DDAS Accident Report

Accident details

Report date:	17/03/2004	**Accident number:**	244
Accident time:	07:45	**Accident Date:**	09/08/1998
Where it occurred:	Shorandam, Kandahar	**Country:**	Afghanistan
Primary cause:	Unavoidable (?)	**Secondary cause:**	Inadequate equipment (?)
Class:	Excavation accident	**Date of main report:**	01/02/1999
ID original source:	none	**Name of source:**	MAPA/UNOCHA
Organisation:	Name removed		
Mine/device:	PMN AP blast	**Ground condition:**	grass/grazing area hard
Date record created:	17/02/2004	**Date last modified:**	17/02/2004
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

inconsistent statements (?)

long handtool may have reduced injury (?)

partner's failure to "control" (?)

request for machine to assist (?)

use of pick (?)

visor not worn or worn raised (?)

inadequate investigation (?)

Accident report

An investigation on behalf of the UN MAC was carried out and its report made available in September 1999. The following summarises its content.

At the time of the accident the demining group was using a one-man drill and two-man teams.

The victim had been a deminer for eight years. He had last been on leave 15 days before and last attended a revision course seven days before. The accident occurred on ground described as "grazing and residential" land in "medium hard" condition. The mine was identified from pieces found at the site.

The investigators found that the victim was investigating a detector reading in a squatting position and using a pick. He had used two markers. He "finished one layer" [presumably slicing layers from the ground] and rechecked with the detector. The reading was still there so he started excavating again without placing any markers. He hit a mine at 07:45.

The accident investigators reported that he was not injured because he was wearing protection. [See “Related papers”.]

The victim's visor was broken and his pick was damaged.

The Team sub-commander said that the mine was very deep and victim made a mistake placing the marks.

The Section Leader said that the hardness of the ground may have contributed to the incident, that the victim may have placed the marks poorly, and that he sustained "superficial injuries" and deafness. He thought that back-hoes might help prevent such incidents.

Conclusion

The investigators concluded that the accident occurred because the victim was using unauthorised drills and equipment. His field supervision was poor. They acknowledged that the mine may have been deeply buried but thought that problem "could have been overcome" with the use of correct procedures.

Recommendations

The investigators recommended a return to the three-marks procedure for indicating detector readings pending a re-evaluation of the two-mark method. They further recommended that the Section Leader be disciplined and demoted. They added that the accident illustrated the advantage of wearing visors and jackets because the victim was uninjured and should be referenced in training courses. [See “Related papers”.] They added that the quality of the visor should be examined, pointing out that it had "broken into pieces".

Victim Report

Victim number: 318

Name: **Name removed**

Age:

Gender: Male

Status: deminer

Fit for work: presumed

Compensation: not made available

Time to hospital: not recorded

Protection issued: Frag jacket
Helmet
Thin, short visor

Protection used: Frag jacket, Helmet, Thin, short visor

Summary of injuries:

INJURIES

minor Arms

minor Head

severe Hearing

COMMENT

See medical report.

Medical report

An initial casualty report described the victim's injuries as: "Head (frontal area) superficial wounds and left and right arm superficial multiple wounds. Both ears have deafness." The victim's vital signs were a pulse of 80/min, BP of 120/80 and Respiration of 18/min.

The casualty report included a medic's sketch on which a left shoulder and forehead laceration and hearing damage were indicated. [A doctor's report from the field hospital was not translated - the failure to translate it being unique among the recent records at this UN MAC].

An initial accident report sent to the UN MAC reported that the victim sustained minor head and arm injuries, along with severe hearing loss. That report also mentioned that the victim was treated on site and taken to the ICRC hospital in Kandahar, then returned to the field medical unit. [The investigators did not mention the ICRC or the injuries recorded by the field medic.]

Analysis

The primary cause of this accident is listed as *"Unavoidable"* because it is possible that the victim was working as directed by his organization when the accident occurred. If the victim were working with his visor raised, that would represent a *"Field control inadequacy"* because his error was not corrected by his partner or his field supervisors.

The failure of the victim's thin (3mm) visor probably indicates that it had hardened with age and the failure to replace it was management's responsibility. The secondary cause is listed as *"Inadequate equipment"*.

The difference between the initial injury report and the investigator's findings is profound - leading one to wonder whether the investigators took so long to conduct their inquiry (their report was stamped 1st February 1999 - almost six months later) that the demining group decided to make light of the accident by pretending that the victim (who's injuries were minor) had not been injured at all. It seems unlikely that he would have been taken to the ICRC hospital if he had not been injured.

Whether or not the demining group decided to make light of the injuries, it seems that the accident investigators may have suppressed parts of the available information in order to make an argument supporting the use of visors and frag-jackets. They ignored the initial report of injury, made little of the shattered visor, and failed to get the field doctor's report translated. These do not promote confidence in their objective assessment of the accident.

Related papers

Sketch maps of the accident site were included in the accident file.

A photograph of the victim's visor showed it in four pieces. It is possible that these caused his forehead laceration.

Documents were not made available for copying.