# DDAS Accident Report

## Accident details

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| **Report date:** | 28/12/2007 | **Accident number:** | 444 |
| **Accident time:** | 09:00 | **Accident Date:** | 18/11/2006 |
| **Where it occurred:** | Task 104, Tower 62, Kabul Naghlu Power line, Butkhak village, Bagrami district, Kabul province | **Country:** | Afghanistan |
| **Primary cause:** | Inadequate survey (?) | **Secondary cause:** | Field control inadequacy (?) |
| **Class:** | Excavation accident | **Date of main report:** | 28/11/2006 |
| **ID original source:** | OPS/27/447-06 | **Name of source:** | UNMACA |
| **Organisation:** | [Name removed] | | |
| **Mine/device:** | PMN-2 AP blast | **Ground condition:** | rocks/stones<br>soft |
| **Date record created:** | 28/12/2007 | **Date last modified:** | 28/12/2007 |
| **No of victims:** | 1 | **No of documents:** | 3 |

## Map details

| | | | |
|---|---|---|---|
| **Longitude:** | 34° 50' 33" | **Latitude:** | 61° 42' 18" |
| **Alt. coord. system:** | WGS-84 | **Coordinates fixed by:** | GPS |
| **Map east:** | | **Map north:** | |
| **Map scale:** | | **Map series:** | |
| **Map edition:** | | **Map sheet:** | |
| **Map name:** | | | |

## Accident Notes

handtool may have increased injury (?)

visor not worn or worn raised (?)

protective equipment not worn (?)

partner's failure to "control" (?)

inadequate training (?)

## Accident report

The report of this accident was made available in August 2007 as a PDF file. Its conversion to a text file for editing means that some of the formatting has been lost. The substance of the BoI report is reproduced below, edited for anonymity. The original PDF file is held on record.

## Details of the Accident Site

The accident occurred at the base of an electrical tower which forms part of the Kabul to Naghlu Power-line. The towers are numbered from the Kabul end of the line and the accident took place at Tower No 62.

[The accident tower.]

[The accident crater, showing little excavation.]

During the rule of the Afghan Communist Government the base of electrical towers along the power-line were mined with AP mines to ward off Mujahadeen elements from cutting the power supply to Kabul and thieves who would steal the metal components of the towers to sell in the local bazaars.

In 1996 a German contractor was to rehabilitate the power-line so the Government of the day (Taliban) assigned clearance of the towers and a corridor between two towers to be conducted. The clearance went ahead involving [four Afghan demining groups].

According to information made available to the BOI, the line was also surveyed and cleared during 1996.

In 2004 [another demining group] were tasked by the Kabul AMAC to survey the towers 25x25m around the base of all towers and a 10m wide corridor between the towers. According to the survey Team Leader (TL) a technical survey was not conducted on the section of power-line where the accident occurred. An assessment was conducted instead which was based on information from the clearance that was carried out in 1996.

Information provided by [name removed] [Demining group] MCT 15 Section Leader (SL) in 1996 is that the Government was pushing hard to get the clearance done. They identified many towers that they stated were previously cleared and free of threat. Mr [name removed] mentions that his section had an incident where an AP mine was discovered in the ground directly underneath one steel braces at the base of a tower. He states that he had expressed his concerns several times to the Government Authorities about the likelihood of all of the tower bases being mined. He goes on to state that the Government Authorities declared that clearance was only required around the towers and not inside.

On 29 Oct 06 an accident involving a staff member of KEC (The Indian contractor currently engaged to refurbish the power-line) detonated a PMN2 AP whilst he was excavating at internal base of Tower No 60. Towers 60 and 62 are located in what was addressed as MF Code 01-0103-11-041 during the 1996 clearance. The [name removed] survey data of the time corroborates the information supplied by Mr [name removed] that some towers were considered clear and others were considered to be mined.

Information obtained by [Survey demining group] ST 14 in 2004 from local authorities, the local population, power-line guards (ANP), and Kotchi people who set up their camps in the area, was that they were all confident that the area under the power-line and towers was clear. UNMACA LIAT 3 conducted a survey in May of 2006 and was provided with the same information.

However, there has been information that has surfaced during the investigation that there have been two accidents along the power-line in addition to those at Towers 60 and 62. The additional accidents involved a team member from [Demining group] MCT 15 and a sheep. Both accidents occurred some time ago and the actual locations of the incidents could not be fully determined.

## The Task

As a result of a mine accident involving a staff member of KEC, the contractor assigned to the rehabilitation of the Kabul to Naghlu Powerline on 29 Oct 06, an assessment was conducted by the Kabul AMAC to determine the likelihood of more mines being present around the electrical towers.

