

11-25-1991

# DDASaccident281

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> 281
<b>Accident time:</b> not recorded	<b>Accident Date:</b> 25/11/1991
<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> Handling accident	<b>Date of main report:</b> [No date recorded]
<b>ID original source:</b> KMOD 37/SER 27	<b>Name of source:</b> Various/AVS 2001:K5
<b>Organisation:</b> Name removed	
<b>Mine/device:</b> Pt Mi Baa 111 AT blast	<b>Ground condition:</b> sandy
<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 (?)

inadequate investigation (?)

inadequate communications (?)

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.

The victim had arrived in Kuwait on 17<sup>th</sup> June 1991, so had been working there for five 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.

An experienced ex-pat deminer was working on manual clearance of PTMIBA-III AT mines. The mines were surface laid and in a regular pattern. He had disarmed several that morning and had changed with his No2. He returned after a rest break and approached the next mine in the row. He was witnessed approaching the mine, bending down and it is believed he had a tool in his hand. He reached the mine and his partner reported that he was brushing the sand from the top of the mine when it detonated.

The victim was "torn limb from limb" and died instantly. His PPE was either "not penetrated" or "disintegrated" depending on the source.

The team managers had been informed at a daily meeting a few days before that according to the plan of operations it was expected that the group would soon reach an area containing these mine. The Pt Mi Ba 111 was officially designated as a 'NO TOUCH" mine which should be prepared for disposal in situ. This was because information suggested that the mines were detonating spontaneously due to fuze failure as a result of age, temperature etc. Several had apparently detonated spontaneously at night.

Unfortunately, either the Team Leader had not been passed this information by the team Manager, or had decided to over-rule it. It is possible that the information was simply not passed on in time because the deminers worked more quickly than expected. Whatever the reason, a failure of communication in the management chain meant that the victim was working in a manner that was known to be unsafe at the time of the accident.

## Victim Report

<b>Victim number:</b> 357	<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> not recorded (worn)
Helmet	
Short visor	
Trousers/leggings	

### Summary of injuries:

FATAL

COMMENT

Victim "blown limb from limb": immediately fatal. No medical report was made available.

### Analysis

The primary cause of this accident is listed as a "*Management/control inadequacy*" because the practice of defusing the Pt Mi Baa 111 mines had been identified as dangerous and the order to destroy in-situ had been given. It was a management failing that the order was delayed in the command chain. 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.