DDAS Accident Report

Accident details

Report date:	18/05/2006	**Accident number:**	240
Accident time:	08:40	**Accident Date:**	24/03/1998
Where it occurred:	Chawni, Jali district, Paktia Province	**Country:**	Afghanistan
Primary cause:	Field 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:**	hard metal scrap
Date record created:	17/02/2004	**Date last modified:**	17/02/2004
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

handtool may have increased injury (?)

pressure to work quickly (?)

request for clearance with explosive charge (?)

request for machine to assist (?)

squatting/kneeling to excavate (?)

visor not worn or worn raised (?)

inadequate metal-detector (?)

Accident report

At the time of the accident the demining group was working in two-man teams operating a one-man drill. An investigation on behalf of the UN MAC was carried out and its report made available in September 1999. The following summarises its content.

The victim had been a deminer for eight years. He had last been on leave 35 days before and last attended a revision course three months before. The accident occurred on ground described as a hard hillside. The mine was not positively identified, but was believed to have been a PMN.

The investigators determined that the victim was working in a "breaching lane" when he got a detector reading. He marked the point and started to prod. He found some old food tins and continued prodding. His right hand became tired so he moved his bayonet to his left hand just before the mine went off at 08:40. The victim lost his left eye, two fingers of his left hand and had minor injuries to his right hand and body.

The victim's bayonet was lost in the accident and his helmet was not made available for the investigators to inspect.

The victim was treated on site, then moved to a field medical unit before being evacuated to hospital in Peshawar, Pakistan.

The Team Leader said that the victim was working properly and working in a squatting position because the "area had slope". He said the accident was preventable if the victim had placed an explosive charge before prodding. He said that the area was heavily mined and the deminers became tired, so mission duration should be reduced.

The Section Leader said that the mine's position may have been moved by rain. He thought recurrence could be avoided by clearing such areas with a back-hoe.

The victim said that his detector was reading continuously so he put his helmet on to prod. He found some food tins and continued work but became tired so changed hands. He said that the accident occurred because the ground was hard, he was unused to using his left hand and the metal contamination meant that he could not centre the detector reading.

Conclusion

The investigators believed that the victim "failed to keep the balance" when he changed hands with his prodder and so prodded at the wrong angle.

Recommendations

The investigators recommended that deminers be relaxed while working and treat all readings as if they were mines. They added that the command group should not apply pressure to work quickly, and should keep all equipment damaged in an accident for inspection by the investigators.

Victim Report

Victim number: 313

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 Abdomen

minor Arm

minor Hand

severe Arm

severe Eye

AMPUTATION/LOSS

Fingers

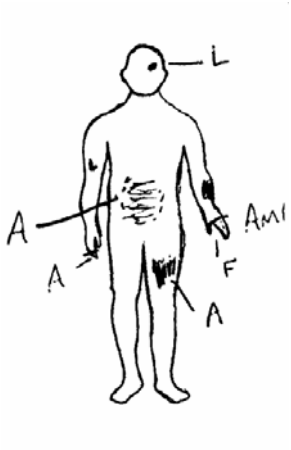
COMMENT

See medical report.

Medical report

The field medical report stated that the victim had lost vision in his left eye, suffered traumatic amputation of his left thumb and index finger, fractured/dislocated his left wrist and elbow, suffered laceration and bruising to right hand and abdomen.

A medic's sketch is reproduced below.



His vital signs were recorded as pulse 110/min, BP 130/90.

The field doctor recorded the injuries as; traumatic amputation of polix and index fingers of left hand, arm and forearm abrasion. Left hand thigh abrasion and right hand. Abdomen abrasions. Left eye injuries and loss of vision.

Photocopied photographs in the file showed light abdominal and left thigh/knee abrasions.

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because the victim was working without a visor or with his visor raised and his error was not corrected. The use of a short bayonet as an excavation tool frequently leads to severe hand injury in prodding incidents and its continued issue may have represented a management failing. The secondary cause is listed as *"Inadequate equipment"*.

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