9-11-1997

DDASaccident149

HD-AID

Humanitarian DeminingAccident and Incident Database

DDAS Accident Report

Accident details

Report date:	16/05/2006	**Accident number:**	149
Accident time:	not recorded	**Accident Date:**	11/09/1997
Where it occurred:	Pajak Village, Dehyak district, Ghazni Province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Inadequate equipment (?)
Class:	Detection 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 hard
Date record created:	13/02/2004	**Date last modified:**	13/02/2004
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 investigation (?)

inadequate metal-detector (?)

inadequate equipment (?)

inconsistent statements (?)

partner's failure to "control" (?)

vegetation clearance problem (?)

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 available. The following summarises its content.

The victim was reported to have been a deminer for one month, have completed a refresher course six months before [note conflict] and had worked for 48 days since his last leave. The ground where the accident occurred was described as medium hard agricultural land with bushes. A photograph showed that the "bush" was sparse 18" high scrubby, multi-stemmed leafless plants that appeared very dry and were reported to be very difficult to cut. The demining group claimed to have found fragments of the device from which to identify it as a POMZ.

The investigators determined that the victim did not use a tripwire feeler before using the detector, despite the known presence of tripwire mines. They decided that he then moved the detector head quickly and so pulled a tripwire with it.

The Team Leader stated that tripwires are undetectable with a "Philips" (Schiebel AN/19) mine detector.

The Section Leader stated that the tripwire was undetectable. He said the problem could be overcome by burning, except in this case an ammunition store was nearby so they could not burn.

The victim's partner stated that the tripwire went through a "bush" so rendering it impossible to see. He said such areas should be burnt off.

The victim blamed the presence of bush, and suggested that areas such as this should be burnt first.

Conclusion

The investigators concluded that the accident occurred because the tripwire feeler was not used and that the failure of the command group to tell the deminer to use a tripwire feeler was a contributory cause.

Recommendations

The investigators recommended that all Team Leaders and Section Leaders should ensure that deminers were fully equipped and use the equipment at appropriate times, that all detecting/prodding procedures should be carried out according to the established procedures, and that the Section Leader should "strongly advised" about his poor command and control. [It seems likely that tripwire feelers were not available.]

Victim Report

Victim number: 191

Name: **Name removed**

Age:

Gender: Male

Status: deminer

Fit for work: yes

Compensation: not made available

Time to hospital: not recorded

Protection issued: Helmet

Thin, short visor

Protection used: not recorded

Summary of injuries:

INJURIES

minor Hands

severe Abdomen

severe Body

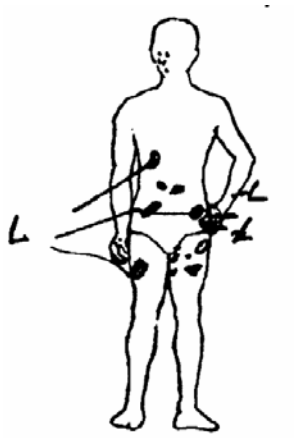
COMMENT

See medical report.

Medical report

The victim's injuries were summarised as severe fragment lacerations to both his hands, his chest and his lower abdomen.

A medic's sketch (reproduced below) showed injuries concentrated on the lower torso and thighs, with small fragment damage on the right hand.



The demining group reported that the victim had sustained serious injuries to both thighs when he detonated a POMZ while using a detector.

A claim was forwarded to the insurers by the UN MAC on 23rd April 1998 saying that the victim suffered multiple penetrating injuries of abdomen anterior wall and posterior wall (both buttocks) – gluteal and sacral regions. "Some fragments (pellets) remain". The insurers were informed that the victim was ready to return to work on 23rd April 1998.

No record of compensation payment was found in June 1998.

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because the victim appears to have been working incautiously and his error was not corrected. No mention is made of his helmet and visor, which may not have been worn.

The investigators imply that some equipment may not have been available to the victim - from which it is inferred that a tripwire feeler may not have been available. This, and the failure to supply an adequate, working detector, is a serious failing of management. The secondary cause is listed as *"Inadequate equipment"*.

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.

Gathering of further accident and medical treatment detail was prevented by the UN programme manager who denied all access to records in September 1999. Access has continued to be denied up to the date of completion of this version of the database.