# DDAS Accident Report

## Accident details

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| **Report date:** | 18/05/2006 | **Accident number:** | 253 |
| **Accident time:** | 10:45 | **Accident Date:** | 26/10/1998 |
| **Where it occurred:** | Shekho village, Ahmad Khail District, Paktia | **Country:** | Afghanistan |
| **Primary cause:** | Field control inadequacy (?) | **Secondary cause:** | Inadequate equipment (?) |
| **Class:** | Excavation 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:** | hard<br>rocks/stones |
| **Date record created:** | 18/02/2004 | **Date last modified:** | 18/02/2004 |
| **No of victims:** | 1 | **No of documents:** | 1 |

## Map details

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| **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

handtool may have increased injury (?)

inadequate medical provision (?)

partner's failure to "control" (?)

squatting/kneeling to excavate (?)

visor not worn or worn raised (?)

## Accident report

An investigation on behalf of the UN MAC was carried out and its report made available in October 1999. The following summarises its content.

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

The victim had been a deminer for four years. It was 40 days since his last leave and two months since his last revision course. The accident occurred on a hard hillside with gravel and rocks. The mine was identified from fragments found at the site.

The investigators determined that the victim was investigating a detector reading wearing his helmet and in a squatting position as he and his partner cleared an uphill breach. He was prodding with his bayonet when the mine detonated at 10:45. The investigators decided that "he was not wearing his helmet properly".

He was blown back down the slope four metres and lost both eyes, had severe face injuries and his right hand was amputated at the forearm.

The victim's visor was damaged and his bayonet "lost".

The victim was treated at the site and taken to a local hospital where air evacuation was requested. When permission was refused, they drove the victim to another airport, arriving at 16:45 where the victim was temporarily admitted to hospital waiting for a flight. At 18:00 they were told the flight could not happen until 10:00 the following day. The flight at 10:00 was never actually arranged [ staff reported that this was a bureaucratic failure] and the victim died at 15:45 on the following day while still waiting for it. [The bureaucratic failure was denied by the then MAC manager but no other explanation for the failure to organise a flight was offered.]

### Conclusion

The investigators concluded that the victim ignored safety procedures by prodding in a squatting position without wearing a helmet properly and prodded at too steep an angle. They added that the  Section Leader had displayed poor command and control.

### Recommendations

The investigators recommended that the UN MAC investigate the poor evacuation procedure, that field supervisors ensure deminers adhere to technical guidelines, that the Section Leader be disciplined, and all demining groups arrange for the retirement of over-aged deminers [the victim's age was not given in the report].

## Victim Report

**Victim number:** 327

**Name:** **Name removed**

**Age:**

**Gender:** Male

**Status:** deminer

**Fit for work:** DECEASED

**Compensation:** not made available

**Time to hospital:** more than 29 hours

**Protection issued:** Helmet

Thin, short visor

**Protection used:** Helmet

**Summary of injuries:**

severe Eyes

severe Face

AMPUTATION/LOSS

Arm Below elbow

FATAL

COMMENT

No medical report was made available.

## Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because the victim was working with his visor raised and his error was not corrected by either his partner or the field supervisors.

The loss of the victim's hand and lower arm indicates that he was prodding down onto the mine and illustrates the danger of using a short bayonet as an excavation tool. The secondary cause is listed as *“Inadequate equipment”*.

The continued use of a short bayonet in Afghanistan ignores tooling advances made in other theatres. While some trials on university-designed equipment have been made in the region, none have been made using the tools found appropriate in other theatres (September 1999). This may be seen as a management failing.

The medevac failing was reported to have been caused by the accident happening at a time when a planning meeting was taking place at the MAC (in Pakistan) so the individual(s) with the authority to authorise an air evacuation were not at their desks.