

DDAS Accident Report

Accident details

Report date: 22/01/2004	Accident number: 9
Accident time: end of day	Accident Date: 23/11/1997
Where it occurred: Darwishtoolak Village, Pargham District, Kabul Province	Country: Afghanistan
Primary cause: Field control inadequacy (?)	Secondary cause: Management/control inadequacy (?)
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
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

partner's failure to "control" (?)
handtool may have increased injury (?)
pressure to work quickly (?)
squatting/kneeling to excavate (?)
visor not worn or worn raised (?)

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 available. The following summarises its content.

The victim had been a deminer for seven years. It was ten days since he had last attended a revision course, and two days since he was last on leave. The ground being cleared was described as the medium-hard bed of a dry lake. The victim's bayonet was destroyed and the visor damaged. The investigators claimed to have found fragments to confirm that the mine involved was a PMN.

The investigators decided that the deminers were hurrying to finish for the day. The victim investigated a reading and found nothing. He used the detector again and found the same reading so started to prod again and applied pressure at the wrong angle.

The Assistant Team Leader said the victim was using two stones to mark and marked the reading correctly both times he used the detector. He thought that the victim was working properly and the accident was not preventable.

The Section Leader said the victim was using two stones to mark and marked the reading correctly both times he used the detector, so he was working properly. He thought that the mine was at an angle in the ground and said that mine dogs should be used in these areas.

The victim's partner said that he investigated the reading for the second time and placed a single mark, then started prodding squatting. He said he was working properly. He said the visor should be longer and thicker to limit injury.

Conclusion

The investigators concluded that the victim worked too quickly and ignored proper detector procedure and failed to maintain the correct angle when prodding.

Recommendations

The investigators recommended that demining activity should be carried out "smoothly", and that deminers must try to maintain the correct angle when prodding.

Victim Report

Victim number: 19	Name: [Name removed]
Age:	Gender: Male
Status: deminer	Fit for work: not known
Compensation: not made available	Time to hospital: not recorded
Protection issued: Helmet	Protection used: Helmet
Thin, short visor	

Summary of injuries:

INJURIES

minor Arm

minor Eye

minor Face

minor Hand

minor Leg

severe Hand

AMPUTATION/LOSS

Fingers

COMMENT

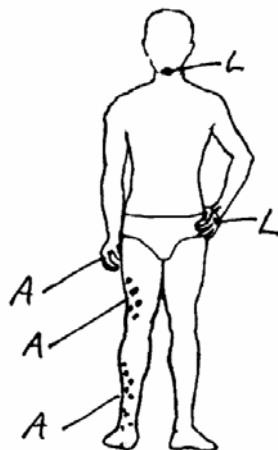
See medical report.

Medical report

The victim's injuries were summarised as amputation of three fingers of his right hand, minor injuries to his chin, left leg and left arm.

A photograph showed the victim with a mangled right hand on which there was no skin apparent and no definition of fingers.

A medic's sketch (reproduced below) showed abrasions on the right thigh and right shin, lacerations on the left hand and a laceration on the chin. No right hand injury was shown [the artist was apparently confused reversing the image in his mind].



The demining group reported the injuries as: right hand polex, index and medianus amputated, other wounds. Left hand lacerated. Right thigh and shin superficial lacerations: chin lacerated: Left eye foreign bodies: "face trauma by helmet".

The insurers were informed on 25th November 1997 that the victim suffered amputation of his right thumb, middle and index fingers and injuries to his chin, left arm and left leg.

No record of compensation was found in June 1998.

Analysis

The primary cause of this accident is listed as a "*Field control inadequacy*" because the victim was working improperly and his errors were not corrected.

The investigators failed to identify the improper use of protective equipment which led to eye injury. If the visor failed (which could have happened with the thin visors in use) this would be a serious management failing. Moves to upgrade them were happening in late 2000.

It is possible that the visor was too damaged to see through properly (as was seen frequently during 1998 and 1999), in which case the failure to provide useable equipment would be a serious management failing.

The victim's leg injury demonstrates that he was not lying down to "excavate". His squatting position 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 further management failing.