DDAS Accident Report

Accident details

Report date:	17/05/2006	**Accident number:**	152
Accident time:	not recorded	**Accident Date:**	14/08/1997
Where it occurred:	Bahlol Village, Ghazni 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:**	MAPA/UNOCHA
Organisation:	Name removed		
Mine/device:	PMN AP blast	**Ground condition:**	grass/grazing area hard
Date record created:	13/02/2004	**Date last modified:**	13/02/2004
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 (?)

inconsistent statements (?)

partner's failure to "control" (?)

squatting/kneeling to excavate (?)

visor not worn or worn raised (?)

request for long handtool (?)

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. He had last attended a revision course four months before and had last been on leave 21 days before the accident. The ground at the accident site was described as grazing land with “medium hard” ground on a steep slope. The demining group claimed to have found fragments of the device identifying it as a PMN.

The investigators determined that the victim was clearing a breaching lane. He got a detector reading, marked it with a single stone, and began to prod in a squatting position. During prodding he initiated the mine. The victim was wearing a helmet and visor.

The Section Leader stated that the deminer was working properly *in a prone position* when the accident occurred: then argued that the use of a pick in such circumstances would lower risk.

The Team Leader said the deminer marked the detector signal wrongly and then prodded incorrectly, but also said it would be safer to use a pick.

The deminer's partner also stated that the deminer had been working properly apart from applying too much pressure with his prod.

Conclusion

The investigators concluded that the deminer ignored proper marking procedure (three rocks), prodded in a squatting position and prodded on to the top of the mine.

Recommendations

The investigators recommended that Team Leaders and Section Leaders should ensure that all deminers prod in accordance with approved procedures, that all deminers should be told to follow marking procedures properly, and that Section Leaders must be told to ensure that deminers prod in the prone position when possible.

Victim Report

Victim number: 195

Name: **Name removed**

Age:

Gender: Male

Status: deminer

Fit for work: not known

Compensation: 100,000 Rs

Time to hospital: not recorded

Protection issued: Helmet
Thin, short visor

Protection used: Helmet, raised visor

Summary of injuries:

INJURIES

minor Eye

minor Genitals

minor Hands

severe Hearing

COMMENT

See medical report.

Medical report

The victim's injuries were summarised as minor injuries to his right hand and left eye.

The demining group reported the injuries as injury to his right eye, left hand, "head trauma and ear bleeding", right ear deafness, injury to genitals – "painful testes".

A disability claim was submitted on 30th December 1997 saying that the victim had seen an ENT, a psychiatric and an eye specialist. His hearing loss was assessed at 20% on 30th November 1997. Psychiatric medication was advised on 18th November 1997. No eye injury assessment was included.

A compensation payment of 100,000 Rs was made on 25th March 1998.

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because the victim was working with his visor raised (allowing eye injury) and his error was not corrected.

The victim suffered remarkably low injuries unless he was well back from the blast, so it looks as though he did not prod directly down onto the mine. He may have been approaching it at the right angle and clipped the side of the pressure plate. For this reason the primary cause of this accident would have been listed as unavoidable if he had been wearing his visor properly.

It is highly unlikely that the victim could have sustained any genital injury had he been lying down, so the investigator's view that he was squatting seems most credible. The lies told by the field supervisors are apparent in their statements.

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 UN MAC's failure to issue SOPs for the use of a pick or to ensure the tool's withdrawal from the toolbag if it was not to be used, represents a further management failing

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), in which case the management's failure to provide useable equipment may have been responsible for the injury.

The victim's severe deafness is common in Afghan claims from this period, when insurance favoured such injury and it was difficult to test the validity of hearing-loss claims.

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.