10-20-1997

DDASaccident141

Humanitarian Demining Accident and Incident Database
AID

DDAS Accident Report

Accident details

Report date:	15/05/2006	**Accident number:**	141
Accident time:	10:45	**Accident Date:**	20/10/1997
Where it occurred:	Pajak Village, Dehyak District, Ghazni 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:**	dry/dusty hard
Date record created:	13/02/2004	**Date last modified:**	13/02/2004
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

inadequate investigation (?)

inconsistent statements (?)

partner's failure to "control" (?)

squatting/kneeling to excavate (?)

use of shovel (?)

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. The victim had attended a revision course seven months before and had been on leave 16 days before the accident. The ground being worked on was described as medium hard. A photograph showed a dry clay soil with clumps of grass. The demining group claimed to have found fragments of the device proving that it was a PMN.

The investigators determined that the victim had got a detector reading, marked it and then started to excavate using a shovel and without wearing his helmet and visor. They said that during the investigation people pretended the victim has been marking the cleared area when the accident occurred but in the original accident report it was mentioned that the accident occurred during prodding – the investigators decided that "this is their pretext to confuse investigation".

The Team Leader, Section Leader and the victim's partner all said that the victim was marking the cleared area and was collecting soil from an uncleared area when the accident occurred.

Conclusion

The investigators concluded the victim was negligent to use the shovel to investigate the detector reading. They decided that he received fatal injuries to his head because he was not wearing the safety helmet, and that the Section Leader showed poor command and control.

Recommendations

The investigators recommended that no one should prod in the squatting position when the ground was suitable for the prone position, that the use of shovels to investigate readings should be stopped, and that the command group must stress the need to obey safety procedures to the deminers. They further recommended that disciplinary action should be taken against the Team Leader, Assistant Team Leader and Section Leader, observing that the team had suffered four accidents in as many months. They took this to imply that the poor command and control of the command group could be a contributory factor and recommended that changes to the command group be made.

Victim Report

Victim number:	181	**Name:**	**Name removed**
Age:		**Gender:**	Male
Status:	deminer	**Fit for work:**	DECEASED
Compensation:	500,000 Rs (100%)	**Time to hospital:**	not recorded
Protection issued:	Helmet Thin, short visor	**Protection used:**	none

Summary of injuries:

INJURIES

minor Chest

severe Arm

severe Eyes

severe Face

severe Hands

severe Head

FATAL

COMMENT

Victim died in a coma 17 hours 15 minutes after accident. See medical report.

Medical report

The incident occurred at 10.45 a.m. and the deminer died the next day at 4.00 a.m. in coma. The victim's injuries were summarised as serious injuries to his head, face and hands that were fatal: maxila - mandible fracture, head trauma, concussion and compression of skull, left humerus fracture, all body superficial wounds. A sketch showed fragment injuries all over the body and limbs, with serious wounds to upper left arm, lower face and right side of the head. A photograph showed the right side of head as an open wound, lips eyes and nose invisible.

The demining group reported to the insurers on 20th October 1997 that the victim (prodding without helmet) suffered severe facial injuries, a penetrating wound to his cranium, fracture mandible left, fracture left maxilla, fracture left humerus, and fragments to the body. He died on the night of 20/21st October 1997.

A claim was sent to the insurers on 17th November 1997 along with a photograph showing severe facial injuries. His injuries were described as half of the face shattered including upper and lower jaws, the inside of his nose and right eye destroyed, contusion of brain, superficial injury of chest wall.

A compensation payment of 500,000 Rs [maximum allowable] was awarded on 15th January 1998 for the victim's death four and a half months after the incident.

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because the victim was working improperly and his errors were not corrected. The working position (squatting) combined with the head and upper body injuries imply that he was leaning forward with his head and face in the fragment cone associated with the blast.

The issue of a shovel for excavation in demining was inappropriate. The secondary cause is listed as *“Inadequate equipment”*.

Bearing in mind the condition of visors in use in Afghanistan, questions over why the victim did not wear his helmet and visor would have been appropriate. It is possible that the visor was too damaged to see through properly (as was seen frequently during field visits in 1998, 1999), in which case the failure to provide useable equipment may represent a serious management failing.

The use of the shovel and an upright position to "excavate" were both 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 management failings.

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.