

# DDAS Accident Report

## Accident details

<b>Report date:</b> 06/04/2006	<b>Accident number:</b> 291
<b>Accident time:</b> not recorded	<b>Accident Date:</b> 16/03/1992
<b>Where it occurred:</b> not made available	<b>Country:</b> Kuwait
<b>Primary cause:</b> Management/control inadequacy (?)	<b>Secondary cause:</b> Management/control inadequacy (?)
<b>Class:</b> Handling accident	<b>Date of main report:</b> [No date recorded]
<b>ID original source:</b> KMOD 53/SER 44	<b>Name of source:</b> Various/AVS 2001:K14
<b>Organisation:</b> [Name removed]	
<b>Mine/device:</b> Valmara 69 AP Bfrag	<b>Ground condition:</b> not applicable
<b>Date record created:</b> 19/02/2004	<b>Date last modified:</b> 19/02/2004
<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

no independent investigation available (?)

inadequate investigation (?)

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 13<sup>th</sup> May 1991, so had been working there for ten months.

An ex-pat mine clearance team was clearing the forward edge of the main barrier minefield. The edge was sown with VS – T trip flares and V-69 bounding fragmentation mines, all with tripwires deployed.

Operators had disarmed many V-69 mines but some had detonators that were stuck in place. These were placed in a designated area for disposal at the end of each day. At the end of the day, the team leader instructed all the other members to pack up the equipment while he went to the stock of V-69 bounding fragmentation mines a safe distance from the rest of the team to try to remove the remaining detonators, or to destroy the mines if this was not possible. Some det-wells were wet and after they had dried the detonators would drop out easily.

It is variously reported that orders were varied (or that “Custom & Practice” had evolved) to allow the use of artery forceps (tweezers) to extract detonators. This speeded up the end-of-day process. The victim had been tasked with removing those detonators that did not fall out easily.

It is believed that the victim was using artery forceps to extract a detonator when he inadvertently prodded into it. The detonators are “stab-sensitive”. The mine activated and he was killed instantly. No details of his injuries were made available.

The company’s managers denied knowing that artery forceps were used to extract detonators. Field people believe that this was a cynical attempt to save face. Field operatives claim that it was a known and approved short-cut to avoid having to prepare a controlled demolition at the end of each day. All sources to date report that it had been going on for weeks or months [depending on source] with the knowledge and approval of the management from Team-Leaders to “the top”.

## Victim Report

<b>Victim number:</b> 367	<b>Name:</b> [Name removed]
<b>Age:</b>	<b>Gender:</b> Male
<b>Status:</b> supervisory	<b>Fit for work:</b> DECEASED
<b>Compensation:</b> not made available	<b>Time to hospital:</b> not recorded
<b>Protection issued:</b> Frag jacket	<b>Protection used:</b> not recorded
Helmet	
Short visor	
Trousers/leggings	

### Summary of injuries:

FATAL

COMMENT

Severe fatal injuries from blast and fragmentation.

No medical report was made available.

### Analysis

The primary cause of this accident is listed as a “*Management/control inadequacy*” because the victim was tasked to carry out an activity that involved unacceptable risk whether or not forceps were used.

The change to using tweezers (forceps) to save time when removing detonators was apparently a move to copy US practice. Clearly the risk of prodding into a stab-sensitive detonator was not considered high. Those in management who made this decision bear some responsibility for the accident. The attempt to pretend that the change was not “formal” implies that some people recognised that responsibility belatedly.

There is a paucity of reliable data for many of the accidents that occurred in Kuwait. If any reader has additional detail, please send it for inclusion.