Provisionally LIAT 3 was dispatched from Kabul to conduct a survey of the local populous.

[Demining group] MCT 21 was also tasked with excavating under Tower 60 (the scene of the accident) and towers 61 and 62.

A briefing was conducted by the Area Manager Kabul AMAC on 13 Nov 06 to the Mr [name removed] the Acting TL of MCT 21 at the AMAC. Mr [name removed] advised when interviewed that he was briefed only on the accident that took place on 29 Oct 06, the site and the task. He was not briefed on the history of the site by the AMAC.

Mr [name removed] was informed that he was to excavate 9x9m around Tower 60 (a tower with a 7x7m base) and 5x5m around towers 61 and 62 (Towers with 3x3m bases). The dimensions of the excavation allowed for a one metre wide excavation around the outside of the base of the towers. Full excavation technique was to be conducted down to 20cm.

The clearance under towers 60, 61 and 62 commenced on 14 Nov 06. Two MCT sections were employed in the area but were on two separate tasks at two separate sites. They were sections 1 and 2 incorporating Clearance Parties (CPs) 1 through to 6. Section 2 was tasked on towers 60, 61 and 62.

A CP was assigned to each tower. On the morning of 18 Nov 06, Section 2 had one deminer from CP6 absent from work. The deminer present from CP6 was Mr [the Victim] the person that was involved in the accident.

## Accident Scenario

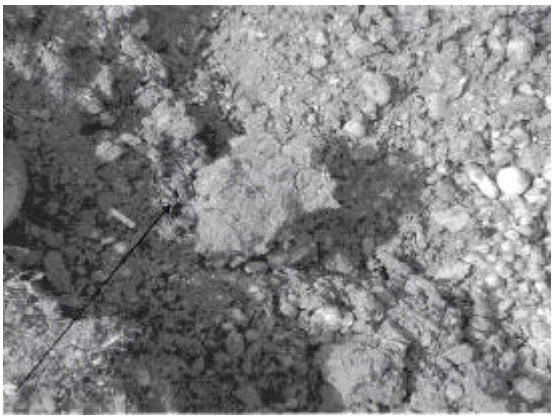
The Acting TL briefed the sections on the clearance activities and requirements for the day. He advised [the Victim] to remain in the Admin Area and not go to his worksite as he did not have a partner in his CP.

The Acting TL departed to the Section 1 site whilst the SL [name removed] accompanied CP4 and CP5 to towers 60 and 61 respectively and briefed them at each worksite.

Unknown to either the Acting TL or the SL [the Victim] collected his equipment and moved to his worksite at Tower 62. Once there he laid out his equipment next to his metal detector test boxes (including his PPE) and advanced to the excavation site under the tower. He had his bayonet with him and was observed by the medic [name removed] from his location 100m away in the direction of Tower 61 to be inside the excavation at Tower 62.

Given the distance, not much could be done to stop the deminer and get him away from the excavation before he detonated the mine.

Upon hearing the detonation and seeing the black smoke rise from below Tower 62 all work ceased, the deminers moved out of their excavations. The Acting TL, the SL, the other deminers and the medic moved to the scene of the accident and found [the Victim] first sitting then slumping down on at the side of his excavation facing back towards Tower 61. His bayonet was behind him covered in blood, he was not wearing a demining apron, helmet or visor and he had sustained serious injuries to his legs, arms, and head.



[The accident crater showing friable ground with pebbles.]

The deminers cleared the ground around the victim and the medic approached and provided first aid and stabilized him at the scene. He was then evacuated by ambulance via Arzan Qemat Clinic to the Emergency Hospital in Kabul.

[The Victim] never regained consciousness and expired as a result of his injuries at 21:00hrs on 19 Nov 06.

[From IMSMA form: the site was flat open hillside with “medium” dry soil and light grass. The weather was clear, calm and mild.]

## Summary

There are several issues to be considered in summing up the circumstances that led to the accident which caused the death of Mr [the Victim], [Demining group] deminer MCT21, Section 2.

1. There were extenuating circumstances surrounding the initial clearance of the power-line during 1996. Based on the statements and interviews obtained there was streamlining by the Government of the day to accelerate the demining of the power-line. To the point that they ruled out towers along the route that they for reasons only known to them. They did so even after a mine accident at one of the towers that they had ruled out.
2. The power-line was addressed for clearance by MF survey, MDDs and MCTs. It should be noted that in 1996 mine dog sets were attached to the manual clearance teams. There were no mine dog groups working independently nor were there mine dog sets attached to survey teams. The recording of the clearance relates to a minefield (MF-041) and the documentation does not indicate numbered towers. The towers were not numbered until the survey assessment was conducted in 2004. Clearance of MF-041 is recorded by all organizations involved in the clearance in square metres and it cannot be determined who cleared under the towers or what method was applied. Interviews and statements from those involved in the clearance indicate that some towers were checked by MDD, some were excavated, some only had clearance around the tower and some were ruled out by the Government as not to be cleared. Copies of the relevant 1996 and 2004 survey and clearance documentation can be found at Annex F.
3. The documentation from the original clearance and completion reports was utilized when the power-line was resurveyed in 2004 to mark the 10m wide corridor and 25x25m around all towers. No technical survey was conducted on the area containing the towers involving the KEC accident and the [Demining group] accident.

