

11-10-1991

## DDASaccident280

Humanitarian Demining Accident and Incident Database  
*AID*

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# DDAS Accident Report

## Accident details

<b>Report date:</b> 18/05/2006	<b>Accident number:</b> 280
<b>Accident time:</b> not recorded	<b>Accident Date:</b> 10/11/1991
<b>Where it occurred:</b> not made available	<b>Country:</b> Kuwait
<b>Primary cause:</b> Management/control inadequacy (?)	<b>Secondary cause:</b> Inadequate training (?)
<b>Class:</b> Excavation accident	<b>Date of main report:</b> [No date recorded]
<b>ID original source:</b> KMOD 34/SER 24	<b>Name of source:</b> Various/AVS 2001:K4
<b>Organisation:</b> Name removed	
<b>Mine/device:</b> Valmara 69 AP Bfrag	<b>Ground condition:</b> sandy soft
<b>Date record created:</b> 19/02/2004	<b>Date last modified:</b> 19/02/2004
<b>No of victims:</b> 2	<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 (?)  
pressure to work quickly (?)  
protective equipment not worn (?)  
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.

Victim No.1 had arrived in Kuwait on 8<sup>th</sup> June 1991, so had been working there for five months.

Victim No.2 had arrived in Kuwait on 22<sup>nd</sup> May 1991, so had been working there for five and a half months.

The demining group were a commercial company with a time penalty on their work. International staff were paid very well. The group worked in three-man teams with a two-man drill. They used the Schiebel AN-19 detector.

The victim had not been trained as a deminer by his employer although years previously he had completed the basic engineers course in the British army, including minefield breaching. The victim was employed as a member of the "Oilfield teams" tasked to drive around through the fires and check the ground for bomblets. Two men sat on the front of a "Landrover" or "Suburban" and when they spotted bomblets, they which were destroyed in-situ by their trained Team Leaders. The victim returned from a month's leave before the rest of his team, and was seconded to a minefield clearance team on the beaches.

The victim asked not to be sent to the minefields because he had no experience or training, but his request was turned down. When he arrived at the site he was given some in-situ training.

The team were looking for V-69 bounding fragmentation mines on the slope of the beach. The drill was to destroy the mines in-situ because they were often sea-damaged. For example, a few days previously a V-69 with its fuze broken and the ball bearings exposed had been found.

PE4 was used for demolition, with the charge placed according to ease of access. 1/2 stick or a full stick was used depending on ease of placement.

The victim was coming to the end of his shift when he discovered a V-69 and began to expose it for demolition. His partner reported that the victim was racing against the tide to get the job finished, when suddenly the sand gave way and he slid into the hole he was excavating. This may have been because of his heavy weight and the sand getting wetter (softer) as the tide advanced.

The mine functioned, bounded and detonated. It is not clear whether it detonated against his lower body or at a distance from it.

The victim was wearing a helmet and visor. The visor was torn off and the Rayban sunglasses underneath were broken. Witnesses report that his eyesight was unaffected. The victim's helmet was "damaged". His Protective equipment was not penetrated, but he was not wearing the trousers. The victim was not wearing leg protection because he was too big to wear it comfortably (a problem reported by other large men in the team).

The victim's partner (Victim No.2), made a claim for post-traumatic stress following the accident and is reported to have received approx £100,000 settlement. He was 20m away when the accident occurred.

After the accident Victim No.1 was talking and could see. One arm had been removed below his shoulder and one arm was "hanging by a thread". He lived for 4 hours after the accident. A large man (approx 250 lbs or 114kg) he complained of constriction in his chest during MEDEVAC.

He had many fragments in his legs which were only discovered later (self-sealed).

The victim was evacuated by Helicopter and transferred to a better equipped hospital because his injuries were too extensive for field treatment. He could hear and respond throughout the MEDEVAC.

PPE was not modified following the accident.

Beach clearance by hand was suspended after the accident and the work was completed by machines, (armoured HYMAC and Bulldozer).

## Victim Report

<b>Victim number:</b> 355	<b>Name:</b> Name removed
<b>Age:</b>	<b>Gender:</b> Male
<b>Status:</b> deminer	<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> Frag jacket; Helmet; Short visor
Helmet	
Short visor	
Trousers/leggings	

### Summary of injuries:

INJURIES

severe Chest

severe Legs

AMPUTATION/LOSS

Arm Above elbow

Arm Above elbow

FATAL

COMMENT

No medical report was made available.

## Victim Report

<b>Victim number:</b> 356	<b>Name:</b> Name removed
<b>Age:</b>	<b>Gender:</b> Male
<b>Status:</b> deminer	<b>Fit for work:</b> yes
<b>Compensation:</b> £100,000	<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:

COMMENT

Post- traumatic stress. No formal medical/psychological report was made available

## **Analysis**

The primary cause of this accident is listed as a "*Management/control inadequacy*" because the managers knew that Victim No.1 was inadequately trained for the task, and was not provided with full PPE of a size that he could wear (although it is not clear how much his leg injuries contributed to his death), yet still tasked him with the job. The secondary cause is listed as "*Inadequate training*".

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.