DDAS Accident Report

Accident details

Report date:	22/01/2008	**Accident number:**	501
Accident time:	08:55	**Accident Date:**	11/09/2001
Where it occurred:	Qura Baraza - MAG/S/0285 - Rania district, Kurdistan	**Country:**	Iraq
Primary cause:	Other (?)	**Secondary cause:**	Other (?)
Class:	Excavation accident	**Date of main report:**	21/10/2001
ID original source:	None	**Name of source:**	NGO involved
Organisation:	[Name removed]		
Mine/device:	Pt Mi Baa 111 AT blast	**Ground condition:**	dry/dusty hard rocks/stones
Date record created:		**Date last modified:**	22/01/2008
No of victims:	1	**No of documents:**	1

Map details

Longitude:		**Latitude:**	
Alt. coord. system:	Not made available	**Coordinates fixed by:**	
Map east:		**Map north:**	
Map scale:		**Map series:**	
Map edition:		**Map sheet:**	
Map name:			

Accident Notes

inadequate investigation (?)

Accident report

The report of this accident was made available in 2007. It is the medical data surrounding the accident and does not include the accident investigation. The substance of the report is reproduced below, edited for anonymity. The original file is held on record. Text in [ ] is editorial. If the original investigation report is ever made available, this record will be updated.

Board of Investigation Medical Report

Incident: Mine Accident

Location of Incident: Qura Baraza – MAG/S/0285

Date of accident: 11th September 2001

Time of accident: approx. 0855 hrs

Casualty Age: 30 y.o.

1. Following is a medical report on the fatal mine accident involving deminer [the Victim] (also referred to in this document as "the casualty") following a mine accident at Qura Baraza – MAG/S/0285 minefield in Rania district at approx. 0855 hrs on 11th September 2001. The report also contains copies of the following documents:

- Casualty report (Patient Care Record) completed by the treating medics [Name removed] and [Name removed] (Appendix.1)
- [International demining NGO] Accident Communication form (Appendix 2)
- Emergency Hospital Erbil admission form (Appendix 3)
- Map of the minefield illustrating location of body parts (Appendix 4)
- Death Certificate (Appendix 5)

2. At approx. 0855 Hrs on Tuesday 11th September 2001 the deminer [the Victim] was fatally injured while performing manual demining duties for [International demining NGO]. The accident was caused by the accidental detonation of Pt Mi Ba III anti-tank mine. It should be noted that the casualty had been accepted to participate in the next Team Leaders course. At the commencement of the shift he was congratulated by all members of GS8 for being accepted for a demining team leader course. He was extremely happy on the day of the accident. He was married with one child and had no history of depression.

[It is known that the victim was wearing the demining group's normal PPE because photographs of the armour and visor were included among the pictures of the victim.]

3. Injuries Resulting From Incident:

The casualty received massive trauma with fatal disruption to all body systems. The force of the blast caused massive traumatic lesions and obliteration of the body. The largest of the remains was that of the left leg, which remained largely intact and was attached to some components of the lower torso and chest – this was found approx. 45 metres from the detonation site. The detached left forearm and hand were found badly traumatised approx 150 metres from the detonation site. Other body components were scattered over a radius of approx. 200 metres from the detonation site. Obviously the injuries were immediately fatal.

4. At the time of the accident [International demining NGO] medic [Name removed] ([International demining NGO] I.D No. 608) was on standby in the ambulance at the administration area. He was observing the deminers at work in the minefield. The second medic, [Name removed] was on standby in the rest area. Medic ID. 608 stated that he heard an explosion and then saw flame, dust and the casualty's body fly into the air. He then immediately approached the accident scene, accompanied by Deputy Team Leader [Name removed] ([International demining NGO] ID No: 351). The DTL inspected the accident scene and gave safety clearance for medic 608 to proceed. Section Leader [Name removed] ([International demining NGO] ID No: 642), who was in the rest area, immediately informed the Team Leader [Name removed] ([International demining NGO] ID No: 346) via radio that there had been an accident. Operations were immediately stopped as per Emergency SOP.

5. The team leader stated that he was performing duties in another part of the mine field and was not in immediate proximity to the accident site. He stated that by the time he had reached the accident site, medic 608 was at the accident scene.

6. Medic 608 stated that when he arrived at the accident site, human remains and debris were still falling from the sky. The second medic (609) arrived within two minutes of the accident. Both medics stated that it was immediately obvious that the victim was fatally wounded. They commenced a systematic assessment of other team members to ensure there were no other casualties. A head count was conducted. Both medics took control of scene management by controlling, calming and observing the deminers. Two deminers were in need of assistance, one deminer was vomiting and another deminer suffered a syncope episode (he fainted).

7. The Team Leader contacted Koya communications base via radio informing them that there had been a mine accident. He was instructed to communicate with Charlie UNOPS Base on Channel four and the mine accident information was correctly communicated as per Emergency SOP (refer to Appendix 2). All deminers returned to the admin area and both medics commenced collecting the body parts from the safe areas and placing them in a body bag. The body bag was then loaded onto the stretcher and then into the ambulance. Both

medics then escorted the body to Suleimanya Emergency Hospital. The ambulance departed the scene with the corpse at approximately 0930 hrs and arrived at Suleimanya Emergency Hospital at approximately 1100 hrs. The casualty was declared dead on arrival in the casualty department by Dr. [Name removed] at 1105 hrs. The body was then transferred to the Suleimanya Forensic Laboratory for autopsy.

