DDAS Accident Report

Accident details

Report date:	15/05/2006	**Accident number:**	138
Accident time:	11:20	**Accident Date:**	23/09/1997
Where it occurred:	Gulany Haji Faraj Minefield, Darbandikhan District	**Country:**	Afghanistan
Primary cause:	Unavoidable (?)	**Secondary cause:**	Inadequate equipment (?)
Class:	Excavation accident	**Date of main report:**	30/09/1997
ID original source:	SB	**Name of source:**	MAG
Organisation:	Name removed		
Mine/device:	PMN AP blast	**Ground condition:**	hard rocks/stones
Date record created:	13/02/2004	**Date last modified:**	13/02/2004
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

no independent investigation available (?)

inadequate equipment (?)

handtool may have increased injury (?)

squatting/kneeling to excavate (?)

Accident report

The demining group was operating a three-man team with a two-man drill at the time of the accident. One man used the detector, marked any readings, and another man came forward to excavate the reading, feel for tripwires and cut any undergrowth. A third man at any one

time was resting. The demining group issued full body protection and their drills assumed the deminer would lie prone while excavating.

An internal report was made available by the demining group. The following summarises its content.

The accident area was undulating and steep with dry earth and rock. The team had found "many" PMNs in the area prior to the accident. The deminer was clearing a safe-lane and was using a prodder to inspect a reading when a PMN exploded at 11:20. He suffered minor blast injuries to his neck and chin as well as small injuries to both hands in the dorsal area and his right shoulder. His visor and helmet took most of the blast. The victim walked out of the accident area and was taken to the Emergency hospital in Sulymania along with two deminers with the same blood group. The ambulance broke down so the victim was transferred to the other vehicle in the convoy.

Another deminer said that he was kneeling on both knees at the time of the accident.

The victim said that he started prodding 15cm from the centre of the reading. The ground was very hard and as he pushed the prodder it slipped forward and initiated the mine.

The demining group appointed an internal "Investigating Specialist" to write a report on the accident. His report records that the casualty arrived at hospital at 12:45.

On visiting the site the investigator found that the safe lane markings were confusing and did not conform to SOPs. The ground was loose and crumbly on the surface but very hard underneath. He found the prodder, which was badly bent and 4 inches were missing from the end. He calculated from the crater that the mine was laid to a depth of 5cm.

Conclusion

The victim had been wearing a locally made ballistic jacket which had provided insufficient protection to the shoulders, but the investigator concluded that the victim's helmet and visor saved had him from serious injury.

Recommendations

The investigator recommended that deminers should be re-instructed about marking systems. That the ground should be softened with water, the ambulance should be checked regularly and the jackets should be inspected and strengthened where necessary.

Victim Report

Victim number: 178

Name: **Name removed**

Age:

Gender: Male

Status: deminer

Fit for work: yes

Compensation: not made available

Time to hospital: 1 hour 25 minutes

Protection issued: Frag jacket
Helmet
Short visor

Protection used: Frag jacket, Helmet, Short visor

Summary of injuries:

INJURIES

minor Arm

minor Face

minor Hands

minor Neck

COMMENT

See medical report.

Medical report

No formal medical report was made available. In the other documents the injuries were described as "blast and fragment injuries to anterior neck and chin, right shoulder and small fragment damage to both hands in dorsal area. IV fluid was given (normal saline) and 500mg of Ampicillin."

The victim's time off work was recorded as ten days.

Analysis

The primary cause of this accident is listed as *"Unavoidable"* because the victim appears to have been working properly when the accident occurred.

The demining group's SOPs usually require deminers to work prone and the victim was not doing so, but there seems to have been a variation of SOP for Iraq allowing deminers to excavate in a kneeling position.

The short visor (attached to a helmet) issued by this demining group may have allowed the victim to sustain chin/throat injuries. The gap between a collar and the visor can be wide, especially when the helmet is tipped back on the head and the visor standing well away from the face. Alternatively, the visor may have been raised. In either case the protection was inadequate. The investigator's concern about the standard of the frag-jacket implies that it may also have been inadequate. The secondary cause is listed as *"Inadequate equipment"*.

The demining group's management was concerned to make a thorough investigation and brought in an "objective" and critical observer to make the investigation. This resulted in an unusually informative internal report.