

DDAS Accident Report

Accident details

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| Report date: 18/05/2006 | Accident number: 288 |
| Accident time: not recorded | Accident Date: 13/01/2002 |
| Where it occurred: not made available | Country: Kuwait |
| Primary cause: Management/control inadequacy (?) | Secondary cause: Inadequate training (?) |
| Class: Other | Date of main report: [No date recorded] |
| ID original source: KMOD 53/SER 44 | Name of source: Various/AVS 2001:K11 |
| Organisation: Name removed | |
| Mine/device: VS 1.6 AT blast | Ground condition: sandy |
| Date record created: 19/02/2004 | Date last modified: 19/02/2004 |
| No of victims: 1 | No of documents: 1 |

Map details

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|--------------------------------|------------------------------|
| 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

no independent investigation available (?)

inadequate investigation (?)

inadequate training (?)

inadequate communications (?)

inadequate medical provision (?)

inadequate equipment (?)

Accident report

The details of Kuwait Boards of Inquiry are considered 'Commercial in Confidence'. The following summary is gathered from various documentary and anecdotal evidence made available during the research. All anecdotal evidence is drawn from sources who were in Kuwait at the time of the accident.

The victim had arrived in Kuwait on 14th July 1991, so had been working there for six months. He was employed as an accountant.

A commercial company had been given an extensive contract to clear many areas in Kuwait. The company's management decided to give a better understanding of "Life in the field" to some of the office workers and a two-day recce was organised. The Oilfield Operations Manager was responsible for the first day, which was a visit to the barrier minefield in the south of Kuwait. This was a 1½ hour's drive from the base and so on the edge of the radio coverage for vehicle mounted Motorola radios. There was no alternative communications system available at that time, so it was essential for people to "book out and in" with the ops room. They also had to provide detail of their proposed route and specify check in times. The company had two operations rooms, one at the HQ and one in the oilfields.

On the first day, two vehicles took two passengers from the office to visit the barrier minefields near the Kuwait/Saudi southern border. A "Hospital Trauma pack" and a VHF radio were carried in one vehicle. The recce was successful and went without accident.

On the second day, the two most senior country Managers in the commercial demining company went on the recce. They took a different vehicle (without radio or trauma pack). As on the previous day, the intention was to visit a part of the main barrier minefield laid by the Iraqis, which was believed to be easily identified by a wire fence on each side. The plan was to approach from the North, and stop at the home (North) fence, to observe the mines.

Instead of a Manager driving each vehicle, inexperienced office personnel travelled in one vehicle and the two Managers went in the second. The Manager's vehicle led the way. Both vehicles were Land Rover Discoveries (petrol) but only one was equipped with a vehicle radio. The other had a hand held radio.

The Managers in the lead vehicle were unfamiliar with the details of the area they visited and were apparently unfamiliar with the conventions of minefield marking used. As a result, the vehicles were not approaching a South facing minefield as they expected, but a North facing one. There had been a large Iraqi position there and a "C" shaped minefield had been laid to protect it. The normal South facing minefield was in place until it met the main N/S highway from Kuwait City to Saudi Arabia. The minefield then turned and ran along the road for several hundred metres before turning West. This meant that the low enemy side of the fence was the first fence that would be seen by anyone approaching from the North. Minefields in the area were conventionally marked with a low (20cm) fence on the enemy side and a high (2 meter) fence on the home side.

There was an access track running alongside the "low" enemy fence. There was a minefield clearance team close by and they used the track during their work.

When the two managers arrived in the area they drove on the access track. They saw the two meter high home-side fence and did not realise that it was far too high to be the "enemy" fence, or wonder why the access track was so far away from the minefield. Neither did they notice a breach through the minefield (made by the "Big Red One" machine) less than 100 metres away from the accident site. The mechanical breach started from the access track and ended at the home fence. It did not continue past it into the area believed by the Managers to be the minefield. The breach was obvious and clearly marked, so indicating where the mined area was.

The Managers turned off the track and drove up to the fence. In doing so they drove straight through the minefield followed by the victims in their vehicle. The lead vehicle drove through three or four rows of VS1.6 anti-tank mines. The following vehicle, with the office staff and the only vehicle radio, activated a VS1.6 anti-tank mine as it followed.

The R/H front wheel activated the mine and the blast/debris shattered the R/H passenger wheel assembly and window. The victim's face was injured by metal components from the wheel and brake assembly being driven through the floor of the vehicle. The blast destroyed the vehicle's radio.

The minefield clearance team working nearby came when they heard the explosion to help get the victims out. The Managers went to the damaged vehicle to render first aid. They extracted the casualty, who had severe facial injuries to his R/H side. The victim later said that his feet were fortuitously on the left hand side of the foot-well, so escaped serious injury.

Using the undamaged vehicle (which was driven out of the minefield after a route had been cleared by hand), the Managers transported the victim and his colleague (who was in shock) to the hospital at Ahmadi.

They tried to call for assistance on the hand-held radio, but were out of range. By the time they were in range and could pass a message it was not possible to launch a helicopter because weather conditions were bad at the helicopter base and hospital. The casualty was transported by vehicle towards the hospital and met a US Army medical team on the road. The army medics gave first aid and stabilised the casualty.

The victim, after major facial reconstructive surgery over several years, made a full recovery. He is reported to have been continuously employed by the demining company and to now (2001) be the personnel manager.

The Managers later claimed that the Bedouin had taken the minefield fence away, but the low "enemy" fence was still in place (as witnessed by people who worked at the site on the following day).

Victim Report

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| Victim number: 364 | Name: Name removed |
| Age: | Gender: Male |
| Status: supervisory | Fit for work: yes |
| Compensation: not made available | Time to hospital: not recorded |
| Protection issued: None | Protection used: none |

Summary of injuries:

INJURIES

severe Face

severe Head

COMMENT

No medical report was made available.

Analysis

The primary cause of this accident is listed as a "*Management/control inadequacy*" because the victim was led into a minefield by the demining group's country Managers who had not recognised the danger they drove into. The Managers had not researched the area they visited and did not take elementary precautions regarding communications and trauma equipment. It is possible that they themselves were inadequately trained or prepared for the clearance tasks in Kuwait. The secondary cause is listed as "*Inadequate training*".