

DDAS Accident Report

Accident details

Report date: 15/05/2006	Accident number: 133
Accident time: not recorded	Accident Date: 23/12/1997
Where it occurred: Kohai Nigar, Ward 6, Kandahar city	Country: Afghanistan
Primary cause: Field control inadequacy (?)	Secondary cause: Unavoidable (?)
Class: Excavation accident	Date of main report: [No date recorded]
ID original source: none	Name of source: MAPA/UNOCHA
Organisation: Name removed	
Mine/device: Fuze	Ground condition: agricultural (abandoned) hard
Date record created: 13/02/2004	Date last modified: 13/02/2004
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 investigation (?)
inconsistent statements (?)
partner's failure to "control" (?)
request for machine to assist (?)
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 five and a half years. He had attended a revision course three months previously and had been on leave 42 days before the accident. He was working on ground described as "hard agricultural land" [a photograph showed a deep excavation in compacted ground].

The investigators decided that the victim got a detector reading and investigated it but found nothing. He checked with the detector and still got a reading, so squatted to prod thinking it was a fragment. The device which exploded was assumed to be an MUV fuze because of the presence of POMZ fragments in that minefield.

The Team Leader said that the deminer was working properly and was investigating the same reading for the third time when his bayonet struck the fuze. He said the main cause of the accident was the hardness of the ground (which had been driven over by tanks). He said back-hoes or other techniques should be used on such hard ground.

The Section Leader said the deminer was checking the reading for the third time when the accident occurred and that he was working properly.

The victim said he was investigating the same reading for the third time when the accident occurred. He was working properly and the hard ground caused the accident. He recommended the use of back-hoes on such hard ground.

The victim's partner said the victim was working lying prone and doing his job properly. The fuze was under pressure and exploded just by being touched so the deminer was not at fault. He recommended the back-hoe be used for excavating such sites.

Conclusion

The investigators concluded that the victim was squatting when the ground was suitable for lying prone, and that he showed "poor judgement" by thinking the fuze was a fragment.

Recommendations

The investigators recommended that the team command group must make deminers lie prone to prod when the ground is suitable, that all readings should be treated as a mine, and that Section Leaders should supervise properly and enforce the prone prodding requirement.

Victim Report

Victim number: 169	Name: Name removed
Age:	Gender: Male
Status: deminer	Fit for work: presumed
Compensation: not made available	Time to hospital: not recorded
Protection issued: Helmet	Protection used: not recorded
Thin, short visor	

Summary of injuries:

INJURIES

minor Eyes

minor Face

COMMENT

See medical report.

Medical report

The investigators summarised the victim's injuries as slight burns to his face, light abrasions to his eyelids and dust and earth in both eyes.

A medic's sketch showed minor abrasions on the face. A photograph showed no obvious facial injury.

The insurers were informed on 30th December 1997 that the victim had sustained eye injuries (foreign bodies both eyes) in an accident on 24th [sic] December 1997. [A UN MAC accident summary also changes the date to 24th December 1997.]

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 injuries show that the victim was not wearing his protective equipment (or not wearing it properly) and this error was not corrected. The inconsistencies in the statements from supervisors imply that some were lying, and the UN MAC's failure to address the problem of dishonesty among field supervisors represents a failure of management.

The victim was prodding for something with very different dimensions from a mine, so may have been working as trained when the accident occurred [see Related papers]. For this reason, the secondary cause is listed as "*Unavoidable*".

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 SOPs for local conditions, or enforce their own standards may be seen as a 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.

Related papers

No other documents were made available.

The belief that the device was a "fragment" may be misleading. An MUV fuze complete with detonator is 11cm (4.33") long and constitutes rather a large detector reading.

The picture below is of an MUV fuze and detonator common in Afghanistan. It is possible that pressure applied with a bayonet in the wrong place could dislodge the pin easily – especially if it were already partly pulled. The victim was prodding for something with very different dimensions, so may have been working as trained when the accident occurred.