4. LIAT 3 when conducting their survey in May 2006 relied upon documentation from the 1996 clearance combined with information gathered from the local populous, Kotchi people, local authorities and police guards. The information provided by the people and authorities, etc could be considered as current and reasonably accurate. However, unknown to the QMIT the documentation was not 100% reliable.
5. The background information and documentation for the clearance in 1996 was difficult to trace in full. It seems that documentation has gone astray or is located somewhere at an IP office, desk, home, or has been lost entirely. This shows poor filing and book keeping by the Kabul AMAC and the IPs involved. This situation meant that not all of the necessary information could be made available to the LIAT in May 2006 and possibly to the MCPA ST 14 in 2004.
6. Command and control on the clearance site was not good. Both the Acting TL and the SL departed into the field after the morning briefing and neither was at a vantage point to observe the three sites and the Admin Area. Therefore they had no way of observing and preventing the deminer from leaving the Admin Area where he had been instructed to remain.
7. Excavation 62 was not being conducted in accordance with the [Demining group] excavation drill. The Acting TL and the SL both stated that they had instructed the deminers to have 20cm distance x 20cm depth of full excavation to their front at all times. The SOP states that there must be a minimum of 1m fully excavated and all spoil is to be at the rear of the deminer. It was evident at the scene of the accident that virtually no spoil was being removed at all.
8. The deminer disobeyed the specific direction of the Acting TL that he was given during the morning brief. In addition to disobeying the direct of the Acting TL he entered his excavation without a CP partner in location and without PPE.
9. The medic saw the deminer inside the excavation from a distance of 100m and did not shout to him to stop what he was doing and get out of the excavation.
10. There was no briefing to the Acting TL from the AMAC Kabul regarding the minefield history of the power-line. Consequently there was no information provided to the MCT sections involved about the minefield history the task site. Although the team members were briefed that they were there as a result of the mine accident that occurred on 29 Oct 06 it is quite clear (In the case of the dead deminer at least) that there was a belief that there was no further mine threat likely.

[IMSMA form: the team started work at 07:00 and worked until 13:00 with a break every 30 minutes. The detector that they could not use under the towers was the CIEA MIL D-1. The victim was last on leave from 17/10/06 to 17/10/06.]

## Conclusions

The conclusions of the members of the BOI are as follows:

1. The Government of the day in 1996 took great risks in ruling out sites for clearance even after concerns from members of the clearance organizations were expressed to them and there had been at least one mine accident in an area that they had ruled out for clearance.
2. The information required to be recorded at the time does not allow the possibility of identifying exactly what towers were cleared and what towers were excluded, what method was used to clear under the towers or by whom.

3. The Kabul AMAC dating back at least to 1996 has not implemented good book keeping practices and the is a requirement to check all files for completion and to seek out missing documentation and ensure that all files are complete.
4. An on site briefing did not take place between the Kabul AMAC and [Demining group] hence valuable information was not identified and passed on.
5. The command and control on the demining site was poor and standards were not properly employed or maintained.
6. The deceased deminer acted under his own volition and disobeyed the Acting TL when he went to the worksite at Tower 62 and he completely disregarded SOPs and the most basic safety requirements. He has most likely done so out of over-confidence that there was no likely mine threat where he was working.
7. The post accident procedures were good and the team members and medical staff reacted appropriately and in accordance with procedures. The actions taken to get the victim to the required level of treatment and the time taken were well expedited.

