

# DDAS Accident Report

## Accident details

<b>Report date:</b> 30/01/2008	<b>Accident number:</b> 541
<b>Accident time:</b> 12:30	<b>Accident Date:</b> 09/10/2007
<b>Where it occurred:</b> Nr Jaffna, Kaithady subdistrict, Chavakacheri District, Northern Province	<b>Country:</b> Sri Lanka
<b>Primary cause:</b> Field control inadequacy (?)	<b>Secondary cause:</b> Unavoidable (?)
<b>Class:</b> Excavation accident	<b>Date of main report:</b> 03/11/2007
<b>ID original source:</b> None	<b>Name of source:</b> [Name removed]
<b>Organisation:</b> [Name removed]	
<b>Mine/device:</b> Type 72 AP blast	<b>Ground condition:</b> clay dense vegetation soft trees
<b>Date record created:</b>	<b>Date last modified:</b> 30/01/2008
<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> SL Grid	<b>Coordinates fixed by:</b> GPS
<b>Map east:</b> E 127032	<b>Map north:</b> N 495290
<b>Map scale:</b> Chavakacheri	<b>Map series:</b> ABMP
<b>Map edition:</b>	<b>Map sheet:</b> 4
<b>Map name:</b> 1:50,000	

## Accident Notes

inadequate investigation (?)  
no independent investigation available (?)  
metal-detector not used (?)  
standing to excavate (?)  
use of rake (?)

## Accident report

The report of this accident was made available in January 2008 as an IMSMA file. Its conversion to a text file has led 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 report: **03. 11. 2007**

Date of accident: 09.10.2007, 12:30

Place of accident: Nr Jaffna, Kaithady subdistrict, Chavakacheri District, Northern Province

GR: E 127032; N 495290; GPS: SL Grid

Map name: Chavakacheri

Map series: ABMP

Map sheet: 4

Map scale: 1:50,000

The accident happened in a field and at a roadside.

### Accident description

On the time of the incident [Name removed] was carrying out mine clearance by raking method in a lane where he earlier had found 7 AP mines Type 72. The area he was raking was free from vegetation and no large tree roots or any other obstacles was in the near vicinity of the ground where he was raking. The soil conditions were loose clay. The Team Leader had been checking the deminer 10 minutes before the incident and the section leader had left his lane just a few minutes before the incident. [The Victim] did by raking detonated a mine (most likely a Type 72) which broke off the rake handle and made the rake bend but not break.



[The broken rake handle and bent tines.]

[The Victim] sustained no injuries but was taken to Jaffna Teaching Hospital for routine check.



[The accident site.]

Due to the soil conditions and the fact that there were no major obstacles at the scene of incident it is most likely that [the Victim] has mis-used his rake and by force struck the ground which set of the mine. The Team Leader has on several occasions reminded his team to be careful since it is a minefield which is densely mined and also since they had an accident in the same minefield on the 9<sup>th</sup> of October.

[This report (made by the ex-pat Operations Manager) is for an accident that occurred on 9th October, so the investigator appears to be “confused”. Presumably another accident occurred later and the two reports have become mixed, but no report of the later accident has been made available.]

The Victim was taken to Jaffna teaching hospital within 32 minutes of the accident.

[A picture of the Victim's PPE showed mud spatters on the visor and no obvious damage to the frontal apron.]

### Victim Report

<b>Victim number:</b> 713	<b>Name:</b> [Name removed]
<b>Age:</b> 28	<b>Gender:</b> Male
<b>Status:</b> deminer	<b>Fit for work:</b> yes
<b>Compensation:</b> Not appropriate	<b>Time to hospital:</b> 32 minutes
<b>Protection issued:</b> Frontal apron Long visor	<b>Protection used:</b> Frontal apron, Long visor

#### Summary of injuries:

COMMENT: Non-injurious accident.

## **Analysis**

The Primary cause of this accident is listed as a "Field control inadequacy" because the investigator determined that the ground was easy to work in and the deminer was working too roughly with the rake, but his error was not corrected. Photographs show that the ground was not without some root systems, so the secondary cause is listed as "Unavoidable" because it may be that the Victim was working as trained when the accident occurred.

The "Inadequate investigation" listed under "Notes" refers to the fact that the investigator appears to have confused this accident with another. Also, the investigation was carried out by a single person and without recording any evidence in support of the conclusions. This may be acceptable in a non-injurious accident, but reflects badly on the National Authority which is unable to carry out independent investigations of accidents at this time (due to ongoing conflict in Sri Lanka).

The demining group had put in place the use of a long tool (rake) that kept the Victim far enough away from a blast to avoid injury, and his PPE was effective at protecting him from any risk remaining at that distance. Had he been using conventional short hand-tools, some injury would have been expected.

Stand-off (distance from the detonation) is the most effective PPE and the Rake Excavation system makes use of this. It is possible that the extreme length of the tool makes initiation of small AP blast mines with the Heavy rake more likely, but any increased risk of initiation is offset by the reduced chance of that initiation resulting in injury. The accident is a good example of balancing an effective demining process and PPE to result in a very low risk of injury.