DDAS Accident Report

Accident details

Report date:	16/05/2006	**Accident number:**	148
Accident time:	not recorded	**Accident Date:**	15/09/1997
Where it occurred:	Laghawat Village, Deyak District, Ghazni 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:**	agricultural (abandoned) hard
Date record created:	13/02/2004	**Date last modified:**	13/02/2004
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 investigation (?)

inadequate metal-detector (?)

safety distances ignored (?)

visor not worn or worn raised (?)

inadequate area marking (?)

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. Victim No.1's partner is not mentioned in the investigation of the accident.

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

Victim No.1 had been a deminer for 18 months. Victim No.2 had worked as Section Leader for 18 months with the demining group. Both victims had attended a revision course six months before, and both had been on leave 52 days before. The ground where the accident occurred was described as "agricultural land with medium hard ground". The demining group claim to have found fragments identifying the mine as a POMZ.

The investigators determined that Victim No.1 was scratching a mark to show the end of the breaching land outside the area actually cleared (he should have left a 50cm safety margin the other way) when his bayonet pulled the tripwire attached to the mine. The mine was three metres away from the deminer when it was initiated. They thought that Victim No 2 did not maintain the proper safety distance and so was hit by some fragments.

Victim No.2 stated that he was 20m from the accident – the required distance – when injured. He thought that the tripwire might have been "undetectable".

Victim No.1's partner said he was working properly and the hidden and undetectable tripwire made the accident unavoidable.

Victim No.1 said he had been working properly and that trip wire was hidden and undetectable.

Conclusion

The investigators concluded that the deminer was negligent when he scratched at the end of his clearance lane and that the Section Leader showed poor performance by not maintaining a proper safety distance.

Recommendations

The investigators recommended that no deminers should be allowed to ignore lane marking safety procedure, and that the command group should stress the need to leave a safety margin of 50cm at the end of a breaching lane.

Victim Report

Victim number: 189

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 Arm

minor Chest

minor Face

minor Neck

severe Arm

severe Eyes

AMPUTATION/LOSS

Eye

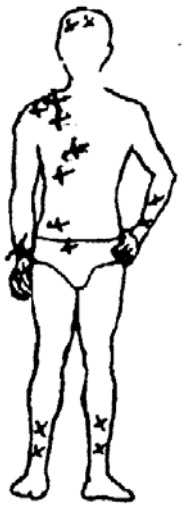
COMMENT

See medical report.

Medical report

Victim No.1's injuries were summarised as: fragments to chest, neck, right arm and wrist, left arm, light trauma on the forehead.

A medic's sketch is reproduced below.



The insurers were informed on 15th January 1998 that Victim No.1 had suffered the loss of his left eye and foreign bodies to his right eye.

The demining group submitted insurance claims on 2nd March 1988 for the victim, stating that treatment for the removal of foreign bodies was not yet complete.

The insurers were informed on 19th March 1998 that Victim No.1 had injuries to the nerves in his right arm, total loss of his left eye, and a right eye VR 6/60. A disability of 75% was assessed on 24th February 1998.

No record of compensation being paid was on file in June 1998.

Victim Report

Victim number: 190 **Name: Name removed**

Age: **Gender:** Male

Status: supervisory **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 Arm

minor Body

minor Chest

minor Face

minor Leg

COMMENT

See medical report.

Medical report

Victim No.2's injuries were summarised as: fragments to left arm, right thigh, right arm, face and chest.

A medic's sketch is reproduced below.

The insurers were informed on 15th January 1998 that Victim No.2 had suffered severe multiple injuries. (See “Related papers” - where the victim was interviewed and said he had 20 days off work, so indicating the "severity" of his injuries.)

The demining group submitted insurance claims on 2nd March 1988 for the victim, stating that treatment for the removal of foreign bodies was not yet complete.

No record of compensation being paid was on file in June 1998.

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because Victim No.1 appears to have been working improperly despite the presence of a supervisor, who did not correct him. If the tripwire were not detectable, however, the accident may have been *"Unavoidable"*.

Protective equipment is not mentioned (despite the facial injury), from which it seems safe to infer that the victims were not wearing helmets with visors down.

It is possible that the victims did not wear their visors correctly because they were too damaged to see through properly (as was seen frequently during field visits in 1998, 1999).

Some effort should have been made to test the ability of the detectors to locate the trip-wire involved in the accident (or others found in the area) and the failure to do so may represent a further management failing.

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.

Related papers

Victim No.2, The Section Leader, was interviewed on 29th July 1998 in Kandahar, Afghanistan. He said he had been a deminer for eight years, the first as a deminer but for the last seven as a Section Leader.

The minefield where the accident occurred was an overgrown Russian post at Pajak, Ghazni Province. He was working as a Section Leader and as break time approached went to a deminer and told him to take his break. The deminer marked the end of the area he had cleared while the Section Leader walked away. As the deminer moved the lane-marking rope to mark the cleared area, he pulled a tripwire and set off a POMZ outside the cleared area. The Section leader was hit by fragments on his chest, face, right arm, left leg and stomach. He was 15 metres from the detonation. He had 20 days off work.

He reported that Victim No.1 sustained injuries that were too serious for him to continue as a deminer. The Section Leader did not know what that man was doing or whether he was able to work.