DDAS Accident Report

Accident details

Report date:	18/05/2006	**Accident number:**	252
Accident time:	09:35	**Accident Date:**	15/10/1998
Where it occurred:	Bala Deh, Kandahar city	**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 residential/urban
Date record created:	18/02/2004	**Date last modified:**	18/02/2004
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 training (?)

long handtool may have reduced injury (?)

squatting/kneeling to excavate (?)

use of pick (?)

Accident report

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

At the time of the accident the demining team were using a one-man drill in a two-man team.

The victim had been a deminer for eight years. It was 43 days since his last leave and three months since his last revision course. The accident occurred in a residential area at the ridge of a hill and the ground was described as "hard".

The investigators determined that the victim was clearing a lane when he found a detector reading, marked it, and started to excavate with a pick. He hit the mine with the pick at 09:35 and sustained injuries to his hands and right shoulder.

The victim's visor and pick were damaged. He was treated at the site then taken to the ICRC hospital in Kandahar.

The Team Leader stated that the victim was not using the pick properly in the way that he was taught.

The Section Leader said that the ground was very hard but that in his opinion the method of using the pick that they have been taught is quite good.

The victim's partner said that the victim had been using the pick properly before the accident, but must have made a mistake when the accident happened.

The victim said that he was working properly. He stopped to put his helmet on before using the pick and it was the hardness of the ground that caused the accident. He was working carefully. He thought that "mentally relaxing" might reduce such accidents.

Conclusion

The investigators concluded that the deminer was ignorant of the rules prohibiting excavation with a pick and also that he either marked the detector reading badly or used the pick beyond the first marker. They identified poor field management as a contributory cause because the victim was allowed to use the pick.

Recommendations

The investigators recommend that all demining groups ensure that the pick is only used in accordance with the "relevant SOP which is expected to be released soon" and until that time it is not used at all. They added that Section Leaders should ensure that deminers centre detector readings properly.

Victim Report

Victim number: 326

Name: **Name removed**

Age:

Gender: Male

Status: deminer

Fit for work: yes

Compensation: not made available

Time to hospital: not recorded

Protection issued: Helmet
Thin, short visor

Protection used: Helmet, Thin, short visor

Summary of injuries:

INJURIES

minor Arms

minor Hands

minor Shoulder

COMMENT

See medical report.

Medical report

A medic's report included a sketch showing that the victim had peppered abrasions and fragments on both arms. His vital signs were recorded as pulse 100/min, BP 120/80, Respiration 18.

The field doctor recorded his injuries as superficial injuries to both hands and right shoulder and a right forearm laceration. He added that X-rays showed no fractures. The patient was to return to be checked after five days and be given three weeks rest.

The victim described his injuries after treatment as " left hand thumb which is not working properly and some injuries on my right hand".

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because it seems that the victim either failed to centre the detector reading adequately or carelessly used the pick closer to the reading than was necessary and his errors were not corrected.

The field managers were clearly unaware (in their statements) that the use of a pick was prohibited. They commented on the way they "had been trained" to use it. This lack of awareness indicates a lack of instruction that is a management failing. The secondary cause is listed as *“Inadequate training”*.

The use of the pick in Afghanistan was widespread and the wait for an approved SOP for its use had been very lengthy (in September 1999 it was known to be more than two years since a first draft was produced). A long delay during which the tool continues to be used without appropriate guidance implies a failure of management systems (it's continued use is illustrated in the accidents recorded).

The investigators failed to mention that the victim was not working in the prone position, presumably because the way they had been trained to use a pick was in a squatting/kneeling position (it cannot realistically be used when prone). The picture below shows an Afghan deminer of the period using a pick in a manner observed as typical.