**Recommendations**

The recommendations of the BOI are as follows:

1. The Kabul AMAC research through all documentation pertaining to clearance dating back at least until 01 January 1996 and ensure that all files are made complete. That all clearance information on file is then transferred to a database simplifying document search requirements. UNMACA should ensure that all AMACs follow suit.
2. All site briefings should be conducted on site and include representatives from all entities to be involved in the clearance and conducted by the AMAC Operations staff.
3. All site history pertaining to the clearance must be included in the introduction to site briefings and contained in the site dossier. Then in turn the clearance organizations include the site history in the briefings to their personnel who will be employed at the site.
4. MCT 21 personnel should be stood down to conduct refresher training on SOPs and tested prior to redeployment onto operations.
5. Disciplinary action should be taken against the Acting TL [name removed] and SL [name removed] for employing poor command and control measures at the site and disregarding the [Demining group] SOP for full excavation.
6. Whilst both the Acting TL and the SL were both guilty of poor command and control measures, it is not the opinion of the BOI that there was any negligence involved on their behalf.
7. No further work should commence within 1m of the perimeter of any tower on the power-line until the ground under the tower and the 1m boundary has been verified as clear. The corridors can be considered clear as they have been well trafficked and information and evidence indicate that those areas are clear.
8. Mr [the Victim] chose to disobey the explicit instructions of his Acting TL and move from the Admin Area to his normal worksite at Tower 62. Upon arrival at Tower 62 he commenced excavating with his bayonet using a technique contrary to the [Demining group] SOP for excavation and that he did so without wearing any form of PPE. It is the opinion of the BOI that Mr [the Victim] was guilty of negligence and of complete disrespect for the potential outcome that could result from his actions. [The Victim] paid the ultimate price for his disregard for the SOP. The details of this demining fatality should be widely disseminated across the Programme in an effort to avoid any repetition due to poor supervision and blasé attitudes to demining.

9. AMAC Kabul is to identify sites for re-clearance and [Demining group] manual assets are to conduct clearance at those sites as soon as possible.

## Victim Report

**Victim number:** 591
**Name:** [Name removed]
**Age:** 28
**Gender:** Male
**Status:** deminer
**Fit for work:** DECEASED
**Compensation:** Not made available
**Time to hospital:** 30 minutes
**Protection issued:** Frontal apron
Long visor
**Protection used:** None

**Summary of injuries:**

INJURIES

severe Abdomen

severe Chest

severe Face

severe Head

severe Legs

severe Shoulder

AMPUTATION/LOSS

Fingers

FATAL

COMMENT

See Medical Report

## Medical report

The death certificate recorded under “Clinical notes”: Multiple wounds face, chest, abdomen, right arm, left thigh, left leg. Admitted on 18/11/06 because of his severe condition died on 20/11/06.

IMSMA report: head injury, face injury, eye injuries, fingers of left hand amputated, left leg injury (may be amputated), right leg injuries, Shoulder injuries.

Paramedic statement includes:

The accident happened at 8:00 and I arrived at 8:05 and started to help person. As the health condition of the injured deminer was critical the following aids applied to him:

Air way

Applying Kennel and Sydum Ringer

Control of bleeding

Vial Ampicolaxs Igr (Annikulat Igr)

And then the victim was carried by ambulance to Arzan Qemat Clinic and after applying other necessary help he was carried to Emergency Hospital by Arzan Qemat Clinic ambulance.

Q#2: Which part of the victim body of the deminer had injuries and which helps you have done?

A#2: The victim had the following injuries:

Wide wounds in two sides of (Feki Ulya anti Feki Sufla).

Injuries In both two eyes

Amputation of both first and second fingers of left hand.

Broken left ankle.

Point injuries of chest and right shoulder.

Point injuries of right step.

## Analysis

The IMSMA documentation accompanying the report includes repeated mention of the previous clearance of the area, so there can be little doubt that the Victim believed he was in no danger. For this reason, the primary cause of this accident is listed as “Inadequate survey”. The secondary cause is listed as a “Field Control Inadequacy” because the victim was allowed to enter the mined area without supervision and without wearing PPE.

The quality of the investigation is high and the investigators identified many causes with genuine objectivity - including poor record keeping within their own organisation.

The continued use of the short AK bayonet that has led to many hand losses in Afghanistan was due to the poor command and control within the demining organisation. That lack of command and control was the main cause of this and many other accidents involving this indigenous demining group.

## Related papers

## Follow-up letter

Letter from: Acting Chief of Operations UNMACA, Kabul

Subject: Follow up action on BOI report of accident (C-92) happened to the deminer of [Demining group] MCT-21 in task # 104, Tower 62 of Kabul Naghlu Power line in Butkhak village, Bagrami district of Kabul province

Reference: De-mining investigation report File: OPS/27/447-06 dated: November 20, 2006, of UN-AMAC Kabul.

Report of Board Of Inquiry File: OPS/03/01-21, Dated November 28, 2006.

A fatal demining accident happened on November 18th 2006 at 09:00 in task # 104 of Kabul-Naghlu Power-line in Butkhak village, Bagrami district of Kabul province, a PMN-2 mine exploded on [the Victim] the deminer of section 02, MCT-21 of [Demining group].

