

DDAS Accident Report

Accident details

Report date: 30/01/2008	Accident number: 538
Accident time: 12:50	Accident Date: 28/06/2005
Where it occurred: Trinco, Trincomalee, Eastern Province	Country: Sri Lanka
Primary cause: Field control inadequacy (?)	Secondary cause: Management/control inadequacy (?)
Class: Missed-mine accident	Date of main report: 28/06/2005
ID original source: None	Name of source: [Name removed]
Organisation: [Name removed]	
Mine/device: Fuze	Ground condition: demolition site (explosives)
Date record created:	Date last modified: 30/01/2008
No of victims: 1	No of documents: 1

Map details

Longitude:	Latitude:
Alt. coord. system:	Coordinates fixed by: GPS
Map east: E 024.05.72	Map north: N 037.29.69
Map scale: Trincomalee	Map series: ABMP
Map edition: 01	Map sheet: 28
Map name: 1:50,000	

Accident Notes

inadequate investigation (?)
mine/device found in "cleared" area (?)
no independent investigation available (?)

Accident report

The report of this accident was made available in January 2008 as an IMSMA file. Its conversion to a text file had to the formatting being lost. The substance of the report is reproduced below, edited for anonymity. The original PDF file is held on record. Text in [] is editorial.

From IMSMA report

Date of accident: 28.06.2005, 12:50

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Place of accident: Trinco, Trincomalee, Eastern Province

GR: Long E 024.05.72; Lat N 037.29.69; GPS

Map sheet: 28

Map series: ABMP

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Accident occurred in a field near a military installation.

The cause of the accident was: Without knowing the deminer was burning the device which caused the detonation.

Accident description:

On the 28th of June 2005 [Demining group] QRT did a bulk demolition before going on stand-down. Most of the ammunition went to high order but 3 grenades went to low order and were destroyed by a second demolition.

After the team had located all metal scrap and rests from the destroyed ammunition by raking the whole demolition area and checking inside the broken sandbags that was used as protection during the demolition, they started to clean the area from the broken sandbags and vegetation. The team started to burn all the collected sandbags and vegetation.

In one of the sandbags apparently one fuse was stuck after the demolition and was not discovered by the deminers when they checked the area after non exploded devices. The fuse probably went off by the heat from the fire and injured a deminer in his left arm and in his back with small metal pieces.

The deminer was wearing his protective vest and visor but had his back turned towards the fire when the fuse exploded.

The device involved was one unidentified fuze.

The victim was a 34 year old deminer named [Name removed].

The IMSMA sketch shows injury to the back and upper limbs.

The victim reached Trincomalee General Hospital hospital within 30 minutes of the accident.

Victim Report

Victim number: 711	Name: [Name removed]
Age: 34	Gender: Male
Status: deminer	Fit for work: presumed
Compensation: Not made available	Time to hospital: 30 minutes
Protection issued: Frontal apron Long visor	Protection used: Frontal apron, Long visor

Summary of injuries:

minor Arm

minor Back

COMMENT: No medical report was made available.

Analysis

This accident is classed as a "Missed mine accident" because the device was in an area supposed to have been cleared.

The primary cause of this accident is listed as a "Field control inadequacy" because the search of the area for "throw-outs" from the demolition was not thorough, despite knowing that some devices had not detonated properly. It is not clear whether the search was inadequate because of poor SOPs, poor training or poor immediate command and control.

The secondary cause is listed as a "Management control inadequacy" because the senior management did not ensure that a thorough investigation was conducted, with SOPs and training adjusted if appropriate.

This investigation is listed as "inadequate" under Notes because no medical details were included, no statements were taken from the personnel present and no conclusions and recommendations designed to prevent repetition of the errors that led to the accident were made.