

DDAS Accident Report

Accident details

Report date: 29/07/2006	Accident number: 425
Accident time: Not recorded	Accident Date: 03/09/2004
Where it occurred: Not made available	Country: Afghanistan
Primary cause: Management/control inadequacy (?)	Secondary cause: Inadequate training (?)
Class: Excavation accident	Date of main report: 04/09/2004
ID original source: [Name removed]	Name of source: [Name removed]
Organisation: [Name removed]	
Mine/device: PMN AP blast	Ground condition: not recorded
Date record created: 29/07/2006	Date last modified: 29/07/2006
No of victims: 1	No of documents: 1

Map details

Longitude:	Latitude:
Alt. coord. system: Not recorded	Coordinates fixed by:
Map east:	Map north:
Map scale:	Map series:
Map edition:	Map sheet:
Map name:	

Accident Notes

inadequate investigation (?)

inadequate training (?)

visor not worn or worn raised (?)

inadequate equipment (?)

No independent investigation available (?)

Accident report

This accident involved deminers from a group that have formally decided not to make accident data available to the Humanitarian Demining community. A summarised accident report was made available the day after it occurred - in support of an argument about the need for visors made by the demining group Director.

The following is that summarised report, edited for anonymity.

Sent: Sunday, September 04, 2005 3:26 PM
Subject: Mining accident -3rd Sept 2005

Please find below a brief summary of the accident yesterday.

[Name excised] and [name excised] will be sending you a very detailed report in the next few days. After seeing the site and the deminer I am going to ask him to buy my lottery ticket in the future!!. He was extremely lucky. He detonated an M4 mine 200g HE less than arms length away. He sustained a broken thumb and lacerations of his first two fingers and his face was badly bruised due to the visor hitting him due to the blast effect. (See pictures).

Points

- [Name excised] happy with the professional nature of the deminers work (old excavation signal holes in lane)
- The deminer was wearing his PPE equipment correctly
- The Casevac worked like clockwork line in within three minutes and doctor present.

[Name excised] is certain that the M4 MUV fuse was positioned away from the deminer. Remnants of the fuse body and striker were found on the back wall of the blast crater. If fuse was facing deminer then shrapnel would be present on / in the deminer.



Regarding the visor (see picture) it is a timely reminder due to the email from [name excised]. The visor has absorbed and deflected the blast away from the face. You can see small fragments (Black) around the mouth area and if felt the area has been reduced by 1 to 2 mm in depth. If he had not been wearing it the blast would have hit him squarely in the face and mouth causing massive damage. I am no medic but I don't think I would have been interviewing him this morning!

Hope this gives you an overview and detailed report and statements to follow.

[Name excised]

[No detailed report was made available. The visor damage shown in the photograph above appears to be very light. The (demining group) measurement of damage is hard to follow and meaningless without knowing how the measurement was made.

Further information can be inferred from the photograph of the victim below.



The photograph appears to show a damaged nose, lips and chin. [The eyes have been blacked out to preserve anonymity: they are apparently undamaged.]



The 5mm polycarbonate visor cannot impact the lips as well as the nose and chin. The curvature of the visor means that it cannot bend in the vertical plane without breaking, which it did not do. The injuries shown in the picture strongly imply the entry of blast under the visor.

The victim's body armour is not shown, but a bloodstain implies a light shoulder injury, so indicating that this demining group's minimal body-armour apron without shoulder protection or interface with the visor was probably worn (as shown below). This makes the entry of some blast more likely than if an apron with an IMAS compliant collar had been worn.



The picture above shows the demining group PPE which does not meet the minimum requirements in the current (2006) IMAS.]

Victim Report

Victim number: 567

Name: [Name removed]

Age: Not recorded

Gender: Male

Status: deminer

Fit for work: presumed

Compensation: Not made available
Protection issued: Long visor
Short frontal vest

Time to hospital: Not recorded
Protection used: Long visor, Short
frontal vest

Summary of injuries:

INJURIES

minor Face

severe Hand

COMMENT

No medical report was made available.

Analysis

The primary cause of this incident is listed as a *“Management control inadequacy”* because the field supervisor’s knowledge and experience was inadequate to conduct a reasonable investigation. Because he was apparently unaware of his own shortcomings, it is probable that his training was inadequate, and so *“Inadequate training”* is listed as the secondary cause.

Doubts over the accident investigator’s competence sre compounded by his identification of the device involved in the accident. There is no M4 mine (not listed in Janes Mines and Mine Clearance or elsewhere). I have presumed that he meant a PMN? A PMN does not have an MV4 fuze, so does he mean a PMD-6, which can have an MUV-4 fuze? The PMN is very common in Afghanistan and contains 240g TNT. It also has a striker not entirely unlike that inside an MUV fuze. However, if the investigator cannot accurately identify what are among the commonest devices in the world, one wonders how much training in device identification, demining, mine injury or accident investigation he had received prior to deployment?