

8-14-1996

# DDASaccident361

Humanitarian Demining Accident and Incident Database  
*AID*

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# DDAS Accident Report

## Accident details

<b>Report date:</b> 19/05/2006	<b>Accident number:</b> 361
<b>Accident time:</b> 09:10	<b>Accident Date:</b> 14/08/1996
<b>Where it occurred:</b> Mawatawa MF	<b>Country:</b> Iraq
<b>Primary cause:</b> Unavoidable (?)	<b>Secondary cause:</b> Field control inadequacy (?)
<b>Class:</b> Other	<b>Date of main report:</b> 22/08/1996
<b>ID original source:</b> AB/SW	<b>Name of source:</b> MAG
<b>Organisation:</b> Name removed	
<b>Mine/device:</b> Type 72 AP blast	<b>Ground condition:</b> rocks/stones
<b>Date record created:</b> 21/02/2004	<b>Date last modified:</b> 21/02/2004
<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> MAG/D/008A	<b>Coordinates fixed by:</b>
<b>Map east:</b>	<b>Map north:</b>
<b>Map scale:</b>	<b>Map series:</b>
<b>Map edition:</b>	<b>Map sheet:</b>
<b>Map name:</b>	

## Accident Notes

no independent investigation available (?)  
partner's failure to "control" (?)  
inadequate investigation (?)  
non injurious accident (?)  
disciplinary action against victim (?)  
inadequate metal-detector (?)

## Accident report

An internal accident report was made available by the demining group involved. The report was brief and accompanied by statements from those involved. The following summarises the accident report and adds details from the statements when necessary for clarity.

The investigation by an ex-pat specialist was delayed and by the time it took place the accident area had been cleared. As a result, the investigation relied on the report of a local investigator who had visited the site on the day the accident occurred.

The accident occurred on a “dry, sunny day” in a rocky minefield named “Mawatawa”.

A deminer was working at the end of his lane, moving rocks aside so that he could use his detector. He removed all rocks to a distance of 30cm into the uncleared area, which led the investigator to believe that he could not necessarily see all around the rocks he was moving. The deminer is meant to sweep his Schibel detector half over the cleared area and half over the unknown area, so that each sweep can be only of half the detector-head width. This is 15cm, so a swath of only 15cm of rocks needs to be moved each time.

Photographs showed that the entire area was covered in rocks and sloping [these were poor photocopies and could not be reproduced]. The Victim picked up a rock and moved back with it to put it to one side. He had withdrawn two meters when a dislodged rock rolled into the area he had cleared of rocks and detonated a Type-72a blast mine. The Victim suffered no injuries.

The investigator determined that the accident occurred because of an error in the Victim’s drills. His partner failed to correct his error.

The investigator concluded that accident sites should not be disturbed prior to an investigation by an “International Mines Specialist”, and that the correct drills for clearance (emphasising the detector head overlap) should be “re-emphasised to all demining teams”.

Both the Victim and his No.2 were “given a verbal warning for not complying with SOPs”.

## Victim Report

<b>Victim number:</b> 458	<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> not appropriate	<b>Time to hospital:</b> not appropriate
<b>Protection issued:</b> Frag jacket Helmet Short visor	<b>Protection used:</b> Frag jacket, Helmet, Short visor

### Summary of injuries:

COMMENT

The victim suffered no reported injuries.

### Analysis

The primary cause of this accident is listed as “*Unavoidable*” because the Victim was removing rocks in order to use his detector. He moved a rock with enough caution so that the rocks resting on it did not move until he had withdrawn two meters.

A deminer on his knees can easily see 30cm from his knees (12”) and so the investigator’s claim that he could not see around the stones was “strained”.

The secondary cause of the accident was a “*Field control inadequacy*” because, if the Victim were really in breach of SOPs, his partner or a field supervisor should have corrected him.

No mention is made of PPE in the investigators report, from which it is inferred that PPE was worn appropriately.

The use of the old model of Schiebel detector in Type 72 AP mine area is highly questionable. Many groups acknowledge that it cannot reliably detect this mine at a few centimetres depth in easy soils – and far better detectors are now available.