DDAS Accident Report

Accident details

Report date:	19/04/2006	**Accident number:**	95
Accident time:	not recorded	**Accident Date:**	31/05/1997
Where it occurred:	Ibrahim Khail Village, Gardiz City, Paktia Province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Unavoidable (?)
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:**	agricultural (abandoned) ditch/channel/trench hard
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 metal-detector (?)

handtool may have increased injury (?)

partner's failure to "control" (?)

inadequate investigation (?)

request for clearance with explosive charge (?)

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 briefly available. The following summarises its content.

The victim had been a deminer for three years. He had last attended a revision course two months before and had last been on leave 41 days before the accident. The ground in the area was described as agricultural land – medium hard – a connection ditch near an abandoned military post. A photograph showed that the "ditch" had shallow sloping sides and the accident occurred at the bottom of it – where the mine may have been deeply buried. The sides of the detonation crater were steep and deep.

The investigators determined that the victim did not centralise the reading point from his detector and "did not follow the marking procedures properly". He prodded while in a squatting position. They noted that the device was identified as a PMN (from "found fragments") and that the victim's helmet and bayonet were "destroyed".

The Team Leader said that the victim believed the reading was from a fragment and so did not mark the reading properly so the accident was his mistake. He suggested readings be investigated with an explosive charge in future.

The Section Leader said that the victim was working properly up to the accident, but then made a mistake and hit the mine. He said such accidents could be prevented if deminers worked according to the rules and obeyed their superiors.

The victim's partner said that he was working properly but the mine was too deep to allow him to centralise the reading. He said that in similar areas readings should be investigated by detonating explosives.

Conclusion

The investigators concluded that the accident occurred because the victim did not follow the rules. He failed to mark the position of the detector reading properly and so prodded directly onto the mine.

Recommendations

The investigators recommended that no deminer should be allowed to prod in the squatting position when the ground was suitable for prodding prone; that the team Command Group should stress to deminers the need to follow mine marking procedures properly; and that the Section leader should be disciplined for his poor command and control.

Victim Report

Victim number: 127

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: elmet, Thin, short visor

Summary of injuries:

INJURIES

minor Hand

minor Legs

minor Neck

minor Shoulder

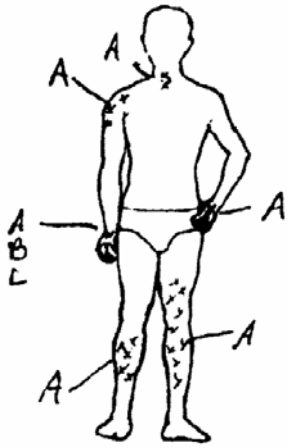
severe Hand

COMMENT

See medical report.

Medical report

The victim's injuries were summarised as deep lacerations on his right hand, both legs, chin and right shoulder.



A medic's sketch (reproduced above) showed abrasions to his neck, right shoulder, lower right leg, lower and upper left leg and left hand, also abrasions, burns and lacerations to his left hand.

A photograph showed deep lacerations between the thumb and forefinger of his right hand, some burn discoloration on thumb and forefinger, and a bandaged forearm and shoulder.

The demining group submitted a claim on 22nd September 1997 but did not list the injuries.

Compensation of 500,000 Rs (100%) was forwarded on 4th December 1997.

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because the victim appears to have been breaking SOPs by not marking his detector reading appropriately and his error went uncorrected. However it is possible that he was working as directed, so the secondary cause is listed as *"Unavoidable"*.

From the injuries listed, it is assumed that he was wearing his visor and that his eyes were not injured. However, the compensation for 100% disability conflicts with the injuries listed, implying that some may not have been recorded.

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 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.