DDAS Accident Report

Accident details

Report date: 19/04/2006

Accident number: 86

Accident time: not recorded

Accident Date: 26/06/1997

Where it occurred: Urgoon Village, Urgood District, Paktika Province

Country: Afghanistan

Primary cause: Field control inadequacy (?)

Secondary cause: Field 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: grass/grazing area soft

Date record created: 24/01/2004

Date last modified: 24/01/2004

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

victim ill (?)

handtool may have increased injury (?)

partner's failure to "control" (?)

inadequate investigation (?)

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 briefly available. The following summarises its content.

The victim had been a deminer for two years. It was five months since he had last attended a revision course and four days since his last leave. The ground where the accident occurred was described as soft grazing land. A photograph showed baked flat ground with clumps of grass and low bushes.

The investigators determined that the victim had investigated a reading in the squatting position with a prod. He was not "wearing his helmet properly". They identified the mine as a PMN (from "found fragments") and recorded that the victim's helmet and bayonet were "destroyed".

The Team leader said that the deminer did not detect, mark or prod properly and that the Section Leader was at fault. Correct procedure should be enforced to prevent recurrence.

The Assistant Team Leader said the victim was careless.

Conclusion

The investigators concluded that, after finding metal fragments twice, the victim believed that the reading was another fragment. He ignored marking procedures and so prodded directly onto the mine.

Recommendations

The investigators recommended that "all deminers must mark reading points properly and prod the reading points in the correct angle and position". Also that all deminers must wear their helmet properly when prodding, and that the Section Leader, Team Leader and Assistant Team Leader should be disciplined for their poor control and command in this instance. They also said that sick deminers must not be deployed, and Team Leaders must be assured that they have the authority to approve sick leave for deminers. [This implies that the victim may have been unwell prior to the accident.]

Victim Report

Victim number: 117
Name: [Name removed]
Age:
Gender: Male
Status: deminer
Fit for work: no
Compensation: 500,000 Rs (100%)
Time to hospital: not recorded
Protection issued: Helmet
Protection used: Helmet
Thin, short visor

Summary of injuries:

INJURIES

minor Chest

minor Face

minor Hearing

minor Leg

severe Eyes

AMPUTATION/LOSS

Fingers

Eyes

COMMENT

See medical report.

Medical report

The victim's injuries were summarised as: serious injury to both eyes, loss of two fingers on his right hand and his right leg injured. The medical report did not include a sketch. It stated that both eyes were "lost", two fingers traumatically amputated and the right leg injured below the knee.

The demining group reported that the victim sustained: severe injury to both eyes, severe injury to forehead and right thumb, fracture right index finger, right leg wound, superficial chest injuries.

A compensation claim was forwarded on 5th November 1997 in which the injuries were listed as: amputation of right index finger, fracture right thumb, facial injuries including blindness of both eyes and a forehead injury, loss of hearing to both ears, and depression.

On 25th October 1997 the victim was assessed as: unable to use his right hand effectively; right leg lacerations healed; some disfigurement of face and forehead. These were taken to represent a 30% disability. On 18th October 1997 his loss of eyesight was assessed as a 90% disability. On 23rd October 1997 his hearing loss was assessed as 25%. He was being treated for depression.

Compensation of 500,000 Rs (100%)was forwarded on 6th January 1998.

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 went uncorrected.

The visor used was 3mm thick: and reported to be several years old. It is possible that the victim did not wear the visor correctly because it was too damaged to see through properly (as was seen frequently during field visits in 1998 and1999), in which case the failure to provide useable equipment would represent a serious management failure.

The use of a squatting position to "excavate" 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.

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.