

# DDAS Accident Report

## Accident details

<b>Report date:</b> 06/04/2006	<b>Accident number:</b> 295
<b>Accident time:</b> not recorded	<b>Accident Date:</b> 23/01/1993
<b>Where it occurred:</b> not made available	<b>Country:</b> Kuwait
<b>Primary cause:</b> Inadequate training (?)	<b>Secondary cause:</b> Field control inadequacy (?)
<b>Class:</b> Handling accident	<b>Date of main report:</b> [No date recorded]
<b>ID original source:</b> KMOD 94/SER73	<b>Name of source:</b> Various/AVS 2001:K18
<b>Organisation:</b> [Name removed]	
<b>Mine/device:</b> NR409 AP blast	<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 (?)

protective equipment not worn (?)

inadequate investigation (?)

inadequate training (?)

## 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.

An ex-pat specialist working for the commercial company decided to "Inert" a NR409 anti-personnel mine. He did this on a table in his bedroom. He secured the safety clip but did not

replace the cover through which the clip should pass. He believed the pin was the key to safety but the pin without the cover serves no purpose.

After replacing the pin, he turned the mine over and put pressure on the base of the mine to try to force it open. The mine detonated. He lost the hand that was holding the mine and had extensive damage to his leg(s) under the table.

The SOP for the mine was apparently to blow-in-situ because the detonator is sealed in place [but other groups find that it can often be removed].

## Victim Report

<b>Victim number:</b> 375	<b>Name:</b> [Name removed]
<b>Age:</b>	<b>Gender:</b> Male
<b>Status:</b> supervisory	<b>Fit for work:</b> not known
<b>Compensation:</b> not made available	<b>Time to hospital:</b> not recorded
<b>Protection issued:</b> Not recorded	<b>Protection used:</b> none

### Summary of injuries:

INJURIES

severe Legs

AMPUTATION/LOSS

Hand

COMMENT

No medical report was made available.

### Analysis

The primary cause of this accident is listed as a "*Inadequate training*" because the victim clearly did not understand how the mine worked or the risks he was running as he attempted to "inert" it. This implies that he was inadequately selected and/or trained to serve as a specialist.

Appropriate field supervision should have prevented the victim taking a live mine to his room, so there may have been a contributory "*Field control inadequacy*". (It is recognised that the victim himself may have been the field supervisor.)

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.