

DDAS Accident Report

Accident details

Report date: 16/05/2006	Accident number: 145
Accident time: not recorded	Accident Date: 07/10/1997
Where it occurred: Tapi Tajbek, Ward No. 6, Kabul City	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) bushes/scrub 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 (?)
inadequate metal-detector (?)
partner's failure to "control" (?)
request for better PPE (?)
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 three and a half years. It was one month since the victim had last attended a revision course and 72 days since his last leave. The ground worked on was described as hard, agricultural land with bushes. A photograph showed sparse dry "bush" on hard ground. The mine "crater" appeared to be quite shallow – at most 6" (15cm) below general surface level. The clearance group claimed to have found fragments of the device that identified it as a PMN. The victim had just successfully exposed a PMN mine, buried unusually deep – as all previous finds in that locality had been.

The investigators found that "the ground was suitable for prodding in a prone position, but the victim was performing prodding in the squatting position. During prodding he failed to maintain the correct prodding angle and applied excessive pressure on the mine...it is presumed that the locator of the victim might not have been working properly..." The deminer's visor and glove were damaged, and his bayonet was reported to have been "lost".

The Team Leader said the victim was squatting and prodding "superficially". He recommended reducing mission time from 60 to 45 days and that old/broken mine detectors should be replaced.

The Section Leader blamed hard ground, continuous reading from detectors, and the unusual depth of the mines.

The victim's partner said he was investigating a very deep reading and was not careful enough. He thought fragmentation jackets should be issued, and the old mine detectors should be replaced.

Conclusion

The investigators concluded that the victim prodded at the wrong angle and that poor command and control allowed the victim to prod squatting.

Recommendations

The investigators recommended that Section Leaders should closely control the deminers they are responsible for, that detectors must be adjusted/checked regularly, that the demining group should issue frag-jackets as soon as possible, and that no team's mission should last longer than 60 days. They said that the Section Leader should be disciplined for poor performance and that the demining group should replace faulty detectors as soon as possible.

Victim Report

Victim number: 186	Name: Name removed
Age:	Gender: Male
Status: deminer	Fit for work: yes
Compensation: not made available	Time to hospital: not recorded
Protection issued: Helmet	Protection used: helmet
Thin, short visor	

Summary of injuries:

INJURIES

minor Arm

minor Body

minor Eye

minor Hands

minor Legs

COMMENT

See medical report.

Medical report

The victim's injuries were summarised as lacerations to his right leg and left hand, a burn on his left hand, minor lacerations to his right arm, hand and left leg.

A claim was forwarded to the insurers on 23rd December 1997. An accompanying photograph showed eye injury and peppered wounds in the lower abdomen. The victim was in hospital until 25th October 1997 and away from duty until 7th November 1997.

No record of a compensation payment was found in June 1998.

Analysis

The primary cause of this accident is listed as a "*Management control inadequacy*" because the detection equipment provided to the deminer was inappropriate for the purpose. The failure of the investigators to recommend that work be stopped until the detector problem was solved is remarkable. The secondary cause is listed as "*Inadequate equipment*".

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 the SOP for local conditions, or enforce their own standards may be seen as a further management failing

It is possible that the visor was worn improperly because it were too damaged to see through properly (as was seen frequently during field visits in 1998,99), in which case the failure to provide useable equipment would be a serious 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

The deminer was interviewed in Kabul on 22nd July 1998 and photographed showing his working position when the accident occurred [he was using a short bayonet].



The victim was working as a deminer again at the time of the interview. He showed his scars – multiple on left leg, left hand and right arm.

He was not wearing a fragmentation vest at the time of the accident because one was not available. He was wearing a visor [not fully down]. The visor was examined and it was marked to 1mm depth, but not punctured.