

# DDAS Accident Report

## Accident details

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| <b>Report date:</b> 12/02/2004                   | <b>Accident number:</b> 118                    |
| <b>Accident time:</b> 08:15                      | <b>Accident Date:</b> 01/06/1998               |
| <b>Where it occurred:</b> Balldozi Okali, Gardez | <b>Country:</b> Afghanistan                    |
| <b>Primary cause:</b> Unavoidable (?)            | <b>Secondary cause:</b> Unavoidable (?)        |
| <b>Class:</b> Excavation accident                | <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> P4Mk1 AP blast               | <b>Ground condition:</b> 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 metal-detector (?)  
squatting/kneeling to excavate (?)  
use of pick (?)

## Accident report

At the time of the accident the demining group were using a one-man drill in two-man teams.

An accident report was made on behalf of the UN MAC and made briefly available in September 1999. The investigators were unable to visit the area and the investigator's report was made entirely from statements. The following summarises its content.

The accident occurred on land described as "medium" hard agricultural land. The victim had been a deminer for six years and had last attended a revision course eight months before. It was 21 days since his last time off. The mine was identified as a P2MK2 from fragments

found at the site and attached to the report. A photograph of the accident site showed a very shallow depression in hard ground.

The victim was working normally and got a reading from his detector which the investigators believe must have been from a fragment beyond the mine (they considered the mine undetectable with a Schiebel AN/19 detector). He marked the reading and while prodding towards it detonated the mine at 08:15. The victim received "superficial injuries on his right hand, forearm, fingers and neck".

**The Team Leader** stated that the mine was undetectable and the only way to avoid the accident would have been for dogs to clear the area.

**The Section Leader** stated that the victim was working properly and that a recurrence of the accident could be avoided by issuing better detectors.

**The victim's partner** reported that he was working properly and the mine went off before he got to the place where the detector had signalled. He thought that dogs should be used in the area.

**The victim** stated that he had been working properly and the accident was caused because the detector could not detect the mine. He thought that better detectors could prevent recurrence.

### **Conclusion**

The investigators concluded that the victim may have caused the accident by prodding at the wrong angle. They decided that there was no damage to his bayonet and so believed that he used a pick instead. The Team Leader knew there were minimum metal mines there and had shown "poor judgment" by not withdrawing the team after an earlier accident involving one.

### **Recommendations**

The investigators recommended that greater efforts be made to ensure that preliminary surveys provided accurate information about the mines in a particular area. They added that as soon as minimum metal mines were found the task should become a mine-dog group task. They recommended that the Section and Team Leader involved should be disciplined and that the regional MAC should investigate the presence of minimum metal mines and reassign tasks appropriately.

## **Victim Report**

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|---|--|
| <b>Victim number:</b> 154                             | <b>Name:</b> Name removed                            |
| <b>Age:</b>   | <b>Gender:</b> Male                                  |
| <b>Status:</b> deminer                                | <b>Fit for work:</b> presumed                        |
| <b>Compensation:</b> not made available               | <b>Time to hospital:</b> not recorded                |
| <b>Protection issued:</b> Helmet<br>Thin, short visor | <b>Protection used:</b> Helmet, Thin, short<br>visor |

### **Summary of injuries:**

minor Arms

minor Hands

minor Neck

minor Shoulders

#### COMMENT

See medical report.

### Medical report

All witnesses reported that the victim suffered "superficial" injuries to his throat and right hand.

The victim reported superficial injuries to the fingers of his right hand, his right arm and his throat.

The casualty report included a medic's sketch (reproduced below) showing injuries on both shoulders, the left hand and the throat.



The field doctor reported injuries as "chest and both arms (shoulders) and left hand superficial injuries.

The victim was given two weeks "site-rest".

### Analysis

The primary cause of this accident is listed as "*Unavoidable*" because the victim may have been working properly when the detonation occurred. He was wearing the protective equipment supplied but there is no suggestion that he was lying down at the time. The investigators' belief that he was using a pick would confirm this, since the pick cannot be used in a prone position, but their decision that a pick was used is not based on any apparent evidence.

In this and other accidents investigated on behalf of the UN MAC at this time there is a tendency for the investigators to apply blame in a manner that is not supported by the recorded evidence. In this case, the investigators did not visit the site at all. 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.

The UN manager of the Country MAC acknowledged some weaknesses in "investigative procedures" but pointed out that the quality of investigations had "improved dramatically" and would "undoubtedly continue to improve". He also asked for it to be noted that "the investigation only *recommends* corrective action", and that it was the MAC that reviewed all investigations and took any appropriate decisions.

Follow up research into the medical treatment and compensation of the victim has not been possible because access to the data was denied by the UN programme manager in September 1999.