# DDAS Accident Report

## Accident details

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| **Report date:** | 15/05/2006 | **Accident number:** | 102 |
| **Accident time:** | not recorded | **Accident Date:** | 15/05/1997 |
| **Where it occurred:** | Abdullah Jan Village, Zabul Province | **Country:** | Afghanistan |
| **Primary cause:** | Field control inadequacy (?) | **Secondary cause:** | Victim inattention (?) |
| **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 |
| **Date record created:** | 12/02/2004 | **Date last modified:** | 12/02/2004 |
| **No of victims:** | 1 | **No of documents:** | 2 |

## Map details

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| **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

long handtool may have reduced injury (?)

inadequate investigation (?)

partner's failure to "control" (?)

pressure to work quickly (?)

visor not worn or worn raised (?)

use of pick (?)

squatting/kneeling to excavate (?)

## 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 and a half years. It was six days since he last attended a revision course and 15 days since his last leave. The accident occurred on medium-hard agricultural land on a hillside.

The investigators determined that the victim was clearing the dry bed of a lake [this appears to conflict with "hillside"] and prodded to investigate an area that the dog had indicated. He used his detector then investigated the reading with a pick. The mine was identified as a PMN (from "found fragments"). The victim's pick handle and his visor were damaged. The victim walked out of mined area unaided.

**The Group Leader** said the victim was working properly, but was careless with the pick.

**The victim's partner** said that the victim was working properly but must have been careless.

**The victim** said that he was working properly with the pick, but was in too much of a hurry.

### Conclusion

The investigators concluded that the victim used the pick to prod the detector reading point having ignored proper marking procedures. They said that the victim was under pressure to increase productivity from the command group – and the command group failed to ensure the deminers were working to proper technical and safety procedures.

### Recommendations

The investigators recommended that no deminer should start prodding before marking the detector reading and that deminers must not be allowed to hurry and ignore safety procedures. They said that the use of the pick to investigate a detector reading point must be stopped and that the command group must ensure that proper procedures are followed. They recommended that the Team Leader and Section Leader should be disciplined for their "poor performance and control" and that all deminers should have a revision course on the proper use of the pick.

## Victim Report

**Victim number:** 135

**Name:** **Name removed**

**Age:**

**Gender:** Male

**Status:** deminer

**Fit for work:** presumed

**Compensation:** none on record

**Time to hospital:** not recorded

**Protection issued:** Helmet

Thin, short visor

**Protection used:** Helmet

**Summary of injuries:**

INJURIES

minor Abdomen

minor Arm

minor Chest

minor Face

minor Foot

minor Hands

minor Neck

minor Shoulder

COMMENT

See medical report.

## Medical report

The victim's injuries were summarised as superficial injuries to his chest, neck, ankle and left hand. The victim reported injury to his nose and shoulder as well. An accident report mentioned injuries to nose, neck, chest, abdomen and both hands.

A photograph showed nose, chest and upper left arm injuries.

The insurers were informed on 20th May 1997 that the victim had sustained injuries to his face, neck, chest, abdomen and both hands.

No record of compensation was found on file.

## Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because the victim was working incautiously and under pressure to hurry. His field supervisors appear to have encouraged bad practice. The secondary cause is listed as *"Victim inattention"* because it seems that he flustered and not thinking clearly.

His facial injury indicates that his visor was worn raised.

The use of a pick and a squatting 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 the SOPs for local conditions, or enforce their own standards may be seen as a 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 UN MAC issued a letter in which it decreed that the use of the pick should be stopped until an SOP for its use has been approved. Also that the Group and Assistant Group Leaders involved in this accident should be disciplined for poor performance of their duties.