6-18-1997

DDASaccident101

Database of Demining Accidents
DDAS

DDAS Accident Report

Accident details

Report date: 15/05/2006

Accident number: 101

Accident time: not recorded

Accident Date: 18/06/1997

Where it occurred: Darwaz village, Anar Darah District, Farah Province

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

rocks/stones

Date record created: 12/02/2004

Date last modified: 12/02/2004

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

inconsistent statements (?)

inadequate investigation (?)

partner's failure to "control" (?)

request for better PPE (?)

squatting/kneeling to excavate (?)

visor not worn or worn raised (?)

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. It was two months since his last revision course and 24 days since his last leave. The area where the accident occurred was described as grazing land on a hillside. A photograph showed it was not steep but was littered with large rocks.

The investigators determined that the victim thought a detector reading was a fragment and was careless when prodding. The mine was identified as a PMN (from "found fragments/pieces"). The victim's bayonet was "lost" and his helmet damaged.

The Team Leader stated that the victim was doing his job properly.

The Section Leader said that the victim was working properly and he believed the orientation of the mine in the ground had been changed – making it hard to prevent such accidents. He said the deminers should be provided with "anti-fragmentation" jackets.

The victim's partner said that the victim was prodding and working properly.

The victim said that he thought the signal was a fragment (he had found many before) and prodded carelessly. He said he should have been prodding prone and that all deminers should do so.

Conclusion

The investigators concluded that the victim made a "wrong judgement" over the detector reading, ignored safe prodding procedures by squatting and ignored proper marking procedures. The Section Leader showed poor command and control.

Recommendations

The investigators recommended that every reading should be treated as a mine and properly marked before starting to investigate. Also that the Section Leader should be disciplined for poor performance by allowing the deminer to work squatting and not to mark properly.

Victim Report

Victim number: 134
Name: Name removed
Age:
Gender: Male
Status: deminer
Fit for work: presumed
Compensation: 25,000 Rs
Time to hospital: not recorded
Protection issued: Helmet
Thin, short visor
Protection used: Helmet

Summary of injuries:

INJURIES

minor Arms

minor Face

minor Hand

minor Legs

minor Shoulder

COMMENT

See medical report.

Medical report

The victim's injuries were summarised as superficial injuries to his left arm and shoulder. A medic's report recorded superficial injury to both arms and left "foreleg".

A sketch showed injuries mirrored front to back (a mistake unless every fragment went through) and recorded fragments and lacerations to the lower face, both upper arms, the right thigh, both shins and the right hand.

The victim's partner recorded injury to the victims nose. A photograph showed a lacerated nose and severely lacerated left shin.

The demining group reported that the victim sustained multiple superficial injuries to his right thigh, both legs below knee, right hand, right arm and shoulder, left arm and shoulder and face. The insurers were informed on 20th May 1997 that the victim had sustained fragment injuries to both arms and his left shin.

Compensation of 25,000 Rs was forwarded on 28th October 1997.

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because his facial injuries indicate that his visor was raised and this error went uncorrected by field controllers.

The victim's failure to use the visor may have been due to the poor condition of the thin visors used (inspected frequently by the researcher and usually found impossible to see through adequately). The secondary cause is listed as *"Inadequate equipment"*.

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 management failing.

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.