

DDAS Accident Report

Accident details

Report date: 17/05/2006	Accident number: 151
Accident time: not recorded	Accident Date: 25/08/1997
Where it occurred: Qalai Muslim, Ward 7, Kabul	Country: Afghanistan
Primary cause: Field control inadequacy (?)	Secondary cause: Inadequate training (?)
Class: Demolition accident	Date of main report: [No date recorded]
ID original source: none	Name of source: MAPA/UNOCHA
Organisation: Name removed	
Mine/device: OZM-3 AP Bfrag	Ground condition: grass/grazing area hard
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 (?)
inconsistent statements (?)
partner's failure to "control" (?)
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 four years. He had last attended a revision course two months before and had last been on leave 39 days before the accident. The ground at the accident site was described as "grazing land: medium hard", meaning a rocky hillside. Despite the fact the survey made of the site prior to clearance had indicated only the presence of PMN mines, a wide range of fragmentation and bounding fragmentation mines had been found. The demining group claimed to have identified the mine involved in the accident as an OZM-3 by finding fragments of it.

The investigators determined that the deminer located a tripwire and informed his superiors. Correct procedure required that the wire be pulled from a safe distance. The deminer pulled the wire from 30 metres while in a standing position.

The Team Leader said that warnings were still being given to the third side (part of procedure) when the mine exploded unexpectedly. He blamed the survey team for not warning them what kinds of mine to expect.

The Section Leader suspected that the victim assumed that mine was not a bounding fragmentation type.

The victim's partner stated that the order for "pulling" had been given prior to the explosion – and this his partner was working properly. He said that the survey team should have warned them about the kinds of mines to expect.

The victim said he was making the rope straight prior to pulling when he stumbled and pulled the rope. He claimed he was in a squatting position when the rope was pulled. He said the rope should be taken to the tripwire properly and straightened to avoid future accidents.

Conclusion

The investigators concluded that the deminer did not execute correct procedures when pulling, did not maintain a proper safety distance from the device, and pulled while standing, which was against procedure. They further commented that the Section Leader exhibited poor command and control.

Recommendations

The investigators recommended that deminers should not be allowed to pull a tripwire "or any other object/obstacle" in a standing position, or be in too much of a hurry and ignore safety distances. They added that the Section Leader concerned should be disciplined for his "poor performance and control", and that survey teams should ensure that accurate information about the mines and types of mines in a particular area was given.

[Correct procedure (dictated by the UN MAC) for the pulling of tripwires was that the wire should not be pulled unless both ends had been located (and by implication the mine identified). The pulling rope should then have been unrolled out to the tripwire, so avoiding accidental detonation if it snagged or needed straightening. The tripwire should then have been pulled from a distance of at least 50 metres (70 preferred) by a person who was prone or behind cover. The procedure stated that the pulling of tripwires connected to a mine was unsafe and time consuming, so should be avoided if possible.]

Victim Report

Victim number: 194

Name: Name removed

Age:

Gender: Male

Status: deminer

Fit for work: yes

Compensation: 40,457 Rs

Time to hospital: not recorded

Protection issued: Helmet

Protection used: not recorded

Thin, short visor

Summary of injuries:

INJURIES

minor Body

severe Leg

COMMENT

See medical report.

Medical report

The victim's injuries were summarised as injuries to his right leg and the right side of body.

There were no photographs. A medic's sketch (vague) implied two penetrations one below the knee and one on the upper thigh.

The demining group reported that the victim sustained injury to his right knee and right leg. The victim had surgery and made a full recovery, returning to work on 15th December 1997.

The insurers made a compensation payment on 17th April 1988 of 40,457 Rs.

Analysis

The primary cause of this accident is listed as a "*Field control inadequacy*" because it seems that the victim was not following SOPs and his error went uncorrected. His version of events is considered "unsafe" because he claimed to have been "squatting", which seems to conflict with his injuries.

It seems likely that the victim was unaware that he was in breach of SOPs as he carried out an unfamiliar procedure, and so there may have been a training inadequacy. The secondary cause is listed as "*Inadequate training*".

A UN MAC accident summary mentions another deminer injured in this accident. The researcher could find no record of that individual in other files so has assumed that a mistake was made.

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.