DDAS Accident Report

Accident details

Report date:	19/04/2006	**Accident number:**	96
Accident time:	not recorded	**Accident Date:**	29/05/1997
Where it occurred:	Mushwani Village, Mirbachakot District, Kabul Province	**Country:**	Afghanistan
Primary cause:	Inadequate survey (?)	**Secondary cause:**	Management/control inadequacy (?)
Class:	Detection accident	**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:**	agricultural (abandoned) bushes/scrub hard rocks/stones trees
Date record created:	24/01/2004	**Date last modified:**	21/02/2004
No of victims:	1	**No of documents:**	2

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

partner's failure to "control" (?)

request for machine to assist (?)

vegetation clearance problem (?)

inadequate investigation (?)

squatting/kneeling to excavate (?)

inadequate equipment (?)

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 two years. It was ten days since he last attended a revision course and 34 days since his last leave. The ground in the area was described as a garden with trees and bushes, medium hard. A photograph showed the accident site close to a wall with a confusion of red stones near the hole left by the blast. The device was identified as an electrically booby trapped PMN ("found fragments") similar to another defused device found at the same site. [The original report said it was a booby trapped grenade.] A photograph of a similar booby trap device that was defused was unclear, but seemed to show a battery and condenser.

The investigators determined that the victim was checking the boundary land and got a reading with his detector and investigated it with his prodder. He prodded in the squatting position but found nothing. As he stood up to recheck the position with his detector the device went off in front of him.

The Sub-Commander said that the victim was working properly and the accident was the result of the unexpected booby trap. He said that such areas should be cleared with a back-hoe.

The Section Leader said that the victim was prodding and was careless. He stated that new equipment for these areas would make clearance safer.

The victim's partner said he was working properly and the accident was caused by the booby trap. He said equipment to clear/burn off bushes before work commenced would make it safer.

Conclusion

The investigators concluded that the victim was checking the safety lane and ignored proper marking and safety procedures. He had received a reading over a long stretch of ground because of the buried wires and so was unable to centralise a reading: as a result he did not mark, but simply started to prod. The device was booby trapped and the pressure of the deminer's weight on the plastic pipe with wires inside caused the detonation when he stood up. In their opinion, the accident could have been avoided if the victim had "observed technical/prodding and marking procedures".

Recommendations

The investigators recommended that the issue of a mine missed in a safety lane should be investigated with the survey teams; that deminers should be reminded that every reading is a potential mine; that when there is a risk of booby traps, the command group should ensure "proper and strict" safety precautions; and that survey teams should ensure that 99.6% of all devices are cleared from boundary lanes, and should make every effort to provide accurate information about the kind of devices in the mined area.

Victim Report

Victim number: 128 **Name: [Name removed]**

Age:	**Gender:** Male
Status: deminer	**Fit for work:** not known
Compensation: 400,000 Rs	**Time to hospital:** not recorded
Protection issued: Helmet Thin, short visor	**Protection used:** not recorded

Summary of injuries:

INJURIES

minor Hand

minor Leg

severe Hearing

severe Leg

COMMENT

See medical report.

Medical report

The victim's injuries were summarised as: minor injuries to legs and right hand.

A medic's sketch showed abrasions to his lower left leg and right forearm and lacerations to his right thigh.

A photograph showed minor injuries to the inside of his right thigh and lower left leg.

The demining group reported that the victim had suffered linear fracture of his left tibia and loss of hearing in his left ear. On 27th May 1997 they added that he had lost his hearing "near totally" and could not be re-employed as a deminer. The injuries were described later as: fractured left tibia, hearing loss in left ear, multiple superficial injuries, and a dislocated left ankle. He claimed a total hearing loss in his left ear and partial in his right. No other serious disability remained on 30th July 1997 when he was assessed by a medical surgeon and his hearing loss was assessed as 75%.

Compensation was forwarded on 28th October 1997 for 400,000 Rs (80% disability).

Analysis

The primary cause of this accident is listed as *"Inadequate survey"* because the "boundary" lane was supposed to have been cleared during survey. It seems likely that the device was missed by the survey team marking the boundary lanes, and that represents a serious failing elsewhere in the management chain. The secondary cause is listed as a *"Management/control inadequacy".*

The use of a squatting position to "excavate" was in breach of UN requirements, but not in breach of the demining group's unauthorised variations to those requirements. The failure of the UN MAC to either listen to field feedback and adapt the SOP for local conditions, or enforce their own standards may be seen as a management failing.

The victim’s severe deafness is common among Afghan claims at this time, when insurance favoured such injury and testing the validity of claims was difficult.

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.

Related papers

The UN MAC issued a letter stating that Section Leaders should keep better control and enforce correct procedures and that disciplinary action should be taken against deminers who disobey their Team and Section Leaders. It also stated that a “missed device investigation” would be started [not made available].