

# DDAS Accident Report

## Accident details

<b>Report date:</b> 16/05/2006	<b>Accident number:</b> 143
<b>Accident time:</b> not recorded	<b>Accident Date:</b> 15/10/1997
<b>Where it occurred:</b> Shatory Village, Sarozah District, Paktika Province	<b>Country:</b> Afghanistan
<b>Primary cause:</b> Field control inadequacy (?)	<b>Secondary cause:</b> Field control inadequacy (?)
<b>Class:</b> Excavation accident	<b>Date of main report:</b> [No date recorded]
<b>ID original source:</b> none	<b>Name of source:</b> MAPA/UNOCHA
<b>Organisation:</b> Name removed	
<b>Mine/device:</b> PMN AP blast	<b>Ground condition:</b> dry/dusty grass/grazing area soft
<b>Date record created:</b> 13/02/2004	<b>Date last modified:</b> 13/02/2004
<b>No of victims:</b> 1	<b>No of documents:</b> 1

## Map details

<b>Longitude:</b>	<b>Latitude:</b>
<b>Alt. coord. system:</b>	<b>Coordinates fixed by:</b>
<b>Map east:</b>	<b>Map north:</b>
<b>Map scale:</b> not recorded	<b>Map series:</b>
<b>Map edition:</b>	<b>Map sheet:</b>
<b>Map name:</b>	

## Accident Notes

inadequate investigation (?)  
handtool may have increased injury (?)  
inconsistent statements (?)  
partner's failure to "control" (?)  
safety distances ignored (?)  
squatting/kneeling to excavate (?)  
visor not worn or worn raised (?)

## 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.

Victim No.1 had been a deminer for three years. Victim No.2 had been a deminer for six months. Both victims were reported to have attended a revision course eight months before [despite one only having been employed for six]. Both victims had been on leave 24 days before. The ground at the site was described as soft agricultural land. A photograph showed flat land with dry clumps of grass.

The investigators determined that a dog had indicated a reading and Victim No.1 used his detector at the site and got two readings 35cm apart. He marked one of the indications and uncovered a MK 7 AT mine. Thinking that the second reading must be a fragment, he began investigating it carelessly and detonated the mine. His bayonet was "lost".

**The Assistant Group Leader** said the deminer reacted violently when he found the AT mine and the bayonet flew from his hand, landing on the PMN.

**The victim's partner** (Victim No.2) said that Victim No.1 was working properly and was marking the cleared area prior to changing over duties when the accident occurred.

**Victim No.1** said that he was detecting and got two readings. After finding an AT mine at one reading he was pulling a bush from the area of the second reading when the mine went off.

**The demining group** said that the victim was prodding for an AT mine located by a dog. When he changed position and lifted his helmet to shout "mine", he leant on his shovel in the uncleared area and let off a PMN.

## Conclusion

The investigators concluded that Victim No.1 did not mark the second detector reading properly and was working in a squatting position when the ground was suitable for working prone. They decided that the victims did not maintain the correct safety distance so two were injured by one blast, and that they were not wearing their helmets when the accident occurred. As a result they decided that the team Sub-Commander had allowed the deminers to ignore correct procedure (the Group Leader was sick on the day so only his assistant was on duty). They also commented that the survey map of the site made no mention of the presence of AP mines.

## Recommendations

The investigators recommended that readings must always be marked properly before starting an investigation, that deminers must always wear the helmet when investigating a reading, and that the safety distance between members of a breaching party must be maintained.

## Victim Report

**Victim number:** 184

**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

**Protection used:** none

Thin, short visor

### **Summary of injuries:**

#### INJURIES

severe Eyes

severe Face

severe Fingers

#### COMMENT

See medical report.

### **Medical report**

Victim No.1's injuries were summarised as: serious injuries to eyes, face, fingers.

An insurance claim was submitted on 12<sup>th</sup> March 1998, saying that the victim had been "blinded" in a mine accident.

No record on a compensation payment was found in June 1998.

### **Analysis**

The primary cause of this accident is listed as a "*Field control inadequacy*" because it is likely that Victim No.1 was working carelessly and his errors went uncorrected. The proximity of Victim No.2 to the blast should also have been corrected. The fact that neither victim was wearing their helmet and visor would have been obvious to any observer, from which I infer that field supervision was absent. The demining group's summary of the accident to the insurers implies a carelessness about detail that should have been corrected.

It is possible that visors were not worn because they were too damaged to see through properly (as was seen frequently during field visits in 1998, 1999), in which case the failure to provide useable equipment may represent a serious management failing.

The use of a squatting position to "excavate" was in breach of UN requirements, but not in breach of the demining group's unauthorised variations to those requirements. The failure of the UN MAC to either listen to field feedback and adapt the SOP for local conditions, or enforce their own standards may be seen as a further 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 accident and medical treatment detail 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.