DDAS Accident Report

Accident details

Report date:	15/05/2006	**Accident number:**	123
Accident time:	11:15	**Accident Date:**	25/05/1998
Where it occurred:	Boundozi	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Inadequate training (?)
Class:	Excavation accident	**Date of main report:**	[No date recorded]
ID original source:	none	**Name of source:**	MAPA/UNOCHA
Organisation:	Name removed		
Mine/device:	P2Mk2 P4Mk1 AP blast	**Ground condition:**	agricultural (abandoned) hard
Date record created:	12/02/2004	**Date last modified:**	08/07/2005
No of victims:	1	**No of documents:**	2

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 (?)

inadequate metal-detector (?)

inadequate training (?)

long handtool may have reduced injury (?)

partner's failure to "control" (?)

squatting/kneeling to excavate (?)

use of pick (?)

visor not worn or worn raised (?)

safety distances ignored (?)

Accident report

An investigation on behalf of the UN MAC was carried out and its report made briefly available in October 1999. The following summarises its content.

At the time of the accident the demining team were using a one-man drill in a two-man team.

The victim had been a deminer for eight years. It was 14 days since his last leave and five months since his last revision course. The accident occurred in an agricultural area and the ground was described as "hard".

The investigators determined that the victim was working normally and registered a detector reading, so marked the spot and began prodding towards it. Before he reached the marked point an undetected mine detonated at 11:15. They found that he was working in a squatting position without wearing his helmet. They also found that he "ignored" correct prodding procedure and so applied pressure directly onto the pressure plate of the mine.

The Team Leader stated that the victim was working properly and that the accident was caused by poor survey not identifying the kind of mine present.

The Section Leader said that the victim was working properly and the task should have been allocated to a mine-dog team.

The victim's partner was ten metres away and said that he was working properly and the accident was unpreventable.

The victim was not interviewed by the investigators.

Conclusion

The investigators determined that the victim prodded at the wrong angle and so detonated the mine. He was in breach of safety procedures because he was squatting and not wearing a helmet.

Recommendations

The investigators recommended that survey teams gather information about mine types accurately, that Team Leaders ensure that deminers lie prone and prod at the right angle while wearing helmets. They recommended that the Section Leader in this case should be disciplined and that Team Leaders should always try to identify the mine type involved in an accident. [The victim identified the mine himself in a later interview – see Related papers.]

Victim Report

Victim number: 159

Name: **Name removed**

Age:

Gender: Male

Status: deminer

Fit for work: yes

Compensation: not made available

Time to hospital: ot recorded

Protection issued: Helmet
Thin, short visor

Protection used: none

Summary of injuries:

INJURIES

minor Eyes

minor Face

minor Neck

COMMENT

See medical report.

Medical report

An initial accident summarised the victim's injuries as "multiple wounds face and foreign bodies both eyes and deep injuries shoulder and neck".

The victim described his own injuries as "superficial facial injuries, one fragment in his shoulder, and shock".

He spent two weeks in hospital, then returned to work.

In July 1998, he had no facial scarring or sight-loss when interviewed by the researcher.

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because the victim was workout a visor and was not corrected.

The field supervisors in this accident appear to have been unaware that it was against the rules to wear no helmet and visor or to work squatting, which implies that their training may have been inadequate. The secondary cause is listed as *"Inadequate training"*. The investigators remained unaware that the victim was using a pick. Their harsh criticism of field inefficiencies must be seen in the context of their inquiry not being made for three months after the accident. The researcher's own informal inquiry uncovered more than their own. It may be understandable that the deminers appear to have deliberately misled them.

The use of the pick and a squatting/kneeling 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 SOPs for local conditions, or enforce their own standards may be seen as a management failing.

It is possible that the visor was too damaged to see through properly (as was seen frequently during 1998, 1999), in which case the failure to provide useable equipment may represent a further management failing.

In 1999, the manager of the UN MAC wanted to add the comment that Afghanis were reluctant “to take responsibility for their own action” and supervisors were reluctant to "criticise"/correct their subordinates. He added that these were “cultural issues…not easily overcome”.

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.

Related papers

The file included maps of the site and photographs showing a hard hillside with patches of scrubby grass.

The victim was interviewed in the field (working again after a few weeks) and said he had been a deminer for eight years. The accident occurred while he was excavating a detector reading in a semi-prone position (both knees were on the ground). He got a detector reading (using a “Phillips” detector) and marked the reading with three stones.

He started working from the closest stone to the middle stone with a pick and when he reached the middle marker there was a P2 Mk2(/1) mine under the marker.

The victim said that the “Philips” detector was not capable of detecting this mine [“Philips” is an Afghan synonym for the Schiebel.] When asked how he knew it was this mine, the victim said that others were found later and since the blast was too small for other mines, it was decided that he had “picked” onto one of these.

The photograph above shows him recreating the position he was in relative to the mine when the accident occurred.

The victim said that he wore his visor, but partly raised.