

DDAS Accident Report

Accident details

Report date: 24/01/2004	Accident number: 92
Accident time: not recorded	Accident Date: 04/06/1997
Where it occurred: Arzu Village, Ghazni Province	Country: Afghanistan
Primary cause: Field control inadequacy (?)	Secondary cause: Inadequate equipment (?)
Class: Survey 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
Date record created: 24/01/2004	Date last modified: 24/01/2004
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 communications (?)
inadequate training (?)
inconsistent statements (?)
inadequate investigation (?)
long handtool may have reduced injury (?)
squatting/kneeling to excavate (?)
use of shovel (?)

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 had been a deminer for five years. The victim was a member of a survey team. It was one month since he last attended a revision course and 29 days since his last leave. The ground where the accident occurred was described as soft agricultural land. A photograph showed a relatively deep and steep sided hole where the device (identified as a PMN without explanation) detonated. The team did not have a Codan Radio, so report of the accident was delayed for 90 minutes.

The investigators decided that the accident occurred because the victim ignored technical safety procedures and used a shovel for investigation and prodding purposes. He applied too much pressure on the device and "caused the explosion".

The victim's partner said that the victim was prodding and doing his job properly.

The victim stated he was prodding properly in the prone position when the accident happened.

Conclusion

The investigators concluded that the accident was caused by the victim's "ignorance" of correct technical procedure. His claim that he was prodding with a bayonet was dismissed because he sustained only very minor injuries to both hands, his bayonet was undamaged and there was evidence of shovel excavation in the same lane.

Recommendations

The investigators recommended that the reading point should be marked properly prior to prodding; that use of a shovel to investigate a reading point must be stopped; and that the acting Team Leader should be disciplined for poor performance and poor control.

Victim Report

Victim number: 123	Name: [Name removed]
Age:	Gender: Male
Status: surveyor	Fit for work: yes
Compensation: none on record	Time to hospital: not recorded
Protection issued: Helmet	Protection used: not recorded
Thin, short visor	

Summary of injuries:

INJURIES

minor Hands

minor Hearing

COMMENT

See medical report.

Medical report

The victim's injuries were summarised as: burst ear drums and superficial fragments/abrasion injury to hands.

A photograph showed only the right hand bandaged. The left was visible and no injury apparent.

The "burst" ear drums did not prevent a return to work on the same day, so is presumed to have been exaggerated.

Analysis

The primary cause of this accident is listed as a "*Field control inadequacy*" because the victim was using an inappropriate tool to investigate a reading and his error was not corrected. The secondary cause is listed as "*Inadequate equipment*".

Management's failure to address the problem of witnesses lying to the investigators represents a serious failure of management. It is a further failure that the group's lack of a radio was not addressed by the investigators and their deployment without radio contact was not criticised.

The victim's working position is inferred from the fact that using a shovel in a prone position is most unlikely.

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 fact that the victim was part of a "survey team" and was engaged in manual demining illustrates the wide variation in activities that fall under the heading "Survey" in various parts of the world.

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.