DDAS Accident Report

Accident details

Report date:	17/01/2008	**Accident number:**	478
Accident time:	10:42	**Accident Date:**	13/08/2006
Where it occurred:	IR No.10/2, Beyr Mathkour, Wadi Araba	**Country:**	Jordan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Unavoidable (?)
Class:	Excavation accident	**Date of main report:**	13/08/2006
ID original source:	NS-10-2/13/08/06	**Name of source:**	JES
Organisation:	[Name removed]		
Mine/device:	No 10 AP blast	**Ground condition:**	dry/dusty hard
Date record created:	17/01/2008	**Date last modified:**	17/01/2008
No of victims:	1	**No of documents:**	1

Map details

Longitude:		**Latitude:**	
Alt. coord. system:		**Coordinates fixed by:**	GPS
Map east:	E 35.184	**Map north:**	N 30.476
Map scale:		**Map series:**	
Map edition:		**Map sheet:**	
Map name:			

Accident Notes

inadequate investigation (?)

metal-detector not used (?)

no independent investigation available (?)

non injurious accident (?)

standing to excavate (?)

use of rake (?)

Accident report

The report of this accident was made available in November 2007 as a PDF file. Its conversion to a text file for editing means that some of the formatting has been lost. The substance of the report is reproduced below, edited for anonymity. The original PDF file is held on record. The accident report is substantially the same as the report for another accident that occurred on the following day.

INCIDENT REPORT

MINEFIELD TASK ID - NS - 10 - 02

SECTOR- NORTH SOUTH, PLACE - BEYR MATHKOUR, REGION - WADI ARABA

INVESTIGATION CONDUCTED BY – [Demining group Programme Manager]

SECTION COMMANDER and TEAM LEADER [Names removed]

TEAM: SITE PREPERATION TEAM

TIME OF ACCIDENT: 10:42 AM

DATE OF ACCIDENT: 13 AUG 2006

NATURE OF INJURY: NIL

TYPE OF MINE: NO-10 ISRAELI ANTI PERS MINE

Details from IMSMA report

The incident occurred during ongoing work in the North South Sector minefields. Buried device detonated while raking with Heavy rake.

A [Demining group] Manual Team One, deminer hit a No.10 AP mine from the top that resulted in a mine blast. The deminer suffered no injuries. He was wearing his protective Vest and Goggles. [Photographs of both Victim and PPE showed no damage.] The tines of the heavy rake were bent.

The crater left by the initiation was approx 15cm deep and 30cm wide.

The ground at the incident site was hard and flat. The weather at the time was clear, calm and hot. There was no vegetation.

The demining team was founded 46 days before the accident. The team had been at the site for 40 days and working at the specific task for five days. They had been working for four hours on the day of the accident.

The investigation was conducted by [Demining group] programme manager. The report was compiled and translated by a Medic. The report was printed on the day of the accident: 13/08/2006.

Statements by the Victim and witnesses were referenced [Not attached].

Apart from date changes and the name of the Victim, this report is identical to the report for the accident that occurred on the following day, 14th August 2006.

Victim Report

Victim number:	638	**Name:**	[Name removed]
Age:	41	**Gender:**	Male
Status:	deminer	**Fit for work:**	yes
Compensation:	Not applicable	**Time to hospital:**	Not applicable
Protection issued:	Frontal apron Goggles	**Protection used:**	Frontal apron, Goggles

Summary of injuries:

COMMENT: Photograph of the Victim showed no injuries to face, hands and arms. Non-injurious accident.

Analysis

The primary cause of this accident is listed as a “Field control inadequacy” because the photographs show that the initiation occurred outside the lane (marking is achieved by side of lane trenches) on ground that had not been “brushed” with the Light rake. In the correct procedure, the Light rake is used before the Heavy rake. It seems that Victim was working in

a manner that conflicted with authorised procedures and his mistake was not corrected. The secondary cause is listed as "Unavoidable" because there is not enough information in the report to be certain of the cause, and the deminer may not have been at fault.

The failure of the demining group's management (who conducted the inquiry) to produce a detailed report probably reflects their impatience at having to investigate a non-injurious accident but is still a significant "Management control inadequacy". This report is substantially the same as a report for a second accident on the following day. The National demining authority should have accepted responsibility for conducting their own independent investigation.

The demining group had put in place the use of a long tool (rake) that kept the Victim far enough away from a blast to avoid serious injury, but the raking process that this demining group has pioneered is only safe if systematically conducted in a disciplined manner. As with any tool, rakes can be misused. The most common misuse is "Hacking" at hard ground with the Heavy rakes, which this man apparently did. The distance still provided some protection and probably prevented injury.

The "Inadequate investigation" listed under "Notes" refers to the fact that there was no evidence of any investigation in the papers provided, and no explanation of what occurred. It is also unacceptable that the report was simply copied and edited for the accident that occurred on the following day.