9-28-2003

DDASaccident543

Humanitarian Demining Accident and Incident Database
AID

DDAS Accident Report

Accident details

Report date:	01/02/2008	**Accident number:**	543
Accident time:	07:07	**Accident Date:**	28/09/2003
Where it occurred:	Poya Kahil village, Pole Alam district, Logar Province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Inadequate training (?)
Class:	Handling accident	**Date of main report:**	Not recorded
ID original source:	None	**Name of source:**	[Name removed]
Organisation:	[Name removed]		
Mine/device:	Fuze	**Ground condition:**	not recorded
Date record created:		**Date last modified:**	01/02/2008
No of victims:	1	**No of documents:**	1

Map details

Longitude:		**Latitude:**	
Alt. coord. system:	Not recorded	**Coordinates fixed by:**	
Map east:		**Map north:**	
Map scale:		**Map series:**	
Map edition:		**Map sheet:**	
Map name:			

Accident Notes

inadequate training (?)

inconsistent statements (?)

no independent investigation available (?)

protective equipment not worn (?)

Accident report

The report of this accident was made available in January 2008 by the Demining group involved. Its conversion to a DDAS file means that some of the original formatting has been lost. The substance of the report is reproduced below, edited for anonymity. The original file is held on record. Text in [ ] is editorial.

ACCIDENT REPORT

[Demining group] GROUP, KABUL SEPTEMBER 2003

1. **Acronyms.**

PS: Paramedic Supervisor

CD: Country Director

DM: Deminer

FTS: Field Technical Supervisor

MO: Medical Officer

SOO: Senior Operations Officer

OPSC: Operations Centre

PAM: Paramedic

PM: Programme Manager

SL: Section Leader

SOP: Standard Operating Procedure

TCM: Training Control Manager

TL: Team Leader

EOD: Explosives Ordnance Disposal

2. Objectives.

The objectives with the current report are:

To deliver the evidences to other staff within the organization.

To draw the attention of other staff to 100% implementation of standards.

3. General Information.

Team/Site description: The incident happened with a deminer of EOD 11 during clearance of UXO.

Location of accident: Poya Kahil village, Pole Alam district, Logar Province
Date & Time: September 28, 2003 at 07:07 hrs local time

Particulars of injured person:

Name: [Removed]

Title: Deminer [Section Leader]

Date of birth:1975

Place of birth: Kandahar

Blood group: O Rh -

Cause of the accident:

Refer to the statement given by injured deminer, he was climbing a hill while taking a BM-12 shell to the demolition pit. He slipped and the accident happened.

Brief description of injuries: Big wound on his left leg and many other small wounds on both legs caused by shrapnel.

4. Chronological Overview of the Accident.

Following describes the actions taken and the instructions given directly after the accident:

At 0707 the accident happened.

The nearest deminer and paramedic of the same EOD team heard the incident and rushed to the incident point. +20 sec.

Paramedic started treating and doing the first aid to the injured. +60 sec

Whole EOD operations were stopped in Logar province. +2 min.

Radio room of OPSC got the report. +3 min.

The injured DM was shifted to the ambulance after first aid and dressing. +13 min.

A delegation left from Kabul to Logar for initial investigation. +23 min.

Operations were standing by in Bagram and Kabul. +25min.

SOO and MO left to the Emergency hospital run by Italians to do necessary preparation for the arrival of the injured deminer. +38 min.

Arrival of injured from Logar to Emergency hospital in Kabul. +83 min.

The delegation of initial investigation briefed the other 3 teams in Logar about the incident. +170min

The delegation of initial investigation arrived back to OPSC. +230min

TCM briefed the country director and others about the incident initial findings. +260min

Resumption of operations in Kabul and Bagram. +261min

The accident was reported to UNMACA and [Demining group] Islamabad. +265min

5. Brief description of how the accident happened:

A BM-12 smoke shell was reported near the Safe UXO Store of [Demining group] teams working in Logar province. The acting TL briefed the SL to take the UXO away and demolish it. Mr. Paya-I-Din was climbing a hill while taking the UXO to the demolition pit, slipped and the accident happened. It is worth-mentioning that the UXO he was carrying did not explode and apparently a BD RPG7 fuse caused the injuries.

6. Injuries of the Casualties

As per the report of Medical officer the injured has a big and many small fragmental wounds on anterior and middle surface of left thigh. And also has some small injuries on right leg and posterior surface of knee joint. The patient has 3rd degree burn on his inguinal area specify scrotum too".

