DDAS Accident Report

Accident details

Report date:	18/05/2006	**Accident number:**	242
Accident time:	not recorded	**Accident Date:**	06/08/1998
Where it occurred:	Shorandam, Naquillind Kalli	**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:**	grass/grazing area hard metal fragments
Date record created:	17/02/2004	**Date last modified:**	17/02/2004
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

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 18 months. He had last been on leave 14 days before and last attended a revision course four days before. The accident occurred on ground

described as "grazing and residential" land in "medium hard" condition. The mine was identified from pieces found at the site.

The investigators decided that the victim was working with a detector beside a stream when he got a signal. He marked it with two marks, one at the centre and one 15cm behind it, then he squatted to prod with his bayonet. He detonated a mine and received injuries to his face and chest.

The victim's bayonet was lost and his visor damaged.

The victim was taken to the ICRC hospital in Kandahar and from there to hospital in Quetta, Pakistan.

The Team Leader said that the two-mark rule was newly introduced and the victim was unfamiliar with it, which may have contributed to his mistake.

The Section Leader also blamed the revised marking procedure, along with the presence of many large fragments in the area.

Conclusion

The investigators decided that the two-mark procedure was unsafe and that the Section Leader showed poor control by not correcting the victim's error.

Recommendations

The investigators recommended that the two-mark procedure should be "stopped" immediately, that prodding should be carried out prone (to avoid chest injury) and that the Section Leader should be disciplined.

Victim Report

Victim number: 315
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 Arms

minor Chest

minor Hand

minor Legs

severe Eyes

severe Face

COMMENT: See medical report.

Medical report

The initial casualty report recorded the victim's injuries as:

"Both eye injury face and all of body and lower and upper members have multiple wounds." His condition was described as "a little poor".

The mine accident report included a sketch showing the deminer with lacerations on his thighs, forearms, top of chest and face and eyes.

The Field doctor described the injuries as: "mild injury of face and nose and mouth. Injury of eyes. Mild injury of thorax".

A photograph showed the victim with dressings on the fingers and thumb of his right hand and over his eyes. The superficial upper chest lacerations were not dressed.

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 it can be inferred that he was inadequately supervised.

The fact that the thin (3mm) visor snapped indicates that it was brittle and was either not polycarbonate or had hardened through prolonged UV exposure. Its issue despite its condition may be seen as a management failing. The secondary cause is listed as *"Inadequate equipment"*.

The accident report was annotated by the then Regional Manager of the area (an ex-pat Technical Advisor) who wrote "Yes!!!!" beside the recommendation to work prone to avoid chest injury - presumably without checking the photograph or medical report to see how light the chest injury was. That individual's known bias towards using the prone position for prodding may explain why the investigators stressed that failing in this and other incidents occurring in that region around that time.

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.

Related papers

A letter from the UN MAC pointed out that the injuries implied that the victim was squatting to excavate. [It did not mention the implication that the visor was not down.] It asked that the supervisors be disciplined.

The accident file included a map of the site. There were also poor photocopies of photographs showing the site and the victim's visor, which had snapped laterally a few centimetres from the top.

Documents were not made available for copying.