The accident occurred at the base of an electrical tower which forms part of the Kabul to Naghlu Power-line. The towers are numbered from the Kabul end of the line and the accident took place at Tower No 62.

In 1996 a German contractor was to rehabilitate the power-line so the Government of the day (Taliban) assigned clearance of the towers and a corridor between two towers to be conducted.

The clearance went ahead involving [four national Demining groups].

According to information made available to the BOI, the line was also surveyed and cleared during 1996.

A team of board of inquiry (BOI) had been assigned to investigate the accident according to their TOR reflected in related BOI letter and come up with the results and recommendations.

The investigation of accident has been completed by assigned team and the following points have been reflected in their report:

**Conclusions**

The conclusions of the members of the BOI are as follows:

10. The Government of the day in 1996 took great risks in ruling out sites for clearance even after concerns from members of the clearance organizations were expressed to them and there had been at least one mine accident in an area that they had ruled out for clearance.
11. The information required to be recorded at the time does not allow the possibility of identifying exactly what towers were cleared and what towers were excluded, what method was used to clear under the towers or by whom.
12. The Kabul AMAC [formerly UNMACA] dating back at least to 1996 has not implemented good book keeping practices and this is a requirement to check all files for completion and to seek out missing documentation and ensure that all files are complete.
13. An on site briefing did not take place between the Kabul AMAC and [Demining group] hence valuable information was not identified and passed on.
14. The command and control on the demining site was poor and standards were not properly employed or maintained.
15. The deceased deminer acted under his own volition and disobeyed the Acting TL when he went to the worksite at Tower 62 and he completely disregarded SOPs and the most basic safety requirements (PPE). He has most likely done so out of overconfidence that there was no likely mine threat where he was working.
16. The post accident procedures were good and the team members and medical staff reacted appropriately and in accordance with procedures. The actions taken to get the victim to the required level of treatment and the time taken were well expedited.

**Recommendations**

The recommendations of the BOI are as follows:

1. The Kabul AMAC research through all documentation pertaining to clearance dating back at least until 01 January 1996 and ensure that all files are made complete. That all clearance information on file is then transferred to a database simplifying document search requirements. UNMACA should ensure that all AMACs follow suit.
2. All site briefings should be conducted on site and include representatives from all entities to be involved in the clearance and conducted by the AMAC Operations staff.
3. All site history pertaining to the clearance must be included in the introduction to site briefings and contained in the site dossier. Then in turn the clearance organizations include the site history in the briefings to their personnel who will be employed at the site.
4. MCT-21 personnel should be stood down to conduct refresher training on SOPs and tested prior to redeployment onto operations.
5. Disciplinary action should be taken against the Acting TL [name removed] and SL [name removed] for employing poor command and control measures at the site and disregarding the [Demining group] SOP for full excavation.
6. Whilst both the Acting TL and the SL were both guilty of poor command and control measures, it is not the opinion of the BOI that there was any negligence involved on their behalf.
7. No further work should commence within 1m of the perimeter of any tower on the power-line until the ground under the tower and the 1m boundary has been verified as clear. The corridors can be considered clear as they have been well trafficked and information and evidence indicate that those areas are clear.
8. Mr [the Victim] chose to disobey the explicit instructions of his Acting TL and move form the Admin Area to his normal worksite at Tower 62. Upon arrival at Tower 62 he commenced excavating with his bayonet using a technique contrary to the [Demining group] SOP for excavation and that he did so without wearing any form of PPE. It is the opinion of the 1301 that Mr [the Victim] was guilty of negligence and of complete disrespect for the potential outcome that could result from his actions. [The Victim] paid the ultimate price for his disregard for the SOP. The details of this demining fatality should be widely disseminated across the Programme in an effort to avoid any repetition due to poor supervision and blasé attitudes to demining.
9. AMAC Kabul is to identify sites for re-clearance and [Demining group] manual assets are to conduct clearance at those sites as soon as possible.

The feedback on follow up action from AMAC especially on last point of recommendation is needed NL than 17th of December 2006. The feedback of [Demining group] on recommendation is needed NL than 21st of Dec. 06

## Letter from Chairman BOI

CA-92 Operations Section, UNMACA Kabul, dated 28th November 2006.

Subject: Board of Inquiry CA-92 — [Demining group] Fatal Mine Accident at Bagrami 18 Nov 06

On 19 Nov 06 a formal Board of Inquiry (B01) was convened by the Chief of Operations UNMACA to inquire in to the circumstances relating to a mine accident involving Mr [the Victim] a [Demining group] deminer that occurred at Bukhak in the Bagrami District of Central Region.

