10-8-1997

DDASaccident144

Humanitarian Demining Accident and Incident Database
AID

DDAS Accident Report

Accident details

Report date:	16/05/2006	**Accident number:**	144
Accident time:	not recorded	**Accident Date:**	08/10/1997
Where it occurred:	Robat-I-Sangi Village, Koshk District, Herat Province	**Country:**	Afghanistan
Primary cause:	Management/control inadequacy (?)	**Secondary cause:**	Inadequate training (?)
Class:	Handling accident	**Date of main report:**	[No date recorded]
ID original source:	none	**Name of source:**	MAPA/UNOCHA
Organisation:	Name removed		
Mine/device:	Fuze	**Ground condition:**	agricultural (abandoned) soft
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 (?)

inadequate training (?)

visor not worn or worn raised (?)

Accident report

An investigation on behalf of the UN MAC was carried out and its report made briefly available. The following summarises its content.

The victim was a Section Leader and had been a deminer for four years. He had last attended a revision course five months before, and was last on leave 51 days before the accident. The ground where the accident occurred was described as soft agricultural land.

The investigators determined that the victim was carrying four UXOs to a Central Demolition Site when he slipped and dropped the UXOs.

The Team Leader said the victim was working properly when the accident occurred.

The victim said he was working properly when he slipped and dropped the UXO (only one of the four).

A deminer witness said that the victim was working properly when a single UXO fell because he slipped. He added that the accident could have been prevented if the victim had not been carrying more than one piece of UXO.

The demining group said that the victim suffered fragments to his face, chest and left hand when he was carrying UXO to put it in the place for disposal when he slipped, and a UXO fell and exploded (identified as an “artillery fuze”).

Conclusion

The investigators concluded that the victim was carrying four UXO at a time, and the UXO may not have been safe to move/carry.

Recommendations

The investigators recommended that Team Leaders should have advanced UXO recognition and destruction training, that all UXO should be examined by Team/Section Leaders to ensure they are safe to move, and that no one should be allowed to carry more than two UXO at a time.

Victim Report

Victim number: 185
Name: Name removed
Age:
Gender: Male
Status: supervisory
Fit for work: yes
Compensation: 7,857 Rs
Time to hospital: not recorded
Protection issued: Helmet
Thin, short visor
Protection used: none

Summary of injuries:

INJURIES

minor Chest

minor Hand

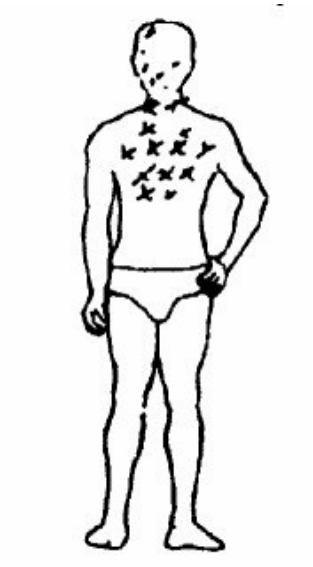
severe Face

COMMENT

See medical report.

Medical report

The victim's injuries were summarised as multiple minor injuries to his face, a deep laceration on his forehead and left ear, multiple superficial lacerations to his chest and superficial injuries to his left hand. A sketch showed fragment injuries to his chest, neck and face. A photograph showed the left arm (elbow) bandaged and damage to the nose.



A disability claim was forwarded to the insurers on December 9th stating that the victim suffered multiple injuries to his face, a deep laceration to his forehead, laceration of his left ear (part "lost"), multiple injuries on his chest and superficial injuries on left hand. He was off work from October 8th – 30th 1997.

Compensation was granted on 31st December 1997 and paid on 5th March 1998 for 7,857 Rs.

Analysis

The primary cause of this accident is listed as a *"Management control inadequacy"* because the victim believed he was working properly. He was carrying multiple UXO and not wearing his helmet and visor – as indicated by his face and ear damage (a point missed by the investigators or possibly not considered necessary). Because the victim was a supervisor this implies that safe SOPs and appropriate training were either not in place or not enforced, which is a management responsibility. The secondary cause is listed as *"Inappropriate training"*.

It is possible that a visor was not worn because it 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 further management failing.

2000 MAC manager comment

"It is… perhaps a little unrealistic of the researcher to suggest that a handful of overworked managers and TAs are capable of writing exhaustive SOP for a relatively new aid sector in a grossly underdeveloped country…" [in only ten years?].

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.