3-19-1998

DDASAccident127

Humanitarian Demining Accident and Incident Database

Follow this and additional works at: https://commons.lib.jmu.edu/cisr-globalcwd

Part of the Defense and Security Studies Commons, Peace and Conflict Studies Commons, Public Policy Commons, and the Social Policy Commons

Recommended Citation

https://commons.lib.jmu.edu/cisr-globalcwd/1013
DDAS Accident Report

Accident details

Report date: 15/05/2006
Accident time: not recorded
Where it occurred: Shoorandam Village, Daman District, Kandahar Province
Primary cause: Field control inadequacy (?)
Secondary cause: Inadequate training (?)
Class: Excavation accident
ID original source: none
Organisation: Name removed
Mine/device: PMN AP blast
Date record created: 13/02/2004
No of victims: 1

Accident number: 127
Accident Date: 19/03/1998
Country: Afghanistan
Date of main report: [No date recorded]
Name of source: MAPA/UNOCHA
Ground condition: hard
Date last modified: 13/02/2004
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 (?)
long handtool may have reduced injury (?)
request for clearance with explosive charge (?)
request for machine to assist (?)
standing to excavate (?)
use of shovel (?)
visor not worn or worn raised (?)
inadequate training (?)
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 since May 1994. He was working on ground described as "medium hard" beside a small stream. He had last attended a revision course one month before.

The investigators determined that the deminer was "excavating" to investigate a detector reading when the accident occurred. He was using a shovel to do so. Investigators were unable to visit the accident site [due to deminer mobility and seasonal redeployment], so the report relied on interviews and written statements.

The Team Leader said the deminer was removing soft soil with the shovel and was careless. He said the use of a back-hoe would prevent repetition.

The Section Leader said the deminer was working properly, removing loosened soil with the shovel. He also said a back-hoe would prevent repetition of such accidents.

The victim said he was "prodding and working properly" but thought the signal was a fragment because he had already found some fragments there. He thought the use of an explosive charge prior to prodding would prevent such accidents.

The victim’s partner said the deminer was working properly when the accident occurred, and that the use of a back-hoe would prevent such accidents in future.

Conclusion

The investigators concluded that the victim had ignored correct procedure and used a shovel to investigate a reading point. Noting that the victim also wore the visor raised, they added that poor control and command by the command group was a contributory factor.

Recommendations

The investigators recommended that the demining group should ensure close supervision to enforce technical procedures and safety measures, and also that the Section Leader should be disciplined for poor performance.

The UN MAC recommended that the demining group must ensure that deminers do not use shovels in this way, and that the Section Leader must be disciplined by losing three days pay.

Victim Report

Victim number: 163  Name: Name removed
Age:  Gender: Male
Status: deminer  Fit for work: not known
Compensation: not made available  Time to hospital: not recorded
Protection issued: Helmet  Protection used: not recorded
Thin, short visor

Summary of injuries:
INJURIES

minor Face
minor Leg
severe Arm
severe Eyes
severe Leg

COMMENT

See medical report.

Medical report

The initial field report recorded the injuries as, “injury of both eyes, multiple injuries on face; left shoulder anterior wounds; fracture of both bones, left leg; fracture of both bones, left forearm; superficial wounds on right thigh and leg”. A sketch made by the field medic shows left arm, hand and leg injury, and face and eye damage.

The insurers were informed on March 24th 1998 that the victim suffered injuries to both eyes, face, left shoulder, fracture both bones left leg, fracture both bones left forearm, wounds to right thigh and leg.

No record of compensation was found in June 1998.

Analysis

The primary cause of this accident is listed as a "Field control inadequacy" because the use of a shovel in this way should not have been allowed, and the victim’s failure to use his protective equipment appropriately should have been corrected. These failings were recognised by the investigators in their recommendation that the field supervisor be disciplined. The fact that the Section Leader appeared to be unaware of his failing may imply poor training, which would be a management responsibility. The secondary cause is listed as “Inadequate training”.

The injuries indicate that the victim was stepping on the shovel when the initiation occurred, so allowing the energy to transfer to his leg and arm with bone breaking force. His eye and face injuries confirm that he was not wearing his visor. This was not noted by the investigators.

The use of the shovel and of a standing 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 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.