

DDAS Accident Report

Accident details

Report date: 15/05/2006	Accident number: 135
Accident time: not recorded	Accident Date: 10/12/1997
Where it occurred: Alizai Village, Dand District, Kandahar City	Country: Afghanistan
Primary cause: Field control inadequacy (?)	Secondary cause: Inadequate training (?)
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: ditch/channel/trench dry/dusty 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 (?)
long handtool may have reduced injury (?)
partner's failure to "control" (?)
request for machine to assist (?)
squatting/kneeling to excavate (?)
use of pick (?)
visor not worn or worn raised (?)

inadequate training (?)

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 years. He had attended a revision course one month before, and it was 40 days since his last leave. The ground being cleared was described as a medium hard streambed on agricultural land. A photograph showed a steep sided gully perhaps a metre deep which appeared to be an irrigation canal (the banks were raised mounds) rather than a natural stream.

The investigators decided that the victim found a detector reading, marked it, and started to excavate with a pick – contravening a UN MAC directive to stop using a pick for excavation. The mine was identified as a PMN (from "found fragments").

The photograph below shows the victim reproducing the position he was in at the time of the accident (taken by the researcher in July 1998).



The Team Leader said the deminer was working properly because he was not badly injured. He thought that new equipment could make a repetition of the accident less likely.

The Section Leader said the deminer was working properly and prodding with a bayonet. He said the back-hoe should be used when mines are deeply buried.

The victim's partner said he was digging with a pick and working properly. He said the hard ground or a failure to mark the reading accurately might have caused the accident.

Conclusion

The investigators concluded that the deminer did not mark the detector reading properly. Further, the command group ignored procedure and allowed the pick to be used after its use had been prohibited.

Recommendations

The investigators recommended that the pick should not be used to investigate a reading point and that the demining group involved should "strongly advise" all their teams to stop such unsafe practices.

Victim Report

Victim number: 172	Name: Name removed
Age:	Gender: Male
Status: deminer	Fit for work: yes
Compensation: not made available	Time to hospital: not recorded
Protection issued: Helmet Thin, short visor	Protection used: Helmet, Thin, short visor

Summary of injuries:

INJURIES

minor Face

minor Hearing

COMMENT

See medical report.

Medical report

The victim's injuries were summarised as a "lower lip abrasion and deafness in both ears", a left ear drum perforation and a "painful" right ear.

A medic's sketch indicated ear damage and a single fragment to his lower right jaw. A photograph showed no obvious injury.

The doctor recommended that the victim be given one week off work.

The insurers were informed on 11th December 1997 that the victim had suffered minor injuries to his lower lip in a mine accident. A claim was later submitted for "left eardrum perforation and deafness, injury to lower lip" and that he was not fit to return to duty with a hearing loss of 20%. That claim was resubmitted on 12th May 1998, saying that the victim was off work until 13th March 1998, when he returned to demining.

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's facial injuries indicate that his visor was worn (at least partly) raised and this error was not corrected.

The UN MAC's failure to issue coherent and consistent guidance on the use of the pick as an excavation tool may explain why it was used incautiously. The Victim cannot have been trained to use it appropriately without training guidelines. The secondary cause is listed as "*Inadequate training*".

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

The use of the pick 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.

Gathering of further medical treatment and compensation details was prevented by the UN programme manager who denied all access to records in September 1999. Access has continued to be denied up to the date of completion of this version of the database.

Related papers

For the UN MAC, a senior Technical Advisor advised immediate release of an SOP for the use of the pick to initiate excavations on hard ground. A suitable SOP was drafted on 1st September 1997, but was still unreleased on 6th August 1998 [still not released in June 1999].

After ten weeks off work the victim returned to work as a deminer.

The Victim was interviewed in July 1998 in Kandahar by the researcher. Working as a deminer again, the victim said he was checking an old irrigation canal with crumbled sides. It was dry and partly filled. The detector signalled and he marked the spot with three stones. He then dug forward from the third stone with a small shovel. He was digging to half a metre (18") deep. After a while he started to use the pick because the ground was too hard. He hit a PMN – believed to be a PMN because there were other PMNs found nearby. He was wearing a helmet and visor, which he believes saved his face. He suffered temporary hearing loss in one ear and was off work for ten weeks in all.

He was photographed showing his position when the accident occurred.

2000 MAC manager's comment

At the time, other TAs, [excised] personnel and MAC management staff did not agree with the TA who made the recommendation to release an SOP for use of the pick. Accordingly, NGOs were advised verbally and in writing that the use of the pick was not authorised..... Delays in issuing the final SOP were partly attributable to other competing high priority issues, lack of technical staff and a changeover of TAs in approximately Aug 98....