DDAS Accident Report

Accident details

Report date:	19/04/2006	**Accident number:**	97
Accident time:	not recorded	**Accident Date:**	29/05/1997
Where it occurred:	Chawni Village, Ali Khail District, Paktia Province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Unavoidable (?)
Class:	Tripwire accident	**Date of main report:**	[No date recorded]
ID original source:	none	**Name of source:**	MAPA/UNOCHA
Organisation:	[Name removed]		
Mine/device:	POMZ AP frag	**Ground condition:**	bushes/scrub hard
Date record created:	24/01/2004	**Date last modified:**	24/01/2004
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

inconsistent statements (?)

partner's failure to "control" (?)

inadequate investigation (?)

vegetation clearance problem (?)

visor not worn or worn raised (?)

victim working prone (?)

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's length of service was not recorded. It was two months since he had attended a refresher course and 31 days since his last leave. The area where the accident occurred was described as a hard hillside with bushes and "trees". A photograph showed a hillside with low bushy plants and no trees.

The investigators determined that the victim got a detector reading and started prodding in a prone position. As he removed loose soil he pulled a tripwire with his hand. A POMZ six metres away was initiated. The device was identified as a POMZ from "found fragments".

The Team Leader said that the victim was working properly but removed the loose soil carelessly. He said deminer partners should point out their errors to prevent accidents.

The Section Leader said that the victim was working properly and the tripwire was under the soil and had become the colour of the ground so was impossible to see. He said deminers should follow rules and regulations to avoid serious accidents.

The victim's partner said that he was working properly and the tripwire was under the ground, so the accident was unpreventable.

The victim said he was working properly and the tripwire was below ground and invisible, so the accident was unavoidable.

Conclusion

The investigators concluded that the victim did not check the area with a tripwire feeler properly.

Recommendations

The investigators recommended that the Team and Section Leaders should stress the need to use tripwire feelers properly and that extra care should be taken in bushy POMZ minefields. They added that the command group should pay strict attention to the use of tripwire feelers and that the need for tripwire feelers to be used properly should be stressed at the forthcoming revision course for the subject team.

Victim Report

Victim number: 129

Name: [Name removed]

Age:

Gender: Male

Status: deminer

Fit for work: presumed

Compensation: none on record

Time to hospital: not recorded

Protection issued: Helmet

Thin, short visor

Protection used: not recorded

Summary of injuries:

INJURIES

minor Eyes

minor Face

COMMENT

See medical report.

Medical report

The victim's injuries were summarised as: superficial wounds on his forehead and a laceration on his right eyelid.

A medic's sketch showed abrasions to forehead and eye.

A casualty report noted laceration on the eyelid. No injury was shown in the photograph.

The demining group reported that the victim sustained fragment injuries to his face and eyelids, but no compensation claim was on file.

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because the investigators seemed certain that the use of a tripwire feeler would have prevented the accident, in which case the victim was working improperly and his error went uncorrected.

If the tripwire was indeed buried, the accident may have been unavoidable using the methods deployed, so the secondary cause is listed as *“Unavoidable”*.

The investigators were at pains to mention that the victim was prone, but did not question the fact that his forehead and eye injuries imply that his visor was not worn or worn raised.

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.