DDAS Accident Report

Accident details

Report date:	15/05/2006	**Accident number:**	131
Accident time:	not recorded	**Accident Date:**	05/01/1998
Where it occurred:	Naghlo Village, Sarubi District, Kabul Province	**Country:**	Afghanistan
Primary cause:	Management/control inadequacy (?)	**Secondary cause:**	Management/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 AP blast	**Ground condition:**	rocks/stones
Date record created:	13/02/2004	**Date last modified:**	13/02/2004
No of victims:	1	**No of documents:**	2

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 (?)

dog missed mine (?)

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

inadequate training (?)

visor not worn or worn raised (?)

Accident report

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 more than seven years. It was 53 days since his last leave and three months since his last revision course.

The investigators determined that the victim was working on the ridge of a stony hill [photographs showed it was very steep and rocky]. He was given permission to leave the area to urinate and went into an area declared clear by a dog survey team. The investigators expressed the view that the area was unsuitable for dogs to clear because it was too steep for them to "sit" when indicating a signal.

The victim said he inadvertently kicked a stone onto a PMN.

The photograph above shows a dog being used for area-reduction on stony ground.

The Team Leader said that inadequate dog training was a possible cause of the accident.

Conclusion

The investigators concluded that the accident had occurred in an area cleared by a Survey Team using dogs although the area was not suitable for dog clearance. There had been a lack of command and control within the survey team to which tensions between the Team Leader and the Set Leader may have contributed.

Recommendations

The investigators recommended that the responsible planning agency must ensure that team building is improved. They said that Mine Dog Set teams should implement a modified survey process properly and that better decisions over when to use dogs were needed.

Victim Report

Victim number: 167

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

severe Hand

severe Leg

COMMENT

See medical report.

Medical report

The investigators summarised the injuries as abrasions and laceration to the face, broken thumb and lacerations on left hand, superficial other injuries to both left and right hands, the eyes and a fracture of the left leg.

The insurers were informed that the victim had stepped [sic] on a mine and sustained injury to face and both eyes, fracture to left leg, and lacerations to his left hand.

No record of compensation was found in June 1998.

Analysis

Whether the victim found a fuse or initiated a mine with a stone is not very important. The fact of an explosive device being left in an area declared clear by a dog-set seems to be the salient point. Accordingly, the primary cause of this accident is listed as a *"Management control inadequacy"* because the appropriate training and use of dog-sets is a management responsibility.

There was a suggestion [see Related papers] that the blast marks were enlarged before the accident investigation, but no reason why that should have been done was given. The victim's injuries were consistent with being close to a significant blast, but not of having stepped on a mine. Quite how the initiation occurred is unknown.

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 making an accurate assessment of the site at the time of the accident impossible.

Gathering of further 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.

Related papers

A letter reporting the accident stated that the victim went into the cleared area to defecate (not urinate) and that the explosion occurred while he was removing earth (and stones) by hand.

In a letter dated 20th April 1998 from the UN MAC Programme Manager to the Director of the demining group, it was stated that "setting aside any irregularities in the investigation process that might have occurred, the mine accident… is very disturbing…. Regardless of which version of the event is considered, it is very clear that the accident took place on a task under the overall responsibility of [the recipient]. If the report process is flawed, it still does not alter responsibility for the accident. The primary cause remains the same: a break down in co-ordination and planning between the Survey Team and the Mine Dog Set. This is a leadership and management failure of the highest order and is the fault of both parties."

"The challenge now is to move beyond the issue of affixing blame, and to determine what steps can be taken to ensure that such a tragic sequence of events does not repeat itself."

A letter dated March 31st 1988 reported that a deminer was injured by a mine in a "reduced area". A subsequent missed-mine investigation implied a conspiracy of rival commercial

demining groups against the dog group, but was incomplete and its findings not accepted. Inconsistencies and vagueness in the report were objected to. The mine was on a well used path and the usual reports of mischief relaying and/or deminers "horsing about" [my term] were raised. The nature of the accident is suspect, with claims that the detonation was unusually small, injuries light and to face and hands rather than foot, etc. [Could it have been a detonator?] The suggestion was made that the "crater" might have been enlarged after the event – implying a cover-up.