DDAS Accident Report

Accident details

Report date: 06/07/2005

Accident number: 414

Accident time: 10:04

Accident Date: 24/08/2004

Where it occurred: Erlalai, Nr Punnalaikadduwan, Valikamam South, Jaffna

Country: Sri Lanka

Primary cause: Field control inadequacy (?)

Secondary cause: Inadequate training (?)

Class: Excavation accident

Date of main report: 25/08/2004

ID original source: SP

Name of source: SP

Organisation: Name removed

Mine/device: P4Mk2 P4Mk1 AP blast

Ground condition: hidden root mat
rocks/stones
woodland

Date record created: 06/07/2005

Date last modified: 06/07/2005

No of victims: 1

No of documents: 1

Map details

Longitude:

Latitude:

Alt. coord. system: MF LK-225

Coordinates fixed by: GPS

Map east: 0122323

Map north: 0505387

Map scale:

Map series:

Map edition: 24.08.2004

Map sheet: GIS Arc Explorer 4.0

Map name: 1:10000

Accident Notes

inadequate investigation (?)

inadequate training (?)

long handtool may have reduced injury (?)

no independent investigation available (?)

use of rake (?)

visor not worn or worn raised (?)

Accident report

The demining group involved made available its accident report during October 2004. The report was compiled in IMSMA format and is summarised below.

“Clearance” was in progress during what was recorded as a “Technical survey”. Confusion over the distinction between survey and clearance was apparent at the time.

“Navigation: Take B71 road 10 kms from Jaffna towards Palaly Airport. Stop 300 meters before big junction (left- Erlalai right-Atchuvely) and find a gas station in the right. In the spot, minelfield LK-225 is in left side of the road, starting 50 meters away. Accident spot is 100 meters to Northeast from gas station. “
“Description: Accident spot terrain type is rocky red clay with heavy vegetation.”

[The picture above shows the accident lane.]

“Technical survey was on-going in minefield LK-225, Punnalaikadduwan, when blast occurred at 10:04 am.

“Experienced deminer **sets up an antipersonnel mine with his heavy rake**. There are two one inch thick bush roots lying horizontally in depth of four centimetres, twenty five centimetres from each other. Antipersonnel mine was situated between the roots. Instead of prodding the spot between the roots, deminer continued raking with heavy rake.

“Deminer is left-handed and uses the rake in the right side of his body, left arm and leg in front, left cheek in front.
“Section leader comes to the spot immediately and finds deminer on knees, bleeding from left cheek and nose, holding his head. Visor is lying on the ground in cleared area, heavy rake has broken into two pieces.

[The picture above shows the Victim’s visor with blood spots on the inside.]

[The picture above shows the roots in the blast crater with the broken handle of the rake pointing inwards.]

“Paramedic comes to spot one minute later, gives first aid, notices a small bleeding wound in deminer’s left cheek and three small bruises in the left arm. Small stone has hit the deminer in the face, entering between fragmentation vest collar (body protection) and bottom of visor (head protection).

“Team leader conducts medevac routines according to Standard Operative Procedure, stopping all mine action in the minefield, evacuating team to admin area, counting deminers and closing the accident lane to remain untouched. Further on, he informs [Demining group] Jaffna administrator, technical advisor and the headquarters. Jaffna administrator confirms the information given earlier to the headquarters.

“Paramedic arrives with deminer to Jaffna Teaching Hospital at 10:35 am, where second aid treatment is given. Deminer is mentally a little bit shaky but desires to leave hospital as soon as possible.

“Deminer wants to go back to demine some more, but is told that minefield is now closed due to the investigation and a head-to-toe-check including x-ray is yet not completed.”

Lesson learned:

1) Wearing protective equipment in a correct manner, leaving not open entrance between body protection collar and head protection visor.

2) Using heavy rake clearance method between two roots, where rake cannot be pulled freely, makes little sense. Instead, prodder is to be used always when a spot is a difficult one to check. After that cutting the roots with pruner, before advancing to heavy rake method.

Victim Report

Victim number: 541

Name: **Name removed**

Age: 31

Gender: Male

Status: deminer

Fit for work: yes

Compensation: not made available

Time to hospital: 31 minutes

Protection issued: Frontal apron
Long visor

Protection used: Frontal apron, Long visor (raised)

Summary of injuries:

INJURIES

minor Arm

minor Face

COMMENT

See medical report.

Medical report

A report signed by the Demining group paramedic gave the victim's name and age and stated:

Initial vital signs at injury site: Pulse: 72, BP: 80 [Up-arrow] Resp: 20

Blood group: B-

Dressing applied.

Casualty left site at: 10:08
Photographs showed a light graze on the upper arm and a minor lesion and swelling on the upper left cheek, not more than 3 vertical cm from the eye.

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because the victim was working with his visor raised and his error was not corrected. The secondary cause is listed as *"Inadequate training"* because the internal investigator noted "lessons learned" that were basic training requirements in the rake-drill.

The investigation is listed as "inadequate" under "Notes" because no statements were recorded, no recommendations were made and the Victim was not identified (except by the medic). The investigation was, however, completed with commendable speed and made available readily.