurers were informed on 27th April 1998 that the victim, a Section Leader, suffered amputation of his right leg below the knee and multiple injuries of left leg and foot.

A medic's sketch of the victim (reproduced below) showed a right leg amputation and lacerations and abrasions to both legs.



The victim was treated at 10:30 by the field medic and received "sen hamercell 500 I.V.; Inj Lignocain 15ml; Inj Disyron 500m; Inj Mauslan 1mp; Ampiclet 1g IV."

His pulse was recorded at 120/min, BP 130/90; Resp 25/min. A pressure bandage was applied and an IV infusion "mixed" of 1000ml and haemacell 500ml given over one hour.

A photograph of the victim showed him on a stretcher with his foot missing and his lower leg split-open.

Analysis

The primary cause of this accident is listed as a "*Field control inadequacy*" because the victim was walking in a cleared area and should have been safe to do so. The quality of clearance was poor and, as a supervisor, he should have ensured that this did not happen.

As a field supervisor, he should have been especially aware of what areas had been cleared or otherwise. If he were inadequately trained, that would represent a significant 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 detail on the victim's medical treatment and compensation was prevented by the UN programme manager who denied access to records in September 1999. Access is still denied at the date of issue of this database.