

10-25-1999

DDASaccident305

Humanitarian Demining Accident and Incident Database
AID

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DDAS Accident Report

Accident details

Report date: 19/05/2006	Accident number: 305
Accident time: 11:20	Accident Date: 25/10/1999
Where it occurred: Suleimanya province, Sharbazher district, Mawat sub-district, Bazaro village	Country: Iraq
Primary cause: Unavoidable (?)	Secondary cause: Inadequate equipment (?)
Class: Excavation accident	Date of main report: [No date recorded]
ID original source: ET	Name of source: ET/AVS 2001:KI02
Organisation: Name removed	
Mine/device: PMN AP blast	Ground condition: dry/dusty grass/grazing area metal fragments
Date record created: 19/02/2004	Date last modified: 19/02/2004
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

no independent investigation available (?)
inadequate investigation (?)
inadequate equipment (?)
incomplete detonation (?)

Accident report

The following information was provided by the demining group involved. It is not an "Accident report" but a summary of the accident provided for this purpose. A request was made for the original accident report in 2000 [not answered in 2004].

The picture below shows the accident site with the victim's helmet and visor lying at the side of the lane.



The accident occurred in a minefield called Palkie that was laid in 1970s. The area was heavily contaminated with metal as a result of shelling during the Iraq-Iran war. The contamination was such that a metal detector could not be used in some places and a "clearance by excavation" method was used.

In one place where a shell had dropped, the victim was excavating using a Russian bayonet when he initiated a mine. The picture below was provided by the demining group and shows how the victim was holding his bayonet at the time of the accident.



The mine was an Iraqi PMN that had been 5cm under the ground surface. The demining group reported that these mines were known to be very sensitive, requiring only a small pressure to be activated - especially when they had been under the ground and exposed to water from rain for a long time. The picture on the right was provided by the demining group and shows how the victim was holding his bayonet at the time of the accident.

Fortunately only the booster of the mine detonated "as the main charge was expired".

The victim's visor and flak jacket protected the covered parts very well. The yellow spots on the picture below show where the fragments struck the victim's frag-jacket.



The deminer was “able to rejoin the work after his injuries had healed”.

Victim Report

Victim number: 385	Name: Name removed
Age:	Gender: Male
Status: deminer	Fit for work: yes
Compensation: not made available	Time to hospital: not recorded
Protection issued: Frag jacket Helmet Long visor	Protection used: Frag jacket, Helmet, long visor

Summary of injuries:

INJURIES

minor Arm

minor Hand

minor Neck

AMPUTATION/LOSS

Fingers

COMMENT

See medical report.

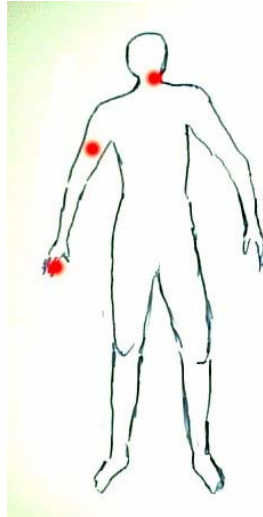
Medical report

No formal medical report was made available. His injuries were recorded as:

He suffered:

“Right hand with traumatic amputation of the tip of index finger; Burning injury on the upper part of the right arm; Bruising injury on the neck; Right hand, fracture on the base of the first metacarpal”.

The sketch of the victim’s injuries shown below was provided.



Analysis

The primary cause of this accident is listed as “*Unavoidable*” because the victim was apparently working to widely approved SOPs when the accident occurred. However, the victim was excavating using a Russian bayonet as a digging tool. This is not an appropriate excavation tool and its use may have made the accident more likely to occur. Its short length and brittle handle made the small detonation from a booster inflict fairly severe hand injuries. The secondary cause is listed as “*Inadequate equipment*”.

The provision of inadequate and unsafe hand tools is a responsibility of management and the failure to do so is a “*Management/control inadequacy*”.

The investigation is considered inadequate because it did not seek to reach conclusions or recommendations that might prevent a recurrence.