

# DDAS Accident Report

## Accident details

<b>Report date:</b> 19/04/2006	<b>Accident number:</b> 78
<b>Accident time:</b> 12:05	<b>Accident Date:</b> 06/08/1997
<b>Where it occurred:</b> Gulany Haji Farag, Derbandikhan District	<b>Country:</b> Iraq
<b>Primary cause:</b> Field control inadequacy (?)	<b>Secondary cause:</b> Victim inattention (?)
<b>Class:</b> Missed-mine accident	<b>Date of main report:</b> 25/08/1997
<b>ID original source:</b> SB/AS	<b>Name of source:</b> MAG
<b>Organisation:</b> [Name removed]	
<b>Mine/device:</b> PMN AP blast	<b>Ground condition:</b> not recorded
<b>Date record created:</b> 23/01/2004	<b>Date last modified:</b> 23/01/2004
<b>No of victims:</b> 1	<b>No of documents:</b> 1

## Map details

<b>Longitude:</b>	<b>Latitude:</b>
<b>Alt. coord. system:</b>	<b>Coordinates fixed by:</b>
<b>Map east:</b>	<b>Map north:</b>
<b>Map scale:</b> not recorded	<b>Map series:</b>
<b>Map edition:</b>	<b>Map sheet:</b>
<b>Map name:</b>	

## Accident Notes

handtool may have increased injury (?)  
inconsistent statements (?)  
inadequate area marking (?)  
inadequate medical provision (?)  
inadequate training (?)  
no independent investigation available (?)  
inadequate investigation (?)

## Accident report

The demining group was operating a three-man team with a two-man drill at the time of the accident. One man used the detector, marked any readings, and another man came forward to excavate the reading, feel for tripwires and cut any undergrowth. A third man at any one time was resting.

A "Senior Mines Specialist" for the demining group carried out an investigation and the report was made available. There was considerable doubt about the reliability of the statements taken during an original investigation so further interviews were conducted and the report prepared (not dated but sometime after 24th August) from which the following is taken. There were two separate accidents occurring five minutes apart at the same site. This was the second of these accidents.

The victim began clearance and located a series of PMNs (six in all). He marked each mine with a wooden picket. As he worked, he marked his lane by taking markers from the right side of the lane and placing them on the left.

The Team leader was preparing to destroy the discovered mines when he was injured in the first mine accident on the site that day [See accident No.227]. After the Supervisor had dealt with that accident he went looking for the deminer who had found the mines, intending to appoint him as the acting Team Leader.

The deminer later said that he was returning to the lane to collect his equipment, but the investigator decided that he was trying to conceal his incorrect marking of the lane. The investigator thought it likely that he was using a spike to knock in the marking stakes when he slipped and detonated a mine, possibly with the spike.

The victim was given first aid and taken to the Emergency hospital in Sulymania. He was not given an IV infusion.

[The protective equipment worn by the victim was not recorded.]

## Recommendations

The investigator recommended that all staff should be briefed on the need to adhere to SOPs, that staff should be told that if they saw unsafe practices they could refuse to work, that an addition to SOPs should be written to cover PMN minefields and that medics must be told "again" to administer an IV cannula to all mine casualties.

## Victim Report

<b>Victim number:</b> 108	<b>Name:</b> [Name removed]
<b>Age:</b> 33	<b>Gender:</b> Male
<b>Status:</b> deminer	<b>Fit for work:</b> not known
<b>Compensation:</b> not made available	<b>Time to hospital:</b> 1 hour 30 minutes
<b>Protection issued:</b> Frag jacket	<b>Protection used:</b> not recorded
Helmet	
Short visor	

## Summary of injuries:

INJURIES

minor Arm

minor Hearing

minor Legs

minor Neck

severe Hand

COMMENT: See medical report.

## Medical report

A medical report from the "Emergency hospital" stated:

Admitted 06/08/97 following a mine injury. Discharged 18/08/97

Diagnosis:

Crushed injury left hand (compound fracture 3<sup>rd</sup> metacarpal with loss of articular surface.

Superficial injury to Left arm, neck, Right thigh and Left leg.

Deaf – pain in both ears following explosion.

Debridement of all wounds in OT.

10/08/97 DBR left arm and delayed primary suture Left leg in OT.

13/08/97 Seen by ENT surgeon

Bilateral perforation of both tympanic membranes.

Suffering from tinnitus.

Treat with antihistamine, Stemetil, Amoxicillin, protect from water completely.

See again after 1 month.

16/08/97 DPC Left arm and Left thigh in OT.

18/08/97 Discharged – to attend OPD for dressings every third day.

02/09/97 Wounds clean. To attend hospital for dressings for approximately 2-3 weeks. Hearing improved. To attend ENT clinic on 14/09/97.

## Analysis

The accident is classed as a "missed mine" accident because the Victim was apparently placing marking pegs to delineate the cleared area (which he had neglected to do properly as he worked) when he detonated a mine. He clearly believed he had cleared the area where he was hammering in markers, so he had "missed" the mine.

The primary cause of this accident is listed as a "*Field control inadequacy*" because the victim was working in breach of SOPs and his errors were not corrected. That he had been selected for a temporary position of authority prior to the accident raises questions about the selection method and the lack of appropriate training. Other mines had been missed in the area, which reinforces the view that field control was inadequate and that training was suspect. The secondary cause is listed as "*Victim inattention*" because it seems likely that Victim had been influenced (excited) by the accident and was rushing to correct an error without thinking properly about where to position the sticks.

The victim may not have been wearing his helmet and visor, or may have had his visor raised. However, the short visor (attached to a helmet) issued by this demining group may have allowed the victim to sustain throat injuries while wearing his equipment correctly. The gap between a collar and the visor can be wide, especially when the helmet is tipped back on the head and the visor standing well away from the face.