DDAS Accident Report

Accident details

Report date:	19/05/2006	**Accident number:**	358
Accident time:	09:15	**Accident Date:**	14/02/2001
Where it occurred:	Zawi Zala Rush S/0062 A	**Country:**	Iraq
Primary cause:	Unavoidable (?)	**Secondary cause:**	Inadequate training (?)
Class:	Excavation accident	**Date of main report:**	14/02/2001
ID original source:	AC/HR/AK	**Name of source:**	ELS
Organisation:	Name removed		
Mine/device:	VS50 AP blast	**Ground condition:**	rocks/stones
Date record created:	21/02/2004	**Date last modified:**	21/02/2004
No of victims:	1	**No of documents:**	1

Map details

Longitude:		**Latitude:**	
Alt. coord. system:	ZZ Rush S/0062 A	**Coordinates fixed by:**	
Map east:		**Map north:**	
Map scale:		**Map series:**	
Map edition:		**Map sheet:**	
Map name:			

Accident Notes

no independent investigation available (?)

inadequate metal-detector (?)

inadequate training (?)

Accident report

The demining group carried out an internal inquiry on the date of the accident and made that report available. The report is reproduced below, edited for anonymity.

Introduction

1. At approximately 09:15 on 14 February 2001, a mine accident occurred in Zawi Zala Rush S/0062A.

2. S/0062 is divided into two parts, A and B. GS7 are conducting manual clearance in ‘A' and GS2 are manually clearing ‘B'. The accident occurred in Part A to deminer [Name excised] from G57.

Accident

3. The deminer was conducting manual clearance utilising full excavation drills. At 09:15 he was excavating the front right comer of his lane he initiated what is believed to be a V550. Operations was halted and the deminer was extracted from the minefield in accordance with [demining group] procedures and transported to Sulaimanyah emergency hospital. This was purely a precautionary measure as the initial assessment was a minor injury/cut to the index finger of his right hand. The initial medical assessment was confirmed by medical staff at Sulaimanyah emergency hospital as minor and the deminer was sent home.

4. The weather was overcast with good visibility.

5. The deminer had changed over at 08:40 and had been in the lane for 35mins.

6. The deminer was wearing his PPE correctly as the vest and visor absorbed and deflected all of the blast. There is evidence of fragmentation impact in the centre of the vest as well as in the centre of the visor.

Deminer

7. [The Victim] has been a deminer since 7 Feb 99. He last attended refresher training over the period 14 - 16 Jan 01. Excavation drills were refreshed. According to his Team Leader he is a good deminer who consistently achieves and most often exceeds his clearance rate. He has no recorded instances of fines or other breaches of discipline.

8. He had been conducting full excavation drills since 17 Jan 01 and had discovered 7 x V550 A/Pers mines during that time. The last mine he discovered prior to the accident was the same morning where he informed the SL, closed the lane in accordance with SOPs, opened and started clearance in another lane immediately next to the closed lane when the accident occurred.

9. Some of the 7 mines that he has found this year were at depths greater than 5cm and were found by conducting checks with the MineLab.

Supervision

10. The Group Supervisor was visiting this minefield from 0700 -0900 and was in the adjacent minefield ('B') when the accident occurred.

Post Accident Action

11. [Two names excised] conducted the internal accident investigation their findings form the basis of this report. They secured the accident sire and briefed the Team Leader of actions required following an accident. Also in attendance was the QA –Supervisor and later the [demining group] Location Manager.

12. In accordance with SOPs the team will stand down for 24 hrs. They will conduct revision Training with the focus on excavation drills and safety, they will also carry out conduct minefield maintenance. Normal operations will commence on Feb 01. The vest visor and trowel have been secured in the [demining group] residence.

13. [One investigator] visited [the Victim] at his home at approximately 17:00 and questioned him on his performance leading up to the accident. In his words "As I was investigating a signal from my MineLab I uncovered a rock (slightly bigger than a tennis ball) and slipped my trowel behind it to excavate it out when the explosion occurred". He also complained of a headache.

Conclusion

14. In conclusion, all drills by the Medical staff, radio operators, supervisory staff were conducted in accordance with SOPs which endorses the training and rehearsals.

15. Opinion at this early stage is that the deminer may have erred in his excavation of the rock that seems to have been lodged against the mine that may have been buried at an angle. Possibly he should have completely uncovered the rock from the front and removed it.

16. Correct wearing of PPE greatly reduces the risk of injury. The metal of the trowel was such that it didn't break up into fragments, it bent out of shape but remained intact.

Victim Report

Victim number:	455	**Name:**	**Name removed**
Age:		**Gender:**	Male
Status:	deminer	**Fit for work:**	yes
Compensation:	not made available	**Time to hospital:**	not recorded
Protection issued:	Frag jacket Long visor	**Protection used:**	Frag jacket, Long visor

Summary of injuries:

INJURIES

minor Hand

COMMENT

No medical report was made available.

Analysis

The primary cause of this accident is listed as *"Unavoidable"* because it seems that the Victim may have been working as trained and according to widely respected SOPs when the accident occurred. The secondary cause is listed as *"inadequate training"* because, as the investigators noted, the Victim may have excavated a rock incorrectly and so inadvertently caused the accident.