DDAS Accident Report

Accident details

Report date:	15/05/2006	**Accident number:**	111
Accident time:	not recorded	**Accident Date:**	14/01/1997
Where it occurred:	Karte Sey District, Shura, Ward 6, Kabu	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Inadequate training (?)
Class:	Handling accident	**Date of main report:**	[No date recorded]
ID original source:	none	**Name of source:**	MAPA/UNOCHA
Organisation:	Name removed		
Mine/device:	Fuze	**Ground condition:**	residential/urban
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 training (?)

safety distances ignored (?)

Accident report

An investigation on behalf of the UN MAC was carried out and its short report made briefly available. The following summarises its content.

The investigators made no comment on the cause of this accident. The victims' length of service was not recorded. The accident occurred in a residential area of Kabul city.

The demining group stated that the Section Leader was carrying a UXO fuze (BM 21 rocket fuze) for disposal when he dropped it and it went off. Three other victims were close by.

The Team Leader said the accident occurred because the Section Leader was careless.

The Section Leader said a small boy had brought him the fuze as he was preparing a "CDS" (a cache of UXO prepared for disposal) and he carelessly dropped it.

Another Section Leader said that the accident was caused by carelessness.

A deminer said the accident occurred when the Team Leader "mistakenly" let the fuze fall.

[No conclusions or recommendations were included.]

Victim Report

Victim number:	144	**Name:**	**Name removed**
Age:		**Gender:**	Male
Status:	supervisory	**Fit for work:**	yes
Compensation:	not on record	**Time to hospital:**	not recorded
Protection issued:	Helmet Thin, short visor	**Protection used:**	not recorded

Summary of injuries:

INJURIES

minor Leg

COMMENT

See medical report.

Medical report

The Victim's injuries were summarised as fragments to heel of left foot and ankle (the Team Leader reported "right foot and ankle").

The demining group reported that this Victim suffered lacerated wounds to his left foot and ankle and was off duty from 14th January 1997 to 5th February 1997. The fragments were removed under general anaesthesia.

The medic reported that the victim injured his left foot.

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because the victims included two supervisors and they were bunched around the fuze when it was dropped. Dropping it could be dismissed as an unavoidable "human error" but the supervisors should have ensured that staff were not close together around a dangerous device.

The failure of the management group to carry out a detailed investigation may be seen as a serious failing. Apparent failings of training are also a management responsibility. The secondary cause is listed as *"Inadequate training"*.

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.