DDAS Accident Report

Accident details

Report date:	22/01/2004	**Accident number:**	7
Accident time:	not recorded	**Accident Date:**	10/03/1998
Where it occurred:	Naghrak Village, Surkhroud District, Nangahar Province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Management/control inadequacy (?)
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:**	soft, wet
Date record created:	11/01/2004	**Date last modified:**	11/01/2004
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 metal-detector (?)

inconsistent statements (?)

long handtool may have reduced injury (?)

partner's failure to "control" (?)

standing to excavate (?)

use of shovel (?)

request for machine to assist (?)

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 available. The following summarises its content.

The victim had been a deminer for two years. It was 36 days since his last leave and less than two months since his last revision course. He was working in the ground around a power pylon described as "lawn, bamboo, bush and damp".

The photograph above shows the ground as grassy and soft/wet with no bamboo or bush. [The researcher photographed the pylon in March shortly after the event and before clearance had been completed]. The type of mine was identified from fragments found at the site.

The investigators determined that the victim used a "long handled shovel" while investigating a detector reading. He was digging by placing his foot on the shovel when the mine went off. The proximity to the power lines made the detectors signal continually in some places. The density of sub-surface roots made the demining group feel it was unsuitable for manual prodding.

The victim was treated at the site, then taken to hospital in Jalalabad, then on to hospital in Peshawar, Pakistan.

The Team Leader stated that the victim was prodding normally and his foot slipped over the mine as he made to recheck the reading with his detector.

The Section Leader stated that the deminer was "working properly".

The victim's partner made the same claim as the Team Leader.

The victim stated he was prodding when it happened.

Conclusion

The investigators concluded that the accident was caused by a combination of mis-management of the Regional MAC and Site office, a lack of understanding of the task's situation, and the carelessness of the victim. They found that the site was not suitable for manual clearance.

Recommendations

The investigators recommended that Site Officers/Operations Officers should "thoroughly study and understand the task conditions" to ensure that they allocate the right resources to the task [this was thought to have been a "back-hoe" job].

The investigators added that Team Leaders' opinions should be considered and that no team should be forced to clear an area which is not possible with their resources. Finally that said that command groups should not allow shovels to be used to investigate a reading and that the demining group "may" consider disciplining the site operations officer/liaison officer and the team command group for poor management skills.

Victim Report

Victim number: 17
Name: [Name removed]
Age:
Gender: Male
Status: deminer
Fit for work: presumed
Compensation: not made available
Time to hospital:
Protection issued: Helmet
Thin, short visor
Protection used: not recorded

Summary of injuries:

INJURIES

minor Body

severe Hearing

AMPUTATION/LOSS

Toes

COMMENT

See medical report.

Medical report

The victim's injuries were summarised as deafness of both ears, first three toes of left foot amputated + metacarpus severely injured and a blunt trauma in his abdomen.

The insurers were informed that the victim was in a mine accident and had suffered deafness, amputation of three toes and blunt abdominal trauma.

A photograph of the victim's left foot showed that the great-toe was missing and there was a partial severance of the foot about 4cm behind the toes, from the underside. [This is an injury consistent with the shovel blade being driven into the foot as the user stepped on it.] At that time the remaining four toes were present.

A medics report noted "trauma in the right hypochondre" and that the victim's pulse was 100/min, BP 130/85 and respiration 20/min. He had injury to "three metatars os practar….abdominal closed trauma… deafness symptoms in both ears".

No record of compensation was found in June 1998.

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because the field supervisors allowed the victim to work in a dangerous manner without correction. There was no convincing evidence of failure of management at regional level among the files.

Having visited the site and spoken with individuals involved, I find the suggestion that the site was overgrown and could not be prodded to be unfounded. The investigators called the site "damp" and it was "marshy" when I visited it. A back-hoe may well have been too heavy to deploy and proven entirely unsuitable.

The use of the shovel and a standing position to "excavate" were both 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 SOPs for local conditions, or enforce their own standards may be seen as a management failing.

Related papers

A sketch and photographs of the site were in the file in October 1999, along with some records of a dispute between the Regional MAC and the demining group about the method of demining suitable for the site. The Regional MAC office had made the site a priority because local people were using the area. The Regional office had no back-hoe available to deploy.

There was a dispute between the demining group and the head of the Regional MAC over whether this area was suitable for manual clearance. The Regional MAC was said to have insisted on manual clearance because it did not have access to a back-hoe, and because similar sites had been manually cleared.