DDAS Accident Report

Accident details

Report date:	15/05/2006	**Accident number:**	114
Accident time:	not recorded	**Accident Date:**	04/01/1997
Where it occurred:	Ward 3, Kandahar city	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Inadequate equipment (?)
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) hard
Date record created:	12/02/2004	**Date last modified:**	12/02/2004
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 (?)

request for better PPE (?)

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 had been a deminer for four years. It was three months since he attended a revision course and 22 days since his last leave. The ground in the area was described as agricultural, uneven and hard, used for growing bamboo. A photograph showed that the bamboo was short and thin, like straw, and had been cleared up to the site of the accident.

The investigators determined that the victim was squatting to prod with a bayonet and applied too much pressure. He used the presence of bamboo to explain why he squatted to prod. The mine was identified as a PMN from "found fragments". His visor was shattered in the accident and his bayonet was "lost".

The team Sub-commander said the victim was squatting to prod and was working properly. The mine was in a "changed" position, which is why it went off.

The Section Leader said that the victim was prodding in a prone position and that the position of the mine was "changed" which is why the accident occurred.

The victim's partner said he was working properly, lying prone to prod.

Conclusion

The investigators concluded that the victim did not use the proper three marks procedure. They decided that he was using the helmet and visor properly but due to the poor quality of the visor it shattered during the accident.

Recommendations

The investigators recommended that the type of visor be replaced as soon as possible to protect against severe eye injury. Also that Section Leaders should stress the need to use the proper marking procedure to deminers.

Victim Report

Victim number: 148
Name: **Name removed**
Age:
Gender: Male
Status: deminer
Fit for work: not known
Compensation: 325,000 Rs (65%)
Time to hospital: not recorded
Protection issued: Helmet
Thin, short visor
Protection used: Helmet

Summary of injuries:

INJURIES

minor Body

minor Chest

minor Face

minor Hand

minor Legs

severe Eyes

severe Hand

COMMENT

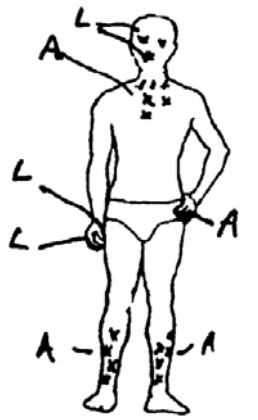
See medical report.

Medical report

The victim's injuries were summarised as injuries to his eyes, face, upper part of chest, feet and hand. A medic's report indicated serious injury to both eyes, minor injuries on lips, minor injuries on fingers of both hands, minor injuries on his chest and superficial thorax injury: left eye ocular damage; right eyebrow injury, and abrasion of his nose.

A photograph showed the deminer's face, severely abraded around nose and mouth.

A medic's sketch (reproduced below) indicated a forehead laceration and extensive abrasions to both shins.



The demining group submitted a disability claim on 10th March 1997 listing the injuries as: injury to face, both eyes, multiple laceration of right hand, fracture of right ring finger. On 10th March 1997 they said that the left eye had been permanently blinded (assessed at 50% disability), and that he still had stiffness of his right thumb (assessed at 15% disability).

No record of a compensation payment was found (the sum payable was calculated at 65%).

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because the victim was working improperly and his errors were not corrected. The failure of the visor implies a twisting force applied on brittle plastic. This indicates that it was raised. Its inadequacy in terms of thickness (3mm) and age (age unknown and records not kept) make it likely that it had UV hardened and become brittle. The failure to provide appropriate protective equipment represents a serious management failing. The secondary cause is listed as *"Inadequate equipment"*.

It is also possible that the visor was too damaged to see through properly (as was seen frequently during 1998), and was worn raised for this reason. If so, the failure to provide useable equipment may represent a further management failing.

Squatting 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 failure of management.

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.