DDAS Accident Report

Accident details

Report date:	18/05/2006	**Accident number:**	241
Accident time:	not recorded	**Accident Date:**	06/08/1998
Where it occurred:	Qualat (Zabul), Garmab	**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 metal fragments
Date record created:	17/02/2004	**Date last modified:**	17/02/2004
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 metal-detector (?)

inconsistent statements (?)

partner's failure to "control" (?)

request for long handtool (?)

squatting/kneeling to excavate (?)

visor not worn or worn raised (?)

Accident report

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

At the time of the accident the demining group was using a one-man drill and two-man teams.

The victim had been a deminer for seven years. He had last been on leave 13 days before and last attended a revision course five months before. The accident occurred on ground described as grazing land in "medium condition". The mine was identified from pieces found at the site.

The investigators decided that the victim was working with a detector when he got a signal from a fragment that was visible, half buried. He squatted to remove it with his bayonet but as he did so initiated a mine that was under the fragment. His visor "was not properly down" and he failed to centre the reading point and approach it at the angle dictated by the SOPs. The victim suffered injuries to his hands and his face, the latter including a lacerated lip and damaged teeth. The victim walked to the safe area.

The victim's visor and bayonet were damaged.

He was treated on site and taken to the ICRC hospital in Kandahar.

The Team Leader said that the deminer was careless when the accident occurred but had found six mines over the last few days and was a good deminer. He suggested that such incidents could be avoided by allowing the use of a pick, by bolting visors in a down position and by persuaded deminers to apply procedures.

The Section Leader said that the victim was working properly with his visor down when the accident occurred. The victim prodded too close to the reading which caused the accident.

The victim said he was prodding with a bayonet when the accident occurred and may have used it at the wrong angle. He claimed to have placed markers as required. He said that such incidents could be prevented if a pick was used instead, that detectors should work properly, and that the reading was investigated in a prone position.

Conclusion

The investigators concluded that the victim prodded in a squatting position at the wrong angle at the centre of a detector reading without lowering his visor.

Recommendations

The investigators recommended that deminers should treat all readings as a mine, prodding should always be done prone, that even visible fragments should be prodded using proper procedures and that supervisors should ensure that procedures are properly adhered to "especially prodding when a small mistake could be the last one".

Photocopies of photographs of the damaged visor and bayonet were not clear. The bayonet handle was broken but may not have shattered. The visor face did not appear badly damaged.

Victim Report

Victim number: 314

Name: **Name removed**

Age:

Gender: Male

Status: deminer

Fit for work: not known

Compensation: not made available

Time to hospital: not recorded

Protection issued: Helmet

Thin, short visor

Protection used: helmet

Summary of injuries:

INJURIES

minor Chest

minor Hand

severe Eyes

severe Face

COMMENT

See medical report.

Medical report

An initial casualty report recorded the injuries as:

"Both eye injury and mult small wounds on the face and chest and laceration of lower lip. Semicomatose."

The field report and medic's sketch did not include details of injuries.

The field doctor described the injuries as: "both eye injuries. Face injury. Multiple injury on chest. Injury on index finger".

The victim reported injuries on his face, right hand and "lap".

A photocopy of a photograph of the victim in the file provided no detail at all.

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because the victim was not wearing his visor properly from which I infer that he was inadequately supervised. Neither his "controlling" partner not the Team Leader told him to lower his visor.

It is also 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 protective equipment represents a management failing.

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 SOPs for local conditions, or enforce their own standards may be seen as a further management failing.