DDAS Accident Report

Accident details

Report date: 15/05/2006

Accident number: 140

Accident time: not recorded

Accident Date: 23/10/1997

Where it occurred: Pajak Village, Dehyak District, Ghazni Province

Country: Afghanistan

Primary cause: Management/control inadequacy (?)

Secondary cause: Inadequate equipment (?)

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: agricultural (abandoned)

grass/grazing area

hard

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

inadequate investigation (?)

inadequate equipment (?)

handtool may have increased injury (?)

partner's failure to "control" (?)

request for better PPE (?)

request for long handtool (?)

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 last attended a revision course one month before, and had last been on leave 16 days before the accident. The group claimed to have found fragments to prove that the device involved was a PMN. The ground being worked on was described as "agricultural, medium hard". [A photograph showed flat clay, dry with sparse grasses.]

The investigators decided that the victim was working with the detector and got a reading. He placed one mark and squatted to prod without wearing his helmet correctly. His bayonet was “destroyed” in the accident.

The team Sub-Commander said the ground was very "stiff" which may have made the deminer exert too much pressure. He said they should be allowed to use the pick in these circumstances to reduce likelihood of injury. [This is interpreted as a request for a long handtool.]

The Section Leader said the deminer was prodding properly but the ground was hard so he used too much force. He said that it would be safer to use a pick.

The victim's partner said that the victim only placed one mark on the reading, and that the "stiffness" of the ground made him apply too much pressure. He said the pick would be safer because prodding with the bayonet was hazardous. He also said the visor of the helmet was impossible to see through.

The victim said that this mine was deeper than the 11 mines he had found just before so he thought it was a fragment. He was working properly but was careless. He said it would be safer to use a pick and that the visor he was issued was impossible to see through.

Conclusion

The investigators concluded that the victim did not use the correct marking procedure, did not use his detector properly and did not use his helmet [and visor] properly. Also the victim squatted and prodded at the wrong angle. They found that the command and control exercised was poor to allow the above to happen.

Recommendations

The investigators recommended that prodding should never be done in the squatting position when the ground is suitable for the prone position. Also that deminers should have the need to wear the helmet properly stressed and that disciplinary action should be taken against the Section Leader for his poor command and control.

Victim Report

Victim number: 180

Name: Name removed

Age:

Gender: Male

Status: deminer

Fit for work: not known

Compensation: not made available

Time to hospital: not recorded

Protection issued: Helmet

Thin, short visor

Protection used: Helmet

Summary of injuries:

INJURIES

minor Arm

minor Face

minor Hand

minor Head

severe Eyes

AMPUTATION/LOSS

Eye

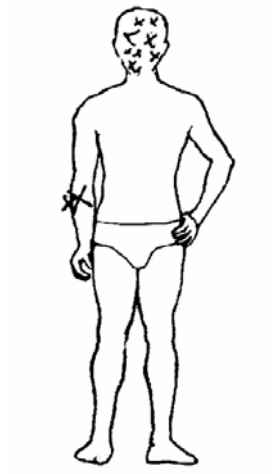
COMMENT

See medical report.

Medical report

The victim's injuries were summarised as serious injuries to both eyes and his right hand. The left eye was lost (left corneal scleral perforation – upper lid laceration) and the right eye seriously injured. The victim reported injury to his right ear, right hand and "head impulses".

A medic's sketch (reproduced below) showed right forearm and facial injuries.



The demining group submitted an insurance report on 2nd March 1998, listing the injuries as a left eye total loss, right eye 75% disability; facial disfigurement; right ear drum 20% disability and multiple wounds on his body.

In a compensation claim made later, his injuries were listed as loss of his left eye, injury to his right eye, multiple injuries to his face, laceration of his right arm and "mild" head injury.

No record of a compensation payment was on file in June 1998.

Analysis

The primary cause of this accident is a listed as a *"Management control inadequacy"* because the visor was too damaged to see through properly (as was seen frequently by the researcher during field visits in 1998,99), which represents a serious management failing. Whether that inadequacy lies with the demining group of the UN MAC is a moot point, with both blaming the other for failure to replace inadequate equipment in 1998 and the UN MAC belatedly recognising some responsibility in 1999. The secondary cause is listed as *"Inadequate equipment"*.

The use of the 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 further management failings.

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 accident and medical treatment detail 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.