9-29-1997

DDASaccident147

HD-AID
Humanitarian DeminingAccident and Incident Database

DDAS Accident Report

Accident details

Report date:	16/05/2006	**Accident number:**	147
Accident time:	not recorded	**Accident Date:**	29/09/1997
Where it occurred:	Kushk district, Herat Province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Field control inadequacy (?)
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:**	agricultural (abandoned) ditch/channel/trench 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 metal-detector (?)

partner's failure to "control" (?)

pressure to work quickly (?)

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 six years. The victim had attended a revision course four months before and last been on leave 42 days before the accident. The ground where he was working was described as "agricultural land alongside a ditch: soft ground". The demining group claim to have found fragments of the mine from which they identified it as a PMN.

The investigators determined that the accident occurred when the deminer used only one marking stone to mark a detector signal, then prodded in a squatting position which "failed him to maintain the correct prodding angle". It is suggested that he was careless because he thought he had detected a fragment (having detected many fragments immediately beforehand).

The Sub-Commander said that the victim was injured because he was not working properly.

The Section Leader said the deminer ignored his partner's correction and prodded without wearing his helmet, believing the signal was from a fragment.

The victim stated that he did not put his helmet on because "it was very streaky and shaking of bush." [He may have meant that the visor was hard to see through.] He blamed his supervisor who had pushed him to work quickly and instructed him to adjust the sensitivity of his detector to zero, so leading him to get a confusing signal.

The victim's partner said he made the mistake of believing the signal was from a fragment.

Conclusion

The investigators concluded that the victim did not follow the marking procedure properly, did not wear his helmet and visor while prodding. They also said that the ground was suitable for prodding in a prone position, but the victim was squatting.

Recommendations

The investigators recommended that marking procedure must be followed properly and all readings must be treated as a mine. They also said that the team command group must stress the need to wear helmets when prodding and that disciplinary action should be taken against the Section Leader for poor command and control.

Victim Report

Victim number: 188
Name: **Name removed**
Age:
Gender: Male
Status: deminer
Fit for work: no
Compensation: 500,000 Rs (100%)
Time to hospital: not recorded
Protection issued: Helmet
Thin, short visor
Protection used: none

Summary of injuries:

minor Arm

minor Chest

minor Hand

minor Shoulder

severe Eyes

severe Face

AMPUTATION/LOSS

Eye

COMMENT

See medical report.

Medical report

The victim's injuries were summarised as loss of both eyes, serious facial injuries and injuries to his right shoulder and left hand.

The demining group reported that the victim had lost both eyes, suffered severe facial injury and injured his left arm.

A disability claim was forwarded to his insurers on December 9th saying that the victim had been left permanently disabled. His left eye had been "destroyed". His right eye was severely damaged and needed further surgery: its vision was "low". He also had severe facial injuries, chest, left arm and right hand multiple superficial wounds and a deep injury to his forehead. A photograph showed bandaged eyes and a chest wound.

A compensation cheque for 500,000 Rs was issued on 31st December 1997 and paid on 5th March 1998.

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. If he had been told to adjust his detector to reduce false alarms, this represents a gross field control inadequacy. If the visor he was given to wear was impossible to see though, the management's failure to provide useable equipment would be a serious management failing.

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 further management failing.

The persistent delays within the UN MAC between the date of compensation cheques being issued and them being paid may deserve investigation.

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.