

# DDAS Accident Report

## Accident details

<b>Report date:</b> 15/05/2006	<b>Accident number:</b> 134
<b>Accident time:</b> not recorded	<b>Accident Date:</b> 24/12/1997
<b>Where it occurred:</b> Kabul Darwaza, Ward 3, Kandahar city	<b>Country:</b> Afghanistan
<b>Primary cause:</b> Field control inadequacy (?)	<b>Secondary cause:</b> Field control inadequacy (?)
<b>Class:</b> Excavation accident	<b>Date of main report:</b> [No date recorded]
<b>ID original source:</b> none	<b>Name of source:</b> MAPA/UNOCHA
<b>Organisation:</b> Name removed	
<b>Mine/device:</b> PMN AP blast	<b>Ground condition:</b> building rubble residential/urban
<b>Date record created:</b> 13/02/2004	<b>Date last modified:</b> 13/02/2004
<b>No of victims:</b> 2	<b>No of documents:</b> 1

## Map details

<b>Longitude:</b>	<b>Latitude:</b>
<b>Alt. coord. system:</b>	<b>Coordinates fixed by:</b>
<b>Map east:</b>	<b>Map north:</b>
<b>Map scale:</b> not recorded	<b>Map series:</b>
<b>Map edition:</b>	<b>Map sheet:</b>
<b>Map name:</b>	

## Accident Notes

inadequate investigation (?)  
safety distances ignored (?)  
long handtool may have reduced injury (?)  
standing to excavate (?)  
partner's failure to "control" (?)  
use of shovel (?)  
visor not worn or worn raised (?)  
mechanical follow-up (?)

## 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.

Both victims had been deminers for seven years and had attended a revision course three months before the accident. It was 22 days since their last leave. On the day of the accident they were working in a "collapsed residential" area. A photograph showed the accident site 50cm from a high wall on land littered with loose earth and rubble.

The investigators determined that Victim No.1 was investigating a pile of spoil deposited by the back-hoe when he got a continuous detector reading and started excavating with a long handled shovel. He detonated a mine. The mine was identified as a PMN (by "found fragments").

A photograph of a damaged shovel (handle and head separated) was included in the report.

**The Team Leader** said the deminer was excavating a reading with a shovel and used it at the incorrect angle. He said the pick should be allowed for prodding.

**The Section Leader** said that the deminer was working properly but must have applied too much pressure on the shovel.

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**The victim's partner** (Victim No.2) said he was 5-6 metres from the deminer when the accident occurred and he did not know why it had happened.

## Conclusion

The investigators concluded that the deminer ignored technical procedures when investigating a reading, the deminer's partner ignored safety distance requirements, and that the command group failed to exercise effective control.

## Recommendations

The investigators recommended that deminers should wear helmet and frag-jacket when investigating the spoil from a back-hoe, that deminers must maintain safety distances, and that the Section Leader should be warned for poor performance. [The recommendation to wear frag-jackets is interpreted as a request for body protection.]

## Victim Report

<b>Victim number:</b> 170	<b>Name:</b> Name removed
<b>Age:</b>	<b>Gender:</b> Male
<b>Status:</b> deminer	<b>Fit for work:</b> yes
<b>Compensation:</b> not made available	<b>Time to hospital:</b> not recorded
<b>Protection issued:</b> Helmet	<b>Protection used:</b> none
Thin, short visor	

**Summary of injuries:**

INJURIES

minor Hearing

COMMENT

See medical report.

**Medical report**

Victim No.1's injuries were summarised as: injuries to ears [a sketch indicated injury to both ears, which were bleeding]

Letters to the insurers indicated that the victim was moderately deafened and off work until 9<sup>th</sup> January 1998. He also suffered depression.

No record of compensation was found in June 1998.

**Victim Report**

<b>Victim number:</b> 171	<b>Name:</b> Name removed
<b>Age:</b>	<b>Gender:</b> Male
<b>Status:</b> medic	<b>Fit for work:</b> presumed
<b>Compensation:</b> not made available	<b>Time to hospital:</b> not recorded
<b>Protection issued:</b> Not recorded	<b>Protection used:</b> none

**Summary of injuries:**

INJURIES

minor Eye

minor Face

COMMENT

See medical report.

**Medical report**

Victim's No.2's injuries were summarised as abrasions to the head [a sketch indicated a single abrasion on the right temporal lobe].

Letters to the insurers indicated that the victim was a nurse and that he sustained an injury to his left eye [not mentioned before] and did not mention the head injury.

No record of compensation was found in June 1998.

## Analysis

The primary cause of this accident is listed as a "*Field control inadequacy*" because, from the investigator's recommendations, it is inferred that visors were not worn when the accident occurred. This indicates a failure of supervision. The close proximity of Victim No.2 to the blast is not explained and indicates a further failure of field supervision as recognised by the investigators.

It is possible that the visors provided were too damaged to see through properly (as was seen frequently during 1998), in which case the failure to provide useable equipment may represent a serious management failing.

It is clear from the statements of field supervisors that they considered the use of a shovel to excavate was "correct" procedure. This implies failing of training or communication among management levels.

The use of the shovel and an upright position to "excavate" were both 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.