

DDAS Accident Report

Accident details

Report date: 18/05/2006	Accident number: 243
Accident time: 11:30	Accident Date: 08/08/1998
Where it occurred: Ali Khail BalaTapa Village, Jaji, Paktia Province	Country: Afghanistan
Primary cause: Field 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: POMZ AP frag	Ground condition: bushes/scrub trees
Date record created: 17/02/2004	Date last modified: 17/02/2004
No of victims: 2	No of documents: 2

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 training (?)
partner's failure to "control" (?)
protective equipment not worn (?)
visor not worn or worn raised (?)
inadequate investigation (?)

Accident report

An investigation on behalf of the UN MAC was carried out and its report made available in September 1999. The following summarises its content.

The demining group were using a one-man breaching drill with two-man teams at the time of the accident.

Victim No.1 had been a deminer for nine months and Victim No.2 had been a deminer for nine years. It was four months since the team had attended a revision course and 52 days since their last leave. The team were working on a hillside with "bushes and trees". The device was identified from fragments found at the site. The hilltop had been a military post and had been protected with four rings of POMZ and a belt of PMNs. The group had found "about 10 mines" and destroyed them in situ.

The investigators determined that at around 11:00 the Section Leader instructed the deminers to pack up and rest until the end of the day. While they were resting Victim No.1 went into the uncleared area for no known reason. When he was 15m into the mined area he noticed a tripwire and "started wrapping it into the stick of a POMZ". A POMZ detonated at 11:30.

Victim No.1 died "on the spot". Victim No.2 was 15m away in a safe area and received "a fragment on his hand. He was treated at the site and evacuated to hospital in Peshawar, Pakistan for further treatment.

The Team Leader pointed out that the victim was a relatively new and inexperienced deminer who ignored his Section Leader.

The Section Leader stated that he was called to the site after the accident and searched up to Victim No.1 with a detector. He thought that a policy of not employing deminers over 40 years old would prevent recurrence of such incidents. He also thought that new deminers should not be deployed in that area, and that no deminers should be deployed there more than once "because it is boring".

Victim No.2 said that Victim No.1 was his partner but his hands trembled too much when he was prodding so he did not allow him to prod. He reported having seen his partner sitting in the uncleared area and asked what he was doing. Victim No.2 said that he was coming, then the mine exploded. [He did not report having seen Victim No.2 deliberately roll up a tripwire.]

Conclusion

The investigators concluded that Victim No.1 was ignorant of safety procedures and caused the accident. They thought it likely that he had gone into the area to look for guns. They said that there were stories that Kalashnikovs had been found in the area by locals, and that the deminers had found ammunition while working. [Presumably the guns had a resale value.]

They decided that the Section Leader should not have allowed the group to rest in the mined area if work was finished for the day and should have monitored the deminers more closely.

Recommendations

The investigators recommended that "command groups" enforce technical and safety procedures. They thought that Victim No.1 was too old to be a deminer (aged 65) and should not have been recruited. They recommended that the Section Leader be disciplined for poor performance.

Victim Report

Victim number: 316

Age: 65

Status: deminer

Name: Name removed

Gender: Male

Fit for work: DECEASED

Compensation: not made available
Protection issued: Helmet
Thin, short visor

Time to hospital: not recorded
Protection used: none

Summary of injuries:

INJURIES

minor Hand

minor Leg

severe Arm

severe Eye

severe Head

FATAL

COMMENT

See medical report.

Medical report

An initial casualty report stated that Victim No.1 had severe chest injury and did not mention a head or eye injury.

The field medical report included a sketch showing that Victim No.1 suffered a deep injury to his "eye and brain" and right hand and lower left leg lacerations.

The site doctor described the injuries as "Deep injury of the left eye and brain. Multiple injury of the left arm and fracture (incomplete) and lacerations of the left leg and right hand."

Photocopies of photographs of Victim No.1 were of a poor quality but appeared to show a large fragment strike in and around the left eye.

Victim Report

Victim number: 317
Age:
Status: deminer
Compensation: not made available
Protection issued: Helmet
Thin, short visor

Name: Name removed
Gender: Male
Fit for work: not known
Time to hospital: not recorded
Protection used: none

Summary of injuries:

INJURIES

minor Eye

minor Face

severe Hands

COMMENT

See medical report.

Medical report

The field medical report included a medic's sketch showing that Victim No.2 suffered injuries to his face, forehead and both hands. The medic treated "eye" damage and dressed the other injuries. The site doctor described the injuries as "Puncturated injury of the left hand with metacarpus 3,4 and 5 fractures. Puncturated injury of the right hand with fracture of the third metacarpus and abrasion of pre-orbital and nose".

The victim was "evacuated to hospital in Peshawar, Pakistan for further treatment".

Analysis

The primary cause of this accident is listed as a "*Field control inadequacy*" because Victim No.1 was allowed to go unsupervised into a mined area and behave with apparent ignorance of the risks.

As the investigators recognised, his error should have been corrected. His training should also have prevented such an error occurring. Any failure of training would be a management failing - and it is curious that a "new" deminer would be recruited at 65 years old when the jobs were apparently in considerable demand. The secondary cause is listed as "*Inadequate training*".

The investigators appear to have been allowing imaginative speculation to influence them when they guessed that the victim was in search of guns. The witnesses did not report this and no guns had been found by the deminers. The investigators stated that the victim rolled up a tripwire and that he was possibly in search of guns without explaining their reasons for believing either contention, or explaining how the two could have been consistent with each other.

Related papers

Documents ordering a Board of Inquiry were included in the file. No Board of Inquiry report was not on file in the MAC in September 1999. (A BoI was considered essential because of the death involved in the accident.)