DDAS Accident Report

Accident details

Report date:	18/05/2006	**Accident number:**	251
Accident time:	08:45	**Accident Date:**	11/10/1998
Where it occurred:	Zaacar-I, Sharif, Kandahar	**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) building rubble ditch/channel/trench hard metal scrap
Date record created:	18/02/2004	**Date last modified:**	18/02/2004
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

inadequate equipment (?)

partner's failure to "control" (?)

request for machine to assist (?)

use of pick (?)

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.

The victim had been a deminer for eight years. He had last been on leave five days before and had last attended a revision course two months before the accident. The accident occurred in a garden described as "agricultural land" that was "medium hard". The mine was identified from fragments found at the site.

The investigators determined that the victim and his partner were clearing a lane into the edge of a canal that was partly filled by a collapsed wall. There was a sheet of metal partly buried in the canal so the victim started to clear the earth away from it with a pick "layer by layer". At 08:45 he detonated a mine with the pick and sustained injuries to his eyes and hands.

The victim's visor and pick were reported to have been "damaged".

The Team Leader said that the victim was wearing a fragmentation jacket and working properly prior to the accident. He thought that such tasks should be cleared with back-hoes.

The Acting Section Leader said that the victim was working properly and that back-hoes should be used where mines are deeply buried and the ground contaminated with scrap metal.

The victim said that he was working properly but the existence of metal in the canal and the hardness of the ground caused the accident. He also thought that back-hoes should be used at those sites.

Conclusion

The investigators determined that the victim ignored technical procedures and used the pick in an unauthorised manner and so caused the accident himself.

Recommendations

The investigators recommended that all readings be treated as mines, and that obstructions like the sheet of metal should have been pulled from a safe distance. They stressed the need for supervision in difficult areas and recommended that the back-hoe be used for canal clearance.

Victim Report

Victim number: 325

Name: Name removed

Age:

Gender: Male

Status: deminer

Fit for work: not known

Compensation: not made available

Time to hospital: not recorded

Protection issued: Frag jacket
Helmet
Thin, short visor

Protection used: Frag jacket, Helmet

Summary of injuries:

minor Arms

minor Hands

severe Eyes

COMMENT

See medical report.

Medical report

The victim's injuries were listed in the medic's report as: "both hands superficial. Injuries both eyes foreign bodies".

The medic's report included a sketch showing fragment injuries along the length of both arms and on the face.

The field doctor recorded the victim's injuries as: superficial injuries to both arms and hands. Both eyes foreign bodies. Right ear deafness.

The victim was treated at the ICRC hospital in Kandahar and taken to a local ENT specialist after clinical removal of foreign bodies from eyes.

Photographs of the victim showed both hands heavily bandaged.

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because the victim wore his visor raised and this error was not corrected, which implies that field supervision (by his partner or the Team Leader) was lacking.

The victim's eye injuries indicate that his visor was not worn down. It's shattered state shows how it was in an old and unserviceable condition. If he could not wear his visor down because it was impossible to see through (as many visors in the theatre are known to have been (1998, 1999) that would represent a serious management failing. The secondary cause is listed as *“Inadequate equipment”*.

Related papers

A follow up letter from the UN MAC stated that the task was better suited to mechanical clearance, that the deminer was using unsafe equipment, and that he had failed to try to move a large metal obstruction in his way. The letter laid most of the blame on the victim, and some on the field supervisors.

The file included maps of the accident site and a photograph of a visor that had cracked in two in an irregular line from top to bottom. The visor showed extensive light scratching (old) and appeared yellow with age. The broken pick was included in the picture.

A photograph of uneven, pitted ground at the side of a ditch with water in it showed the accident site. The land had no vegetation cover at all. It is not known how long after the accident the investigation took place and the photographs were taken.

Documents were not made available for copying.