DDAS Accident Report

Accident details

Report date:	18/05/2006	**Accident number:**	247
Accident time:	not recorded	**Accident Date:**	02/09/1998
Where it occurred:	Dey Yak Pajak Village, Ghazni	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Field control inadequacy (?)
Class:	Tripwire accident	**Date of main report:**	[No date recorded]
ID original source:	none	**Name of source:**	APA/UNOCHA
Organisation:	Name removed		
Mine/device:	POMZ AP frag	**Ground condition:**	agricultural (abandoned) bushes/scrub dry/dusty
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 training (?)

inconsistent statements (?)

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. The victim had been a deminer for eight years. It was one month since he had

attended a revision course and 40 days since his last leave. The accident occurred in "an agricultural type of minefield" with bushes. The device was identified by the Team Leader.

Photographs of the accident site showed sparse, dry and leafless bush that looked as if it would be hard to search except with a feeler (because the thin dry twigs were straight and could confuse the eye in a visual inspection).

The investigators reported that the victim was working normally and looking for tripwires. He found a tripwire and wanted to find whether it was connected to a mine "so he pulled it with his hand and the mine went off". He received injuries to his right armpit, both thighs and suffered hearing loss in his left ear.

The victim was treated at the site, then taken to the IICRC hospital in Ghazni for treatment.

The Team Leader said that the victim made a mistake while prodding.

The Section Leader reported that the victim was prodding, saw a tripwire and applied pressure on it which caused the accident.

The victim said that he was prodding and the wire was covered with soil so he pulled it inadvertently. After the accident he stood up and walked away several metres before he "stumbled".

Conclusion

The investigators concluded that the victim caused the accident by pulling the tripwire. They found that "poor command and control" by the Section Leader was "obvious".

Recommendations

The investigators recommended that all tripwires should be dealt with using the correct pulling drills and that disciplinary action should be taken against the Section Leader for poor performance.

Victim Report

Victim number:	321	**Name:**	**Name removed**
Age:		**Gender:**	Male
Status:	deminer	**Fit for work:**	presumed
Compensation:	not made available	**Time to hospital:**	not recorded
Protection issued:	Helmet Thin, short visor	**Protection used:**	not recorded

Summary of injuries:

INJURIES

minor Chest

minor Hand

minor Leg

severe Hearing

COMMENT

See medical report.

Medical report

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

A radio message transcript described the injuries as "superficial injury on chest, right hand, left leg and his ear can't hear". His general condition was described as "good" and the injury rated priority "3".

The victim reported that his thigh injury was deep and "severe" with the other injuries were superficial - apart from his deafness.

He was treated on site and taken to the ICRC hospital in Ghazni, then returned to the camp for rest.

A photograph of the victim showed him with his right thigh bandaged and using a crutch to walk.

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because (by his own admission) the victim was working with his prodder in a tripwire area, and this error should have been corrected. It is possible that the tripwire was buried and incapable of detection with the detector issued (claimed in other incidents), so the accident might have been *“Unavoidable”*.

It is possible that the group were not issued with tripwire feelers, and if this was so it would represent a significant management failing.

There is no evidence in the file to support the investigators' contention that the victim saw a tripwire and deliberately pulled it to see whether it was attached to a mine. Several of the investigations made on behalf of the UN MAC around this period include speculative explanations that are not justified by the content of the statements recorded, or by the established events.