

# DDAS Accident Report

## Accident details

<b>Report date:</b> 17/05/2006	<b>Accident number:</b> 158
<b>Accident time:</b> not recorded	<b>Accident Date:</b> 23/07/1997
<b>Where it occurred:</b> Qalai Muslim Village, Ward 7, Kabul	<b>Country:</b> Afghanistan
<b>Primary cause:</b> Field control inadequacy (?)	<b>Secondary cause:</b> Field control inadequacy (?)
<b>Class:</b> Tripwire 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> IED	<b>Ground condition:</b> hard residential/urban
<b>Date record created:</b> 14/02/2004	<b>Date last modified:</b> 14/02/2004
<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 (?)  
partner's failure to "control" (?)  
vegetation clearance problem (?)  
request for machine to assist (?)  
protective equipment not worn (?)  
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.

The victim had been a deminer for five years. It was two months since his last revision course and 26 days since his last leave. The accident occurred in a residential area with hard ground conditions. A photograph showed no vegetation. No parts of the device were found and it was presumed to have been a booby trap.

The investigators determined that the victim was clearing a portion of the minefield with bushes, grass and defensive wire. While he was searching for a tripwire with the feeler, the deminer set off a tripwire-controlled device with the feeler. He was not wearing a helmet and visor at the time.

**The Team Leader** said that the victim used his tripwire feeler improperly. He also said, "if we had more developed and modern equipment...we would be able to prevent such accidents".

**The Section Leader** said that the victim did not look carefully enough before using the feeler. He added that "in areas where booby traps and other dangerous mines are laid, the most developed and modern equipment is needed".

**The victim's partner** said that the victim did not use the feeler properly – he also said that "more developed and modern" equipment would prevent such injury.

**The victim** said he had been working properly but has removed the helmet because it was hot. He believed that areas like the one he was working should be cleared by back-hoe machines.

## Conclusion

The investigators concluded that the accident occurred because of deminer carelessness and the injuries to his eyes resulted because he did not wear the helmet and visor.

## Recommendations

The investigators recommended that extra care should be taken when working in complicated areas and that tripwire feelers should be used very smoothly in bushy areas.

## Victim Report

<b>Victim number:</b> 202	<b>Name:</b> Name removed
<b>Age:</b>	<b>Gender:</b> Male
<b>Status:</b> deminer	<b>Fit for work:</b> no
<b>Compensation:</b> 375,000 Rs	<b>Time to hospital:</b> not recorded
<b>Protection issued:</b> Helmet	<b>Protection used:</b> none
Thin, short visor	

## Summary of injuries:

INJURIES

minor Face  
minor Leg  
minor Shoulder  
severe Arm  
severe Eyes  
severe Hand  
severe Hearing

#### COMMENT

See medical report.

### Medical report

The victim's injuries were summarised as minor injuries to his knees, eyes and face.

A photograph showed both hands bandaged and his right shoulder and left wrist bandaged.

A medic's sketch (reproduced below) showed extensive frag/lacerations to his left leg and arm, frag/lacerations of lower right leg, a shoulder injury and lacerations and fragment injuries on the face.



The demining group reported that the victim had suffered foreign bodies to both eyes, multiple lacerations to his face, upper lip, left arm, left hand, left leg and right knee joint.

In December 1997 they described his permanent injuries as: vision loss both eyes, hearing loss left ear. His hearing loss was assessed as 50% on 22<sup>nd</sup> November 1997. The injuries to his right hand and left arm were assessed as a 15% disability on 3<sup>rd</sup> December 1997. His vision loss was assessed at 85% on 2<sup>nd</sup> December 1998.

Compensation of 375,000 Rs was paid on 30<sup>th</sup> March 1998.

## **Analysis**

The primary cause of this accident is listed as a "*Field control inadequacy*" because the victim was not wearing his visor and the error went uncorrected. Other errors may have been similarly uncorrected.

Although the victim said he had removed the helmet and visor because of heat, it is possible that the victim did not wear the visor correctly because it was too damaged to see through properly (as was seen frequently during field visits in 1998, 1999), in which case the management's failure to provide useable equipment represents a serious management failing. Similarly, the issue of inappropriate handtools was a significant management failing.

The victim's severe deafness is common in Afghan claims from this period, when insurance favoured such injury and testing the validity of claims was hard.

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.