DDAS Accident Report

Accident details

Report date: 18/05/2006

Accident number: 245

Accident time: 09:00

Accident Date: 15/08/1998

Where it occurred: Pajack village, Dehyak, Ghazni Province

Country: Afghanistan

Primary cause: Field control inadequacy (?)

Secondary cause: Inadequate training (?)

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: agricultural (abandoned)

bushes/scrub

Date record created: 17/02/2004

Date last modified: 17/02/2004

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 equipment (?)

inadequate metal-detector (?)

vegetation clearance problem (?)

inadequate training (?)

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.

At the time of the accident the demining group was using a one-man drill and two-man teams.

The victim had been a deminer for four years. He had last been on leave 22 days before and last attended a revision course six months before. The accident occurred on ground described as agricultural with many bushes. The mine was identified from pieces found at the site. The area was known to contain POMZ mines with tripwires.

The victim stated that on the day before the accident he had found a POMZ and rendered it safe by replacing the safety-pin, then defused it and destroyed it later.

On the day of the accident the victim was working in a bushy area when at 09:00 he pulled a bush out of the way. In doing so he pulled a tripwire and initiated a POMZ. He suffered hand and chest injuries, and hearing loss. The victim was treated at the site, then taken to the ICRC hospital in Ghazni for treatment.

The investigators found that the victim did not use a tripwire feeler despite knowing that tripwires were present.

The Team Leader said that the victim was searching for tripwires and shook the bush which caused the accident. He said that tripwires should be searched for visually, then by detector carefully.

The Section Leader said that the tripwire was not detectable with a detector because the metal was non-detectable.

The victim reported that he had previously defused a mine at the site. He claimed to have used the detector and a "feeler" but a strong wind shook the bush and caused the accident.

Conclusion

The investigators concluded that the victim caused the accident by not using a tripwire feeler.

Recommendations

The investigators recommended that tripwire feelers must be used prior to removing bushes, that obstacles in tripwire areas must be pulled in accordance with the pulling drill, that no deminer must be allowed to disarm mines, and that the Section Commander should be disciplined for poor command and control.

Victim Report

Victim number: 319

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

Thin, short visor

Protection used: not recorded

Summary of injuries:

minor Body

minor Foot

minor Hearing

severe Chest

severe Hands

COMMENT

See medical report.

Medical report

No field medical report was included in the UN MAC file in September 1999.

The papers in the accident file indicated that the victim had wounds in both hands, his chest and his left leg. His condition was described as "satisfactory but waiting for doctor's further advice."

The original casualty report listed his injuries as: right hand, right foot, chest and abdomen, and gave the injury a Priority 1 rating [from which it can be inferred that they were believed to be severe].

The victim himself reported injuries to his hands and chest, along with a hearing loss, [but his availability for interview implies successful treatment].

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because it seems likely that the victim searched without due caution and that his error was uncorrected. His claim to have disarmed a mine on the previous day adds weight to the view that field supervision was lax (disarming being a breach of the SOPs of which he was apparently unaware). The secondary cause is listed as *“Inadequate training”*.

The victim's injuries were caused by a fragmentation mine, implying that surgery to remove fragments would be required. This is why some injuries are classed as "severe".

The supervisors described searching for tripwires in their statements. They mentioned visual inspection and metal detector search but did not mention using a tripwire feeler. This may imply that the demining group did not have tripwire feelers issued. If they did not, that would be a significant failing of management to provide the equipment they were required to make available.