The accident occurred at 08:00hrs [09:00 elsewhere] on 18 Nov 06 and as a result of the severity of his injuries [the Victim] passed away at 21:00hrs on 19 Nov 06.

Appointments for the BOI are as follows: [Names removed].

A copy of the [Demining group] Mine Casualty Report dated 19 Nov 06 at Annex B and a copy of the Death Certificate is located at Annex C. The Initial Investigation report compiled by [Demining group] is at Annex D. A copy of the Task Order is located at Annex E. [Annexes are held on file.]

**Annex A to BOI CA-92 Dated 29 Nov 06**

Terms of Reference for BOI CA-92

1. The investigation and subsequent report is to cover the following:
   a. When, where and why the incident occurred?
   b. The cause, nature and extent of injuries received by people, as a result of the incident.
   c. The cause, nature and extent of damages to any program or private property. You are to attach photographs of any damaged equipment.
   d. Whether medical treatment and evacuation was adequate, or in any way contributed to the death.
   e. Whether the death, injury or damage to equipment was contributed or caused by:
      (1) Neglect, carelessness or misconduct by the member involved
      (2) Non-compliance with orders, instructions or safety procedures
      (3) Any weakness in the method of command and control
      (4) Any other influencing factor
   f. Whether any immediate action is required to prevent a recurrence of the incident.
2. Your report is to make conclusions on the following:
   a. The key factors which may have contributed to the incident, including any shortfalls in management
   b. Whether there is evidence of any fault, neglect or carelessness on the part of the mine action agency and, if so, which personnel are responsible?
5. Your report is to make recommendations on:
   a. Disciplinary or corrective action to be taken against mine action agency or personnel.
   b. Any other immediate or longer term action that should be taken to prevent such incidents from re-occurring in the future.
3. The following documents are to be attached to your report:
   a. Copy of these Terms of Reference
   b. Copy of Casualty Report
   c. Copy of Initial investigation

d. Statements (translated) of personnel and witnesses

e. Photographs of the site and a sketch map of the incident site

f. Photographs of the involved personnel and any damaged equipment.

g. Any other supporting documentation

4. Your report is to be finalized and delivered to the Chief of Staff no later than 30 November 2006.

5. It is important to note that these terms of reference are not intended to limit the scope of your investigation. You may include any relevant details you see fit.

## Annex B: initial Accident Report

Attached please find a copy of Demining Accident Report No. (CA-92) submitted by [Demining group] field office. The accident happened on Mr. [the Victim] deminer of [Demining group] MCT-21 (born 1978). In result of PMN-2 explosion, he got head trauma plus injuries on his left leg. The accident happened during prodding on 18 Nov 06 at 09:00 hours.

Current status: The victim has been evacuated to Emergency Hospital in Kabul. Unfortunately he died during Night of 19 Nov 06.

We have assigned our OPS Assistant along with QMA to conduct investigation of this accident.

## STATEMENTS

### Witness statement 1

[Former [Demining group] Team Leader in 1996.]

As per requirement, the clearance of the power poles from Naghlo to Sarobi, about 2m around the poles was [Demining group] to clear. The 2m access way was allocated to [Mine dog group] to clear.

Clearance of the power poles from Sarobi to Kabul, just around the poles was the responsibility of [Demining group] and 2m access way clearance was the responsibility of [Mine dog group].

The former government was pushing clearance of the above mentioned poles. Even some poles were not allowed to be cleared and claimed that around and inside the poles were cleaned and free of threat. I can remember that those poles which had been claimed that had no mines. My section had incident. Several times I stated this matter to the concerned government authority of that time.

Our teams have cleared power poles from Sarobi to Karokhail and from Kabul to Karokhail team No.1 of [Demining group].

It s mentionable that inside the poles were out of clearance monitoring and the government authorities claimed as well that inside the poles were cleared and there was no need for clearance, only clearance was needed around the poles.

Signed: 26.11.2006

### Witness statement 2

[Section Leader controlling deminers 250 metres from the accident: deminer since May 1995.]

Please answer the following Questions:

Q#1: Please state your information about the accident, cause of accident and how we can avoid such accidents?

A#1: At 7:30 dated 18/11/06 after prayer and according the brief which was given by Asst TL, I and the Asst TL went to Party #4 and before going there I told to [the Victim] that as his partner is on leave so, he has not to go to work site and stay until we come back and make store for vehicle, area for explosive and detonators. When we arrived to tower No.1 the Asst TL told me that I have to go to party #5. As I arrived there I heard the sound of explosion and I called the doctor and ambulance and went toward the tower #3. When I arrived there I saw the injured deminer that had no helmet and PPE. He didn't accept the advice of the drivers and guards to drink tea and not go to area. (All four deminers and driver are my witness that I told him that don't go to site for work). He with out of obeying our command went to area and the accident happened.

