DDAS Accident Report

Accident details

Report date:	17/05/2006	**Accident number:**	157
Accident time:	not recorded	**Accident Date:**	05/08/1997
Where it occurred:	Darah Village, Gardiz, Paktia Province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Field control inadequacy (?)
Class:	Excavation accident	**Date of main report:**	[No date recorded]
ID original source:	none	**Name of source:**	APA/UNOCHA
Organisation:	Name removed		
Mine/device:	PMN AP blast	**Ground condition:**	agricultural (abandoned) bushes/scrub hard
Date record created:	14/02/2004	**Date last modified:**	14/02/2004
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 investigation (?)

handtool may have increased injury (?)

inconsistent statements (?)

partner's failure to "control" (?)

vegetation clearance problem (?)

squatting/kneeling to excavate (?)

visor not worn or worn raised (?)

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 briefly available. The following summarises its content.

The victim was said to have been a deminer since 24th July 1997 (12 days), although he was also said to have completed a revision course one month previously, and to have worked 37 days since his last leave. The ground conditions where the accident occurred were described as “medium hard” agricultural land beside a small stream. A photograph showed hard ground with low and sparse 18" bushes that had been cut as clearing progressed [they would have hampered detector-use if not cut]. The device involved was identified as a PMN from "found fragments".

The investigators determined that the victim was working in a “small garden”. His detector registered a signal and he prodded and located a fragment. He checked the area with the detector and it signalled again, so he prodded the same area and the mine initiated. The deminer's helmet and bayonet prodder were "destroyed". A photograph showed that the visor has been torn from the helmet on one side.

The Team Leader stated that the deminer was careless because he did not remark the signal after finding the first fragment. He said ground softening and/or magnets to remove fragments would make the job safer.

The Assistant Team Leader said that the victim remarked the signal before prodding a second time and was not at fault. He said that such accidents could be prevented by reducing working hours.

The Section Leader said that the victim was working properly and was prodding in a "half-prone" [squatting] position. He added that such accidents could be avoided by cutting the working day from 6 to 4 hours and each mission should not last more than 45 days.

The victim's partner said that the victim was working properly. He blamed the many fragments in the minefield for the accident and suggested reduced working hours and mission length might increase safety.

The victim said that he was working properly, although his visor might have been raised. He said the accident was caused because there were many fragments and the proximity of bushes made it difficult to be precise with the detector.

Conclusion

The investigator's concluded that the victim mistakenly believed the second reading to be another fragment and ignored the need to use markers, then prodded carelessly. Also, he failed to maintain the correct prodding angle while in the squatting position and did not wear his helmet properly and so received eye and face injuries.

Recommendations

The investigators recommended that all detector reading points must be marked after rechecking and before starting to prod. They added that all deminers must wear their helmets properly while prodding, and that disciplinary action should be taken against the Section Leader because of his poor command and control.

Victim Report

Victim number:	201	**Name:**	**Name removed**
Age:		**Gender:**	Male
Status:	deminer	**Fit for work:**	no
Compensation:	500,000 Rs (100%)	**Time to hospital:**	not recorded
Protection issued:	Helmet Thin, short visor	**Protection used:**	Helmet

Summary of injuries:

INJURIES

minor Face

minor Leg

minor Shoulder

severe Eyes

severe Hand

AMPUTATION/LOSS

Eye

COMMENT

See medical report.

Medical report

The victim's injuries were summarised as serious injuries to his eyes and face, and minor injuries to his shoulder and right leg.

A photograph showed both shoulders bandaged.

A medic's sketch showed burns, abrasions and lacerations on the face, abrasions to both shoulders and to his lower right leg.

The demining group reported that the victim had suffered lacerations to his right eye, facial injury to upper lip and nose, multiple injuries to his right shoulder, arm, axilla and right thumb, and penetrating wounds to his left shoulder, arm and left leg.

On 23rd December 1997 they reported that his left eye had reduced vision, his right eye had been lost and he had lacerations to his face, left shoulder, right leg and right shoulder. 30% disability was assessed on 4th December 1997 for the loss of his fingers and lacerations to his face and body. His visual disability was assessed at 90% on 2nd December 1997. His hearing loss was assessed at 50% on 8th December 1997.

Compensation of 500,000 Rs (maximum payable) was made on 16th March 1998.

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because the victim was working improperly (visor raised) and his error was not corrected. Other errors may have been similarly uncorrected.

It is possible that the victim did not wear the visor correctly because it was too damaged to see through properly (as was seen frequently during field visits in 1998, 99), in which case the management's failure to provide useable equipment may represent a serious management failing.

The use of a squatting position to "excavate" was 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 SOP for local conditions, or enforce their own standards may be seen as a further 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.