

DDAS Accident Report

Accident details

Report date: 19/04/2006	Accident number: 81
Accident time: 07:55	Accident Date: 20/06/1996
Where it occurred: Rayat, Chowman	Country: Iraq
Primary cause: Field control inadequacy (?)	Secondary cause: Unavoidable (?)
Class: Excavation accident	Date of main report: 23/06/1996
ID original source: MT	Name of source: MAG
Organisation: [Name removed]	
Mine/device: M14 AP blast	Ground condition: hard
Date record created: 23/01/2004	Date last modified: 23/01/2004
No of victims: 1	No of documents: 1

Map details

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

inconsistent statements (?)
partner's failure to "control" (?)
squatting/kneeling to excavate (?)
inadequate investigation (?)
no independent investigation available (?)

Accident report

The demining group was operating a three-man team with a two-man drill at the time of the accident. One man used the detector, marked any readings, and another man came forward to excavate the reading, feel for tripwires and cut any undergrowth. A third man at any one time was resting. The demining group issued full body protection and their drills assumed the deminer would lie prone while excavating.

An internal accident report dated 23rd June 1996 was compiled for the demining group and made available. It stated that the team had been working in the minefield for several months and had found "scores" of M14 mines. The ground was very hard so it was watered every morning before starting work at 07:00.

The victim prodded onto a mine at 07:55. There was a 45cm gap between the accident site and the "recognised face of clearance", indicating that the victim was prodding ahead of his end of lane marker. It was difficult to determine whether the victim had prodded the ground up to the site of the explosion.

The victim stated that he was prodding every centimetre, to a depth of 16cm. His partner was observing 10m away, and was also being observed by the Team Leader. "After a while without seeing anything an accident took place".

Conclusion

The investigator concluded that he did not have enough information to determine exactly what the victim was doing at the time of the accident. The explanations he considered possible were that the deminer prodded too much ground before removing soil and possibly overreached, the victim may have seen a mine outside his area and decided to investigate it, the victim simply over-reached and exerted too much pressure while prodding, or that the ground may have hardened after watering and the victim would not have been able to carry out correct drills.

Victim Report

Victim number: 112	Name: [Name removed]
Age:	Gender: Male
Status: deminer	Fit for work: presumed
Compensation: not made available	Time to hospital: 30 minutes
Protection issued: Frag jacket	Protection used: not recorded
Helmet	
Short visor	

Summary of injuries:

INJURIES

minor Arm

minor Hand

COMMENT

See medical report.

Medical report

The medic stated that he treated the victim "for blast abrasions with antiseptic, and dressed the wounds". The casualty was taken to the emergency Hospital at Chowman by 08:30.

A hand-written report from the "Emergency hospital" records the Victim's injuries as:

"Injury R forearm, wrist and hand, Ulnar aspect.

Treatment: DBR and removal foreign bodies (20/06/96)

Penicillin 500mg 1x4 for 5 days

Elevation and instruction for hand exercises.

D/C 21/06/96

For DPC 26/06/96

Note: normal function at time of discharge.

Signed.

Analysis

The primary cause of this accident is listed as a "*Field control inadequacy*" because it seems most likely that the victim was working incorrectly and over-reaching to prod, and his error went uncorrected. It is worth noting that over-reaching by this distance when lying down is physically impossible, so it seems likely that the victim was kneeling or squatting to work.

While this is normal practice, it is against the particularly demining group's published SOPs. It seems that this group vary the SOP for Iraq, although it is not clear why. However, recognising that it is possible that the Victim was working as directed at the time of the accident, the secondary cause is listed as "*Unavoidable*".

One glaring inconsistency in this report was not recognised by the investigator. The ground was reported to be very hard. If the victim had been prodding to a depth of 16cm at 30° to the ground as he claimed, he would have been inserting his tool about 32cm (over 12") into the ground. To do this by hand is impossible in all but loose, dry sand, and the tool was not long enough to reach this depth anyway.

The application of surface water immediately before prodding does little to soften the ground in any place I have tried it. It does have the advantage of reducing dust and making it easier for the deminer to see what he is doing.