DDAS Accident Report

Accident details

Report date:	19/05/2006	**Accident number:**	336
Accident time:	12:04	**Accident Date:**	03/04/2000
Where it occurred:	Mahala Babaji Village, Engeel District, Herat	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Inadequate training (?)
Class:	Excavation accident	**Date of main report:**	14/08/2000
ID original source:	No: MI 02/2000	**Name of source:**	IGM
Organisation:	Name removed		
Mine/device:	M-19 AT blast	**Ground condition:**	agricultural (abandoned) soft
Date record created:	20/02/2004	**Date last modified:**	20/02/2004
No of victims:	2	**No of documents:**	1

Map details

Longitude:		**Latitude:**	
Alt. coord. system:		**Coordinates fixed by:**	
Map east:		**Map north:**	
Map scale:	Task 20-2002-037-125	**Map series:**	
Map edition:		**Map sheet:**	
Map name:			

Accident Notes

use of pick (?)

squatting/kneeling to excavate (?)

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

dog missed mine (?)

safety distances ignored (?)

inadequate investigation (?)

inadequate training (?)

Accident report

Access to the accident data was denied by the MAC programme manager. A brief summary of the accident was provided by a professional researcher who had access to the original documents. That summary is reconstructed here.

[Map references are not recorded in the MAC records, so the minefield task number (when available) is entered in the Map Ref field at the Incident/Accident tab as an identifying feature.]

Victim No.1 had worked in demining for three years. Victim No.2 had worked in demining for 20 months. Their last revision course had been in December 1999. Their last leave had been seven days before the accident. The area had been surveyed in December 1996. The ground in the area was recorded as “agricultural, soft”. The mines found has been “mostly” M19 AT mines.

The site had been cleared by EDDs starting in March 1997 but a clearance certificate had not been issued. A missed Mine accident occurred in June 1999 (when a farmer riding a donkey initiated a mine). As a result, part of area had been resurveyed and a new area also surveyed.

On the day of the accident the Group leader was sick so the Assistant group leader was in charge.

The site of the accident was indicated by two dogs and the two victims moved forward to investigate. Victim No.1 began to excavate at the site with his pick. After some time he changed with Victim No.2. Without waiting for Victim No.1 to withdraw, Victim No.2 set to work with the pick and “immediately” initiated an M19 mine.

Victim No.1 was only a few meters away when the mine detonated. Victim No.2 was killed instantly by being “blown apart”. Victim No.2 received concussion to the back and minor leg wounds. He died from “internal injuries” 15 minutes after the explosion while on the way to hospital.

The bodies were evacuated by UN flight to Jalalabad to be returned to their families.

Conclusion

The investigators found that the use of the pick appears to have been inappropriate, in relation to both force used and angle of use. They found that work to investigate the dogs’ indication may have been rushed because it was “probably” the last indication to be done for the day. They noted that Victim No.2 should have waited until his partner was a greater distance away before beginning work, and found that “poor command and control” appeared to have occurred.

Victim Report

Victim number: 422 **Name:** **Name removed**

Age: 35 **Gender:** Male

Status: deminer **Fit for work:** DECEASED

Compensation: not made available **Time to hospital:** not recorded

Protection issued: Not recorded **Protection used:** not recorded

Summary of injuries:

INJURIES

severe Body

FATAL

COMMENT

Victim was "blown apart".

No medical report was made available.

Victim Report

Victim number:	423	**Name:**	**Name removed**
Age:		**Gender:**	Male
Status:	deminer	**Fit for work:**	DECEASED
Compensation:	not made available	**Time to hospital:**	not recorded
Protection issued:	Not recorded	**Protection used:**	not recorded

Summary of injuries:

minor Legs

COMMENT

Victim died from unspecified internal injuries 15 minutes later. No medical report was made available.

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because Victim No.2 was in breach of SOPs by not waiting for partner to withdraw before starting work. It seems likely that he also used his "pick" carelessly. These errors were not corrected.

The secondary cause is listed as *"Inadequate training"* because group management allowed clearance to go on without appropriately qualified supervisors at the site. The provision of a pick for AT mine clearance may also have been inappropriate. (Search on "use of pick" in this database to see how many accidents occur when using a pick or hoe to excavate.)

The evidence of dogs having missed mines stems from the fact that the area was cleared by dogs previously. The mine in this accident (and the previous civilian accident) had been missed.

The failure to complete an accident report until 4 and a half months after the accident is not uncommon in this theatre and implies a carelessness about the need to learn from accidents quickly. No criticism of the NGO charged with carrying out accident investigations for the UN MAC is intended. The NGO is frequently not provided with the means to carry out investigations in a timely manner.

The failure of the MAC to allow access to accident reports means that the report made here is acknowledged to be unsatisfactory. It will be revised if access is ever allowed. The failure of the MACC to act with transparency is bound to raise questions over what they have to hide.