8. International group supervisor [Name removed] met the ambulance ten minutes after it had departed from the accident site. Group Supervisor [Name removed] then secured the accident scene as per Emergency SOP and awaited arrival of the accident investigators: Location Manager [Name removed] and UNOPS QA Officer [Name removed]. [Name removed] instructed the deminers to assist in collecting remains that had been missed by the medics, these were collected and transported to Suleimanya Hopsital.

[Body parts, this is a forearm and hand, were photographed.]

9. Following the autopsy the body was released from the Forensic Lab and transported to the family home. The body was escorted by the two medics, Location Health and Safety Officer and several members of GS8.

10. Reporting procedures were followed according to [International demining NGO] SOP in an efficient manner. The casualty was correctly assigned a Charlie four categorisation (death).

Follow Up Actions

11. All operations in the south sector were ceased for two days following the accident and operational staff were assembled at Susi fort for refresher training. These staff members were given the opportunity to attend the funeral in Rawandaz. [International demining NGO] Program Manager, South Sector Location Manager, Group Supervisors and Health & Safety Supervisor attended memorial service at the mosque in Rawandaz on September 13th 2001.

12. Medics received refresher training in multiple casualty management, cardiopulmonary resuscitation and scene management procedures following fatal mine accidents. The Health & Safety Supervisor debriefed the [International demining NGO] medics 608 and 609. All members (including Team Leader, Deputy Team Leader, Section Leader and medics) of Team GS8 received psychiatric assessment and counselling by [International demining NGO] Dr. [Name removed] and [International demining NGO] Health & Safety Supervisor.

13. All team members were offered appointments with Psychiatrist Dr. [Name removed] from Suleimanya General Hospital. All GS8 team members declined the offer. However the Deputy Team Leader and one deminer accepted the offer and were referred for an appointment and given one-week leave from operations.

14. The [International demining NGO] doctor will assess all GS8 team members over the next few weeks and renew the offer for counselling and psychiatric treatment.

Comments

15. There was an allegation that the medics panicked during the casevac. This was thoroughly investigated and found to be totally incorrect. Interviews were conducted with the Team Leader, Deputy Team Leader, Section Leader and international Group Supervisor [Name removed]. All stated that the performance of the medics was calm and highly proficient. The medics have in fact had a great deal of experience with similar incidences during the internal conflicts. The TL, DTL and SL all highly praised the performance of the medics during the casevac.

16. This was the first fatal accident in the Northern Iraq Mine Action Program. The massive blast obliterated the casualty. The performance of the medics was extremely professional; they acted in a calm, systematic manner. The medics realised immediately that the casualty was fatally wounded and concentrated on controlling and assessing the deminers. They quickly brought the situation under control and then attended to the corpse. The team leader stated, “He owes the medics for the rest of his life for the way that they worked”.

17. The casualty evacuation was performed very well - all procedures were followed correctly. In such devastating circumstances, leadership and control are extremely important. This accident has been the greatest test of the casevac process and of the training of the medics, team leader, deputy team leader and section leader. The medics acted calmly and proficiently in extremely stressful circumstances. The casevac was performed efficiently and professionally according to the [International demining NGO] emergency Operating Procedure.

18. The medics ([Name removed] & [Name removed]), South Sector Location Health and Safety Officer – [Name removed], South sector [International demining NGO] Dr. [Name removed], GS8 Team leader- [Name removed], Deputy team leader – [Name removed] and section leader – [Name removed] are all to be commended on their professionalism.

[Name removed], Health & Safety Supervisor. Tuesday, 18 September 2001

Report Copy to: [Name removed] UNOPS investigator.

[Name removed] - Acting [International demining NGO] Ops Manager.

[Name removed] [International demining NGO] PM.

Victim Report

Victim number: 661
Name: [Name removed]
Age: 30
Gender: Male
Status: deminer
Fit for work: DECEASED
Compensation: $8,900
Time to hospital: Not made available
Protection issued: Frontal apron, Long visor
Protection used: Frontal apron, Long visor

Summary of injuries:

FATAL

COMMENT: Dismemberment. See Medical report.

Medical report

From accident claim form:

“Massive trauma with fatal disruption to all body systems following accidental detonation of an anti-tank mine. The patients body parts were collected and transported to Emergency Hospital in Suleimanya where he was pronounced Dead on Arrival at approximately 1100hrs.”

[The Victim]’s family received $6,000 US on 21 October 2001. Still awaiting further $2900 from in country funds.

[International demining NGO] have approved payment of $8,900.

[Pictures of the Victim’s body parts are reproduced below.]

Analysis

This accident is included despite lacking any detailed report of how the accident occurred. This is because the medical detail has been requested by demining medics who use the database.

The primary cause and secondary causes of this accident are listed as “Other” because there is not enough information to assess what occurred.

This record will be updated if more information is made available.