

# DDAS Accident Report

## Accident details

<b>Report date:</b> 15/05/2006	<b>Accident number:</b> 103
<b>Accident time:</b> not recorded	<b>Accident Date:</b> 29/04/1997
<b>Where it occurred:</b> Qala-e-Bahadur Village, Kabul Province	<b>Country:</b> Afghanistan
<b>Primary cause:</b> Field control inadequacy (?)	<b>Secondary cause:</b> Inadequate equipment (?)
<b>Class:</b> Other	<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> PMN AP blast	<b>Ground condition:</b> grass/grazing area hard
<b>Date record created:</b> 12/02/2004	<b>Date last modified:</b> 12/02/2004
<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 (?)  
inadequate equipment (?)  
partner's failure to "control" (?)  
request for machine to assist (?)  
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's length of service was not recorded. It was three months since he last attended a revision course and six days since his last leave. The ground in the area was described as grazing land, open and medium hard. A photograph showed it wet and apparently soft [it may have been taken weeks later].

The investigators determined that the victim was clearing a breaching lane bordered by barbed wire. When the wire got in the way too much, he stopped work to pull it aside. In pulling it aside he stepped outside the cleared area and trod on the mine. The mine was believed to be a PMN (from "found fragments") but there was concern expressed that the mine was "an MS3 (anti-lift device)" at the time. The victim's visor was damaged.

**The Team Leader** said that the victim was working properly until he decided to move the barbed wire – then he worked "illegally".

**The Section Leader** said the victim was breaching rules by trying to "pull the barbed wire with hands" and should not have stepped out of the cleared area.

**The victim's partner** said that he had tried to get the pulling equipment but it was in use with another team. When he returned with this news his partner threw a piece of metal at him and stepped into the uncleared area to pull the wire by hand. It was his own carelessness. He thought that areas that give continuous readings (as where there is barbed wire) should be cleared with the back-hoe machine.

## Conclusion

The investigators concluded that the deminer was pulling the barbed wire without following proper demining procedures.

## Recommendations

The investigators recommended that disciplinary action should be taken against the Section Leader for poor command and control; that deminers should clear the area they must tread on in order to move an obstacle; and that before dealing with an obstacle, the deminer must inform the command group who should determine how to deal with the problem.

## Victim Report

<b>Victim number:</b> 136	<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> 500,000 Rs (100%)	<b>Time to hospital:</b> not recorded
<b>Protection issued:</b> Helmet	<b>Protection used:</b> Helmet
Thin, short visor	

## Summary of injuries:

INJURIES

minor Abdomen

minor Arms

minor Chest

minor Hand

minor Hearing

minor Leg

severe Face

severe Neck

AMPUTATION/LOSS

Leg Below knee

Finger

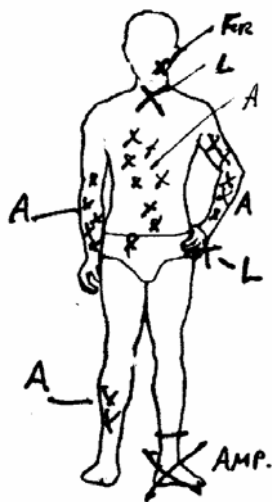
COMMENT

See medical report.

### Medical report

The victim's injuries were summarised as traumatic amputation of his left foot at the ankle, fracture of both upper and lower jaw, penetrating wound on neck; lacerations on left leg, both arms and fingers of left hand; superficial injuries over chest and abdomen. A medical report included "deep injuries on the neck with damage of trachea and oesophagus, amputation of left foot below ankle, injuries "on foreleg with broken" and superficial wounds on left hand, arm, wrist, chest and abdomen.

A medic's sketch (reproduced below) showed the left foot amputated midway between ankle and knee.



The insurers were informed on 1<sup>st</sup> May 1997 that the victim had sustained: fracture upper and lower jaws, amputation of left leg below knee; penetrating wound "anteriorly" neck; lacerated wounds legs, arms, fingers of left hand; abdomen and chest fragments.

A compensation claim was forwarded on 5<sup>th</sup> November 1997 in which his injuries were listed as: amputation left leg below knee, loss of hearing both ears, injury to index finger, amputation of part of left thumb, severe laceration of face and left side of neck tissue resulting in neck and face deformity; stiffness in knee joint, fragmentation of left mandible (not united), and depression. These injuries were assessed on 2<sup>nd</sup> October 1997 and it was decided that

his amputation, finger and thumb problem represented a 75% disablement. His other injuries were assessed as representing a 50% disablement on 20<sup>th</sup> October 1997.

Compensation of 500,000 Rs (100% disability) was forwarded on 23<sup>rd</sup> December 1997.

## **Analysis**

This accident is classed as “Other” because it appears that the victim knowingly stepped into an uncleared area out of frustration at being unable to get the equipment he needed. The primary cause of this is listed as a “*Field control inadequacy*” because the necessary equipment was not made available. The secondary cause is listed as “*Inadequate equipment*”.

If that equipment did not exist, that would represent a serious failure of management systems because the selection, approval and provision of appropriate equipment was their responsibility.

See also the accidents in Afghanistan on 13<sup>th</sup> January 1997 and 1<sup>st</sup> June 1997 where similar circumstances arise.

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.