If the following rules are not followed the accident will happen:

Not obeying the commend of the responsible person

Not following of the accepted procedures and standards.

Not giving good brief.

Q#2: Which equipment the deminer were using that the accident happened?

A#2: Because of the accident only a bayonet which was bloody. I didn't see anything else.

Q#3: You stated that you told [the Victim] deminer not to go to work and stay in store until your coming but he went there without permission and as the store and the lower 62 had a distance of about 400 m so it took time for him to reach there. Why you didn't observe his going and not preventing him from entering the area?

A#4: As I and Asst TL were in Party #4 there was a hill between us and the store that we were not able to see the store, also in that time some soldiers from the military post come to us and asked about the broken wire of the tower and accused us for cutting of the wire, so we were busy to convince them and we didn’t see [the Victim] entering to the work site. After happening the accident we went there and saw that [the Victim] had carried the demining equipments with him so after sending him to hospital we collected his equipments.

## Witness statement 3

[Former surveyor of [Survey demining group] T#14.]

In March 2001 according to order of our office our team was assigned to do assessment in Kabul Sarobi and Kabul Naghlo power towers.

The towers of Kabul Sarobi was made in Russia and the towers of Kabul Naghlo was made In Germany.

We start our assessment work first in Kabut Surobi tower and after finishing it, we start our assessment In Kabul Naghlo (German made towers) that was start from Pakteya Kot of Puli Charkhi. Our team was comprised of 3 Surveyors, 1 paramedic and 1 driver.

Our work procedure was that we assessed four round of the tower in a size of 25m and the corridors in a width of 10m.

We asked the local residents, Mulahs of the mosque, elders, and local commanders about the situation of the area. Also we asked the guards of the power towers that, is the area safe or not? and we received letters from the locals about the areas which were naturally safe and

they assure us that they use the area without having any problem, and no accident happened in the area.

Besides, we took letters from the commanders who were responsible of the towers security that the area is safe and these letters are attached with our reports.

We assessed 8 to 10 towers every day and during our work we found that some towers are cleared by [two named demining groups]. So we consult our office and asked for the documents and maps of the cleared areas. After receiving the maps and documents we compare the area to the maps to know which area is included in which map and after drawing the free sketch or each area we put a copy of previous technical survey map of the related area with it, and submit the result of our activity weekly wise to office.

The areas which had mine or were not guaranteed by local or commanders was recommended to be cleared by demining, also the areas which were cleared by [Demining group] and after clearance accident had happened was recommended to he resurveyed and re-cleared by [mine dog group], because near metallic towers the manual teams could not work effectively.

In some areas which had extra soils on the original level of ground, was recommended to be cleared by backhoe Machine. And finally our work finished.

Then after one or two months the office assigned our team to meet representative of Siemens company who wanted to repair the electric poles, and they wanted us to assure them about clearance of each poles individually, so we briefed them according to their needs for three or four days and finally we agreed that any time they face any problem they should contact us. Finally after some months our work was successfully ended with them.

## Witness statement 4

[Acting Team Leader : experienced since 1995.]

Please answer the following Questions:

QN 1: Please explain you information about the accident?

A # I: Beside the responsibility of section #2 I had the responsibility of section #1 which was working in Qalai Gulbaz Task #109 and I was busy reading the reports of them. Also I was controlling party #4 of section #2 because my location was on suitable high ground.

The accident happened on party# 6 at 8:05.

I was briefed by [name removed] on 13/11/06 to start clearance of the area and he told me that four sides of the tower is safe and we have to start demining operation 1 metre from the stand of each tower in four side of it, so we start our work on 14/11/06 and marked the round of the tower according to instruction of [name removed].

On 15, 16 and 17 of November the weather was rainy and we didn't have operation in the area and on 18/11/06 we received the task order and I in party #4 and the section leader was in Party#5. We told the deminer [the Victim] that until my or section leader coming he must not start Demining operation. This instruction was given by me and the section leader as well to him, but the deminer went to the site and start operation without permission in distance of 600 metres from store while he didn't wear PPE and Helmet.

Q#2: What do yon say that he went to site with the Demining equipment to start work or he went there without having a specific purpose?

A#2: He went to site for demining operation with all necessary Demining equipments but as I mentioned in A#1 we ordered him clearly not to go to site.

Q#3: Based on the injuries and wounds he got in his body, what do you think which equipment was he using in his operation that the accident happened?

A#3: As I was located in a distance of 600m from the accident point I cannot exactly say anything, but maybe he was using the bayonet for work.

Qii 4: For avoiding such accidents what is your suggestion?

