DDAS Accident Report

Accident details

Report date:	15/05/2006	**Accident number:**	130
Accident time:	not recorded	**Accident Date:**	07/02/1998
Where it occurred:	Dargai village, Tani District, Khost Province	**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:	PMN-2 AP blast	**Ground condition:**	grass/grazing area
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 (?)

partner's failure to "control" (?)

mine/device found in "cleared" area (?)

visor not worn or worn raised (?)

inadequate training (?)

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 six years. He was working on land described as "grazing land" [in Afghanistan this means "rocky hills"].

The investigators determined that the deminer was resting while his partner worked when he saw a fuse in the uncleared area at the side of the lane. He picked it up and "started playing" with it and it exploded. The Section Leader was covering for another deminer who had gone to urinate [so was not observing].

The victim stated he was collecting fragments that remained in the cleared area/breaching lane and picked up a part of a "PMN-2" which was covered in soil. He knocked it against a stone to remove the soil and it exploded.

The Sub-Commander said the victim was working improperly because he should have been controlling his partner.

The Section Leader stated the victim was negligent.

Conclusion

The investigators concluded that the victim ignored safety precautions by playing with the fuse and that the absence of the Section Leader was a contributory factor.

Recommendations

The investigators recommended that Section Leaders should not be assigned to cover for deminers in breaching parties, that the command group must stress the danger of touching UXO/devices, and that the Section Leader should be disciplined for his poor performance.

Victim Report

Victim number:	166	**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 Eyes

minor Face

minor Hand

AMPUTATION/LOSS

Fingers

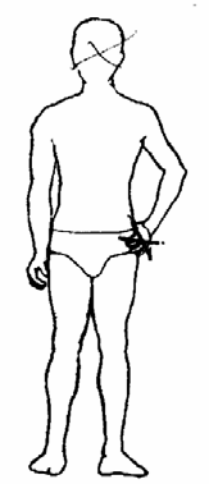
COMMENT

See medical report.

Medical report

The accident report listed the victim's injuries as amputation of five fingers of his left hand, "superficial" injuries to his right hand, face and nose, and foreign bodies to both eyes.

A medic's sketch (reproduced below) showed left hand and facial injury.



A photograph showed that all fingers on the victim's left hand had been traumatically amputated and the palm opened [like a rose]. A later photograph (after dressing) showed that the body of the hand and the thumb were apparently still in place. The victim was looking at the camera and his eyes appear clear, so the eye injury is thought to have been minor.

The insurers were informed on 6th March 1998 that the victim had lost all the fingers of his left hand and got foreign bodies in his eyes in an accident on 15th February 1998 [sic] when a fuse went off in his hand. [Dates were frequently mistranslated in Afghan reports.]

No record of compensation was found in June 1998.

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because (as the investigators found) the field supervisor was absent and the victim's error went uncorrected.

It is possible that the device was left over from the inadequate destruction of a PMN-2 during routine clearance, as has happened in other accidents.

The victim appears to have been unaware of the danger of handling parts of a PMN-2, which implies inadequate training. The secondary cause is listed as *"Inadequate training"*.

Gathering of medical treatment and compensation details 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.

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.