

2-3-1997

## DDASaccident107

Humanitarian Demining Accident and Incident Database  
*AID*

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# DDAS Accident Report

## Accident details

<b>Report date:</b> 15/05/2006	<b>Accident number:</b> 107
<b>Accident time:</b> not recorded	<b>Accident Date:</b> 03/02/1997
<b>Where it occurred:</b> Abasabad Village, Ward 6, Kandahar City	<b>Country:</b> Afghanistan
<b>Primary cause:</b> Field control inadequacy (?)	<b>Secondary cause:</b> Inadequate equipment (?)
<b>Class:</b> Excavation accident	<b>Date of main report:</b> [No date recorded]
<b>ID original source:</b> none	<b>Name of source:</b> MAPA/UNOCHA
<b>Organisation:</b> Name removed	
<b>Mine/device:</b> grenade	<b>Ground condition:</b> bushes/scrub ditch/channel/trench grass/grazing area hard
<b>Date record created:</b> 12/02/2004	<b>Date last modified:</b> 12/02/2004
<b>No of victims:</b> 1	<b>No of documents:</b> 1

## Map details

<b>Longitude:</b>	<b>Latitude:</b>
<b>Alt. coord. system:</b>	<b>Coordinates fixed by:</b>
<b>Map east:</b>	<b>Map north:</b>
<b>Map scale:</b> not recorded	<b>Map series:</b>
<b>Map edition:</b>	<b>Map sheet:</b>
<b>Map name:</b>	

## Accident Notes

inadequate investigation (?)  
inadequate metal-detector (?)  
partner's failure to "control" (?)  
request for machine to assist (?)  
squatting/kneeling to excavate (?)  
use of shovel (?)  
vegetation clearance problem (?)

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 18 months. It was six months since his last revision course and ten days since his last leave. The ground in the area was the "hard and bushy" side of a dry drainage channel. A photograph showed a channel between buildings that may have been for storm water, irrigation or drainage. The ground was grassed, with bush up to a metre high and appeared to be relatively soft.

The investigators determined that the victim got a reading on a "hand grenade or its wire" and his partner came to investigate the reading with a long handled shovel. When he started to "cut/remove the bushes, safety pin of the hand grenade got out". The deminer ran away and after a few seconds the grenade exploded. The device was identified as a hand grenade from "found fragments".

**The Team Leader** said that the area had continual detector readings but that the deminer was working improperly by using a shovel and should have used a tripwire feeler.

**The Section Leader** said that the deminer was working properly but must have been careless with the shovel.

**The victim** said that he was careless and should not have used the shovel – adding that dry channels should be cleared with a back-hoe.

**The victim's partner** said that he was careless and should not have been using a shovel.

## Conclusion

The investigators concluded that the victim did not carry out correct procedures and that his injuries were lessened by the fact that he ran away. They added that the Section Leaders show "poor command and control" by allowing deminers to work in this way. It was the fourth accident with this team in three months, so they thought the command and control was obviously poor.

## Recommendations

The investigators recommended that the Team Leader should lose five days pay, the Section Leaders should be told to stress the need to follow correct procedure, and the use of shovels to investigate readings should be stopped immediately. Also, all deminers should be told to use tripwire feelers in bushy areas.

## Victim Report

**Victim number:** 140

**Name:** Name removed

**Age:**

**Gender:** Male

**Status:** deminer

**Fit for work:** yes

**Compensation:** none on record

**Time to hospital:** not recorded

**Protection issued:** Helmet

**Protection used:** not recorded

Thin, short visor

**Summary of injuries:**

**INJURIES**

minor Body

minor Face

minor Genitals

minor Hand

minor Legs

severe Hearing

**COMMENT**

See medical report.

**Medical report**

The victim's injuries were summarised as superficial injuries to the penis, ear and left hand. A medical report mentioned a foreign body in his right eye and left ear hearing loss.

A photograph showed the victim with a blood spattered penis.

A sketch (reproduced below) showed fragments to side of his abdomen, right forehead, left ear, penis and upper left arm.



The insurers were informed that the victim had sustained fragment injuries to his genitals and both legs. A claim was submitted on 29<sup>th</sup> May 1997 listing his injuries as: left ear drum perforated (20% disability); right eye foreign body – recovered to normal; injuries to glans penis; superficial injuries to left hand, left leg. The victim returned to work on 8<sup>th</sup> April 1997.

No record of compensation being paid was found.

## Analysis

The primary cause of this accident is listed as a "*Field control inadequacy*" because the victim was using a shovel in a way that was not approved but his actions went uncorrected. The issue of a shovel for excavation in demining is an example of "*Inadequate equipment*".

The failure of those involved in the investigation to identify the device better than "grenade" is a management inadequacy. If the grenade had a trip-wire fitted, that would imply a risk of other booby-traps in the area and so was important to record.

The victim's facial injuries indicate that the visor was either not worn or worn raised, and this error should also have been corrected.

The use of a squatting/standing 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 SOPs 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.