The specification of the big wound on the left thigh is as follows:

Length: 6cm

Width: 5cm

Skin and muscles tissue: Lose.

General Condition of the injured person: The deminer was admitted in Emergency Hospital runs by Italian for the period 28th September 2003 to 9th October 2003. He is now at his home and will hopefully be ready back for work after the big stand down around the 1st of December 2003.

7. Damaged Equipment:

In this incident the uniform and the shoes of the deminer were damaged.

8. Technical Evidence

Based on the findings of investigation team from the accident point and shrapnel taken out from the wounds of the deminer after the operation in the hospital, a BD fuse of RPG7 has been exploded and caused the injuries.

9. Evaluation.

In order to accumulate experiences within the SOPs of [Demining group] it is of great importance to evaluate and review all actions taken during and after the accident.

Additionally [Demining group] will forward the present report to the demining community within MAPA. It is hereby the intention of [Demining group] to contribute in a constructive and critical manner with our experiences of the current accident. Doing so we will hopefully eliminate or reduce risks, which are common in the process of EOD operations, faced by fellow demining organizations.

Summary:

Summarizing all factors mentioned above some procedures or regulations have been violated according to the current Demining SOPs within [Demining group]. Unfortunately there are no eyewitnesses to the accident except the injured deminer himself and the statement of him is not answering all the questions raised.

However, based on our investigation it seems that the deminer had put an unsafe BD RPG7 fuse in his paints pocket right on his left thigh that could be seen/imagined from his paints tears. The accident has happened in walking position as the deminer got a big wound on the front of his left thigh and some small shrapnel on the back of his right thigh. In addition he would have gotten many shrapnel on his chest and rest of the body if he had fallen down on a BD RPG7 fuse. [Demining group] will try to encourage the injured deminer to tell the truth exactly how the incident happened after the full recovery of him.

Treatment:

The 1 DM, 2 PAMs performed first aid in the accident, stabilized and prepared the injured for evacuation - more specifically:

- Stopped bleeding
- Prevented shock
- Performed mentally first aid.

The whole process of first aid and stabilization from the time of the accident in centre of Logar province to the hospital in Kabul took 83 minutes.

Summary:

The medical treatment and evacuation was adequate and contributed to keep the patient in a good and stable condition up to and during the evacuation to the hospital.

However, Medevac and Case vac exercises will take place continuously among PAM, PS and DM to obtain the highest possible level of individual medical skills.

10. Conclusion.

Following is the conclusion made by [Demining group]:

Accident: This accident was caused due to the carelessness of the deminer. It seems that the deminer has put a safe BD RPG7 fuse in his pocket that caused the incident.

Cause: The cause of the accident was a BD fuse of RPG7.

Damaged Equipment; Only the uniform of deminer was damaged.

Reporting: Reporting was carried out in a correct and efficient way. But still we have to try and inform all concern within appropriate time. A casualty evacuation plan and reporting system diagram will be developed and given to all concern.

Victim Report

Victim number: 716	**Name:** [Name removed]
Age:	**Gender:** Male
Status: supervisory	**Fit for work:** presumed
Compensation: Not made available	**Time to hospital:** One hour 23 minutes
Protection issued: Not recorded	**Protection used:** None (?)

Summary of injuries:

minor Genitals

minor Leg

severe Leg

COMMENT: See Medical report.

Medical report

No formal Medical report was made available. From the Internal investigation: “As per the report of Medical officer the injured has a big and many small fragmental wounds on anterior and middle surface of left thigh. And also has some small injuries on right leg and posterior surface of knee joint. The patient has 3rd degree burn on his inguinal area specify scrotum too”.

The specification of the big wound on the left thigh is as follows:

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Analysis

The investigators determined that the Victim did not fall over but that fuze detonated in his pocket as he was walking. While the fuze was not strictly in his hands, the accident is classed as “Handling accident” in order to group all accidents where a policy allowing handling of devices is a common feature.

The primary cause of this accident is listed as a “Field control inadequacy” because the Victim was a Section Leader and his error in putting the fuze in his pocket was not corrected. As a Section Leader, one might expect him to have been trained in how to handle UXO and so the secondary cause is listed as “Inadequate training” because he clearly had not learned not to put fuzes in his pockets.

The candour of the demining group involved, and its eagerness to learn from and share lessons derived from accidents, is to be applauded.