

DDAS Accident Report

Accident details

Report date: 19/05/2006	Accident number: 338
Accident time: 14:30	Accident Date: 11/04/2000
Where it occurred: Demining NGO sub-office, Herat,	Country: Afghanistan
Primary cause: Management/control inadequacy (?)	Secondary cause: Inadequate training (?)
Class: Handling accident	Date of main report: [No date recorded]
ID original source: No: MI 03/2000	Name of source: IGM
Organisation: Name removed	
Mine/device: Ordnance	Ground condition: not applicable
Date record created: 21/02/2004	Date last modified: 21/02/2004
No of victims: 2	No of documents: 1

Map details

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

Accident Notes

inadequate investigation (?)
inadequate medical provision (?)
safety distances ignored (?)
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.

No formal accident investigation was found in the MAC files.

During supervision of demining activities in Shin Dand district of Farah Province, Victim No.1 found an unknown device (probably a warhead) on 10th April 2000. He was the Assistant

operations officer. He wanted to investigate the device further, so took it to Herat. The next day, together with a "radio mechanic" he took it into the office and attempted to defuse and dismantle it. It exploded in the office. The two men died immediately. Their injuries were not recorded.

No other details were found on file.

Victim Report

Victim number: 425	Name: Name removed
Age:	Gender: Male
Status: supervisory	Fit for work: DECEASED
Compensation: not made available	Time to hospital: not recorded
Protection issued: Not recorded	Protection used: not recorded

Summary of injuries:

FATAL

COMMENT

Various extreme injuries - immediately fatal. No medical report was made available.

Victim Report

Victim number: 426	Name: Name removed
Age:	Gender: Male
Status: supervisory	Fit for work: DECEASED
Compensation: not made available	Time to hospital: not recorded
Protection issued: Not recorded	Protection used: not recorded

Summary of injuries:

FATAL

COMMENT

Various extreme injuries - immediately fatal. No medical report was made available.

Analysis

The primary cause of this accident is listed as a "*Management/control inadequacy*" because a senior supervisor acted in breach of basic safety SOPs and caused the accident. His selection and training is a management responsibility. His actions imply that he may not have been appropriately trained, so the secondary cause is listed as "*Inadequate training*".

The failure of the MAC to carry out an accident investigation may have been because the accident did not occur while in the mined area. However, it occurred to a demining group under their control that was supposed to operate using UN MAC imposed SOPs. The victims were engaged in rendering safe an item from the mined area, so were technically undertaking

a working task. UXO are often moved before being destroyed. The fact that it was moved to an unauthorised area (the group's office) did not remove the MAC's obligation to carry out an investigation.

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 to other documents is ever allowed. The failure of the MACC to act with transparency is bound to raise questions over what they have to hide.