DDAS Accident Report

Accident details

Report date:	15/05/2006	**Accident number:**	112
Accident time:	not recorded	**Accident Date:**	13/01/1997
Where it occurred:	Samar Khil Village, Behsood District, Jalalabad	**Country:**	Afghanistan
Primary cause:	Victim inattention (?)	**Secondary cause:**	Inadequate equipment (?)
Class:	Victim inattention	**Date of main report:**	[No date recorded]
ID original source:	none	**Name of source:**	MAPA/UNOCHA
Organisation:	Name removed		
Mine/device:	PMN AP blast	**Ground condition:**	grass/grazing area soft
Date record created:	12/02/2004	**Date last modified:**	12/02/2004
No of victims:	1	**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 metal-detector (?)

inadequate equipment (?)

inconsistent statements (?)

inadequate area marking (?)

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 eighteen months. It was three months since he last attended a revision course and 32 days since his last leave. The ground in the area was described as agricultural, "soft and bushy". A photograph showed grasses, not bushes, and seemingly hard ground without rocks.

The investigators determined that the victim was pulling a wire obstacle out of the way when he accidentally stepped into an uncleared area and trod on a PMN [presumably identified by inference].

The demining group said that the victim was marking the safe area when the accident occurred.

The Team Leader said that the deminer was replacing the marking rope with white stones when he made a mistake and stepped out of the cleared area. He said the deminer is a "snuff addict" and may have been affected by the abstinence "because of Ramazan".

The Section Leader said that the deminer had finished marking the cleared area with white stones, picked up his detector and turned – stepping into the cleared area by mistake.

The victim said he was pulling a wire obstacle from his path and accidentally stepped into an uncleared area.

The victim's partner said that they had just changed roles when the victim walked to the end of the cleared area, picked up the detector and turned, placing one foot into the uncleared area.

Conclusion

The investigators concluded that the victim was careless and pulled the wire improperly. He did not have the right equipment to use for pulling wire obstacles – showing poor performance of the "command and control" party. They also noted that the "walls and prominences" were not marked properly on the minefield map – they were shown as outside the mined area when they were actually inside the working area.

Recommendations

The investigators recommended that alternative procedures must be taught for when detector signals continuously; the team involved should have a revision course within two months; the Section Leader should be demoted because of poor command and control; the survey teams must make maps accurately; and that no one should be allowed to use unsafe procedures for the removal of objects from the minefield.

Victim Report

Victim number: 145 **Name:** **Name removed**

Age: **Gender:** Male

Status: deminer **Fit for work:** not known

Compensation: 300,000 Rs **Time to hospital:** not recorded

Protection issued: Helmet

Thin, short visor

Protection used: not recorded

Summary of injuries:

INJURIES

minor Hand

severe Leg

AMPUTATION/LOSS

Leg Below knee

COMMENT

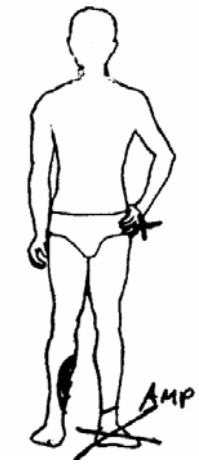
See medical report.

Medical report

The victim's injuries were summarised as amputation and other injuries to his left leg, right leg "profound wound" 8-10cm long, and a left hand first finger superficial wound.

A photograph showed the deminer with his left leg amputated and his right heavily bandaged in the field.

A medic's sketch (reproduced below) showed a left hand little-finger injury, amputation of left leg above ankle and injury to inside of the lower left leg.



The insurers were informed that the victim had suffered amputation of his left leg, compound fracture to his right leg, multiple injuries to his left hand. He had chronic osteomyalitis – stiffness of right tibia, ankle and feet on 24th September 1997. His amputation was assessed as a 50% disability and his fractured right leg was assessed as a 15% disability, so a total 65% disability claim was submitted.

Compensation of 300,000 Rs was paid on 6th November 1997, and on 20th November 1997 the UN MAC asked the insurers to reassess the amount because it was too low. No record of further payment was found.

Analysis

While this may have been a case of "human error", the primary cause of this accident is listed as a *"Management control inadequacy"* because the correct equipment to remove the wire from the victim's working area was not made available. The secondary cause is listed as *“Inadequate equipment”.*

See also the Afghan accident of 29th April 1997 and 1st June 1997 in which problems with wire removal arose.

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.