A# 4: When team is assigned to work in such tasks the number of the section leaders are to be increased because the distance is more and the control is not done as it is required.

Q'5. : What was using by the deminer when he was working and explain which demining equipments were damaged because of the accident?

A#5: Except the bayonet, which was bloody, I didn't see any other damaged equipments in the area.

## Witness statement 5

[Paramedic: two years experience.]

Please answer the following Questions:

Q#1: When the accident happened what were you doing and how much distance you had from the accident point?

A# 1:  While the accident happened I was located in the designed area at 100rn and after the accident happened according to order of team commander I went toward the accident point and the area of the accident was checked by other deminers, and then the injured person was carried to safe area. The accident happened at 8:00 and I arrived at 8:05 and started to help person. As the health condition of the injured deminer was critical the following aids applied to him:

- Air way
- Applying Kennel and Sydum Ringer
- Control of bleeding
- Vial Ampicolaxs Igr (Annikulat Igr)

And then the victim was carried by ambulance to Arzan Qemat Clinic and after applying other necessary help he was carried to Emergency Hospital by Arzan Qemat Clinic ambulance.

Q#2: Which part of the victim body of the deminer had injuries and which helps you have done?

A#2: The victim had the following injuries:

- Wide wounds in two sides of (Feki Ulya anti Feki Sufla).
- Injuries In both two eyes
- Amputation of both first and second fingers of left hand.
- Broken left ankle.
- Point injuries of chest and right shoulder.
- Point injuries of right step.

Q#3: In which hospital the deminer is under treatment and how is his health condition?

A#3: Now the injured deminer is under treatment in Emergency Hospital but according to reports of the doctors his vital signs are not satisfactory.

Q# 4: After which time you reach yourself to injured detainer, which first aids did you apply and how long does it last, also after which time do you carried the patient to hospital and how much time does it last to reach the hospital?

A# 4: The accident happened at 8:00 and I arrived to victim at 8:05 and until 8:20 the first aids applied to him. And the following Aids applied:

Air way

Applying Kennol and Sydum Ringer

Dari (Tasbet Ratel & Painerala)

Control of bleeding

Vial Ampicolax 1gr (Ampkobtx)

## Witness statement 6

[Deminer working at Tower 60 (two years experience).]

Please answer the following Questions:

Q#1: When the accident happened what were you doing and how far was your location from the accident point?

A#1: After getting the daily brief from Assistant Team leader I was near the tower # 60 and I was preparing myself for work that the accident happened nearly 500 metres away from my location .

Q#2: Please state your information about the accident?

A#2: As my location was 500m away from the accident point and also there was two small hills between us so I only heard the sound of accident and as per the command or the Section Leader I stayed in my place for observing my equipments and I didn't go to accident area, so I don't have much Information about the accident.

Q#3: What do you think which mistake of the deminer caused the accident?

A#3: As I was 500 metres away from the accident area and also I didn't go to accident area I can't say anything shout the cause of the accident. Only I remember that while briefing us the Asst TL and Section Leader told [the Victim] not to go the area for work and told him to stay in store, but he ignored their advice and went to area and I think the accident happened because of not following the demining approved procedures.

Q#4: What is your view point for avoiding such accidents?

A#4: I think while working in demining the deminer should follow all the approved rules and procedures and must near PPE and Helmet.

Q#5: What do you know about the experience and work procedure of the deminer that become victim of the accident?

A#5: I do not have much information about the experience and work procedure of [the Victim] only I can say that he was a good man.

## Witness statement 7

[Deminer working on Tower no 61: deminer for four years]

Please answer the following Questions:

Q#1: Please state your information as the most near deminer to victim of the accident?

A#1: I was working around the other Tower that the accident happened and as I heard the sound of the accident I went toward the accident point and when I arrived there I saw that the victim is seen as he is sitting and then he fell down. As per the order of the Asst TL and Section Leader we cleared around him and draw him to safe area.

Q#2: What do you think which mistake of the deminer caused the accident?

A#2:  As he went to site without the section Leader and also he didn't wear the PPE and Helmet, so I think it was the mistake.

Q#3: What do you think, the deminer went to site for demining operation or he went there without having a specific purpose?

A#3: I was away from him so I cannot say anything that how he entered the area and I think each deminer prior to start work should have all the necessary equipments.

Q#4: Where was the partner of the deminer who became victim of the accident?

A#4: His partner was on leave and was not present on accident day.

Q#5: From which date was his partner on leave?

A#5: His partner was on leave from Tuesday.

Q#6: During the accident which equipments were damaged, please name?

A#6: As I went to accident area I saw the bayonet and control box which were bloody and I didn't see any other damaged equipments.