

DDAS Accident Report

Accident details

Report date: 17/01/2004	Accident number: 2
Accident time: 09:30	Accident Date: 04/08/1990
Where it occurred: Bacha Valley, Asadabad, Kunar Province	Country: Afghanistan
Primary cause: Unavoidable (?)	Secondary cause: Management/control inadequacy (?)
Class: Excavation accident	Date of main report: [No date recorded]
ID original source: none	Name of source: [victim]
Organisation: [Name removed]	
Mine/device: MS3 AP blast	Ground condition: not recorded
Date record created: 11/01/2004	Date last modified: 11/01/2004
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

inadequate equipment (?)
inadequate investigation (?)
no independent investigation available (?)
squatting/kneeling to excavate (?)
protective equipment not worn (?)
inadequate medical provision (?)

Accident report

No detailed record of this accident was found. The accident is referred to in a UN MAC country spreadsheet with the single word injury – "minor".

The following is taken from an interview with the victim on 3rd December 1998.

The accident occurred near a former Soviet hill post. The post had been subject to frequent night attack so the Russians had installed "listening devices" in a ring around the hill as an early warning system. The devices were "briefcase sized" and buried, protected against weather by plastic sheets. They were known to be protected by MS3 mines and the demining group, having no explosives for detonation in situ, had the policy of pulling the devices remotely. In all previous cases, pulling had resulted in a detonation of the MS3 mine or mines, activated by pressure-release. The listening devices were located using a Schibel detector. In this case, the victim detected a box, excavated around it and pulled it from a safe distance with a grappling hook. There was no detonation. When the victim returned to the device, he found that there was another listening device beneath it. While excavating around that to get a grappling hook onto it, an MS3 mine beneath it exploded. The 30cm bayonet that was being used as an excavation tool was struck by the listening device and twisted around so that it removed the victim's thumb. The listening device then hit the victim in the face, shattering his jaw. A shard of the bakelite handle of the bayonet hit him in the base of the sternum with a wound he reports to have been 4-5cm deep and 2cm wide (the scar is 2cm diameter, depth "uncertain"). The victim was not wearing protective gear, but was wearing sunglasses, which broke. He had small burns from hot fragments on his arms, face and body. The accident occurred at 09:30 and the victim arrived at hospital (having been driven to the Pakistan border prior to air evacuation by helicopter) at 18:00.

The victim did not think that he prodded onto a mine while excavating. He thought it more likely that the devices were rigged so that lifting the top box pulled the pin from the MS3 mine. The mine has an arming delay which led to it detonating when he had returned to the site. The victim reported no breathing difficulties or lung damage after recovering consciousness. He was knocked out by the impact but came around while still on the site. He also had no ear damage or ringing ears.

After seven months he returned to work in demining. He has worked in demining ever since. He is currently (2003) employed as EOD specialist and Country Manager for a demining NGO working in Angola.

Victim Report

Victim number: 2	Name: [Name removed]
Age: 35	Gender: Male
Status: supervisory	Fit for work: yes
Compensation: £7000 (sick pay)	Time to hospital: 8 hours 30 minutes
Protection issued: None	Protection used: sunglasses

Summary of injuries:

INJURIES

minor Chest

minor Shoulder

severe Face

severe Hand

AMPUTATION/LOSS

Finger

COMMENT

See medical report.

Medical report

A report from a UK hospital dated 20th December 1990 recorded that the victim was admitted to the hospital on 16th December. His injuries were recorded as below.

Ophthalmic injuries: he sustained flash burns and abrasions to both corneas with a left sided hypaemia. On 5th December it was noted that he had developed a left sided herpes simplex keratitis.

Maxillofacial injury: he sustained multiple facial lacerations with impactions of numerous pieces of shrapnel into soft tissue of the face. He had sustained a comminuted fracture of the right body of the mandible. The fracture line involved the lower border in the region of the lower right canine and extended backwards towards the lower right wisdom tooth, with displacement.

His intra-oral injuries involved loss of a 7 unit bonded bridge involving 7 and 3 as abutment teeth.

He has numerous areas of cordite tattooing of the forehead right cheek and lacerations to right mental region, left infra-orbital area, upper forehead and right upper lip.

Injuries to right hand: traumatic amputation of distal phalanx of right thumb associated with fracture and dislocation of the base of the first metacarpal of the right hand and simple dislocation of ring finger MCPJ on the right side.

Chest and abdominal injuries: he has superficial soft tissue injury over the xiphoid cartilage of the thorax and the crest of the right shoulder. There is no evidence of penetration into the thorax or abdomen.

Analysis

The victim's chest injury and the nature of his activity indicate that he was kneeling or squatting at the time of the accident.

The primary cause of this accident is listed as "*Unavoidable*" because the victim appears to have been working according to the operating procedures in place at the time. He appears to have been the victim of a booby-trap deliberately aimed at persons removing the device.

The failure of his management group to supply adequate protective equipment is a significant "*Management/control inadequacy*" that was addressed shortly thereafter by the UN controlled effort.

The failure of the demining group to supply explosives for in-situ detonation is the equipment inadequacy referenced under "Notes".