

DDAS Accident Report

Accident details

Report date: 06/03/2011	Accident number: 676
Accident time: 08:25	Accident Date: 20/06/2010
Where it occurred: Task No: 364/469B, Swailmah village, Al Mafraq Prvince, NE Sector	Country: Jordan
Primary cause: Field control inadequacy (?)	Secondary cause: Management/control inadequacy (?)
Class: Excavation accident	Date of main report: Not recorded
ID original source: None	Name of source: Demining group
Organisation: [Name removed]	
Mine/device: M14 AP blast	Ground condition: hard rocks/stones
Date record created:	Date last modified: 06/03/2011
No of victims: 1	No of documents: 2

Map details

Longitude:	Latitude:
Alt. coord. system:	Coordinates fixed by:
Map east: 36. 13957 E	Map north: 32. 52343 N
Map scale:	Map series:
Map edition:	Map sheet:
Map name:	

Accident Notes

no independent investigation available (?)
standing to excavate (?)
use of rake (?)
long handtool may have reduced injury (?)
non injurious accident (?)
disciplinary action against victim (?)

Accident report

A report of this accident was made available by the demining group involved in late 2010. Its conversion into a DDAS file has led to some of the original formatting being lost. Text in square brackets [] is editorial.

The internal investigation report is reproduced below, edited for anonymity.

Incident investigation for [Demining group] – MINE ACTION TEAM - JORDAN

Task Name: Swailmeh 4 (364/369b), north border project, north east SECTOR

GRID REF: 32. 52343 N: 36. 13957 E, Village Name: swailmeh

Investigation conducted by – [Demining group]

Victim deminer: [Name removed], DATE OF BIRTH: [Not recorded], NIC NO: [Removed]

TEAM LEADER: [Name removed], Team: Golf

TIME OF INCIDENT: 08:25 hrs, DATE OF INCIDENT: 20 June 2010

NATURE OF INJURY: no injuries, TYPE OF MINE: M14 Anti-Personal

IMSMA DETAILED REPORT FOR MINE INCIDENT Sunday, 20 June 2010

Part 1 – Description of the incident

1. Organisation name: [Demining group], JORDAN, Team No: Golf
2. Incident date: 20 June 2010, Time: 08:25 hrs
3. Location of incident: NE SECTOR, Province: AL Mafrag, Village: Swailmah, Project or task No: 364/469B
4. Name of site manager or team leader: [Name removed]
5. Type of incident: uncontrolled detonation of a mine
6. Device was detonated by: Deminer
7. Device detonated while: Raking with Heavy Rake
8. Device was found in an area classified as: a known hazardous area
9. Narrative (Describe how the incident happened. Attach additional pages and photographs or diagrams to assist in clarifying the circumstances surrounding the incident):

While the deminer try to investigate a signal indicated by the metal detector in an expected site of an AP M14 mine, the deminer didn't approach the signal in the proper procedure and hit the mine with the heavy Rake on the pressure plate which activated the mine and caused the blast 200 away from the deminer

Part 2 – Injuries

10. Did the incident result in any injuries? No
11. List people injured and nature of injury: [Name removed], Deminer, No Injury

Part 3 – Equipment damages

12. Did the incident result in any damage to equipment or property? Yes

13. List any mine action equipment or property damage

Heavy Rake, Damaged (not reusable)



[The bent rake-head.]

14. List damage to equipment or property owned by a member of the public or the government. Include contact details of the owner or responsible person. [None]

Part 4 – Explosive hazard

15. Provide details of mines/UXO/ other devices that were involved in the incident.

Device Type:	Method:	Determined by:
AP (Blast) Mine	Buried	Raking

16. State specific device (if known): Anti-Personal Mine, M14

17. Comments (include measurements of any crater resulting from the explosion): Crater Depth: approx. 8 cm / Width: approx. 30 cm

Part 5 - Site conditions

18. Describe the conditions at the site at time of the incident

Ground/Terrain: hard, flat, open

Weather: Clear, mild

Vegetation: medium, burnt, grass

Part 6 – Team and task details

20. Qualifications of Member(s) involved in the incident:

[The Victim], Deminer

21. How long had this team been?

a. At this site? 1 Month & 3 weeks

b. working on this task? 1 Month & 3 weeks

c. working on the day? 2 Hours & 0 minutes

22. Detector type: F3, Serial Number: [Not recorded], Detector status: Functional: Passed to [Name removed] for technical inspection at Swailmeh 4 Site on 20 of June 201. Tripwire feeler used? No

23. Hand tool: HEAVY RAKE

24. PPE: Vest, Visor, [blast boots]

25. Comments: [None]

Part 7 - Medical & First Aid

Medical treatment required? no

26. Medical Support at Incident Site: Medic, 1st Aid Kit, Stretcher, Ambulance, Radio to call forward medic.

27. Was a Mine Incident Drill carried out? Yes

28. Time and distance data

a. Time from incident to SECTION MEDICAL POINT: (1) minutes

b. Time spent at site administering treatment: (NA)

c. Time from evacuation FROM to arrival King Abdullah Hospital: Not Applicable.

Part 8 – Reporting procedures

Reported by: [Name removed], [Demining group] Jaber Office to: [Demining group] Offices & NCDR

Investigation conducted by: [Name removed]

Report compiled/translated by: [Name removed], [Name removed]

Verified by: [Name removed]

Findings:

Approaching drill to the target not as per as SOP.

No use for the marking system.



No use for base stick during the work.

No use for the light rake.

Signed: Tech & Ver. Coord.

Operations manager analysis and recommendations

The deminer tend to use the heavy RAKE more than the light RAKE to investigate the indicated signals by the metal detector and didn't follow the proper procedure to identify the centre of the signal and approach the signal 20 cm from one of the sides.

The individual mistake and the size of the pressure plate of the M14 with using the RAKE to investigate the signals will give the chance to have a non control detonation ,

The result from all the similar incidents with the usage of the proper PPE and the safe distance between the deminer and the target that the handle of the RAKE keep (2m) will insure the safety of the deminer

In the case of [the Victim] the concerns came from the way that the deminer following in detecting and investigating and marking the processed area. He most likely didn't follow the proper procedures and this unfortunately the second time for him that he already received a written warning for a similar case 3 months ago and he repeated the same mistake.

The recommendations is to give the deminer a final written warning and bring the attention for the team leader to give more focus on the deminer to make sure that he will not be in a danger and if he commit any mistake he have to be suspended directly and terminated.

Attachments:

Statements by Injured Members

Statements by Witnesses

Photographs of Injuries

Photographs of Incident Site

Victim Report

Victim number: 859	Name: [Name removed]
Age:	Gender: Male
Status: deminer	Fit for work: yes
Compensation: N/A	Time to hospital: N/A
Protection issued: Frontal apron Mask Visor blast boots	Protection used: Frontal apron, Mask visor, blast boots

Summary of injuries:

COMMENT: No injuries recorded. A photograph of the Victim showed no injuries.

No medical report was made available.

Statements

Statement 1: the Victim

I was searching for 12 o'clock mine using the detector when I found a signal I located it, and started to get closer according to the SOP, as I made the visual check and used the light rake

then started using the heavy rake when the accident happened while am using the heavy rake, I left it and got out of the field to the ambulance area.

Q: Was the exploded mine visible?

A: No, it wasn't.

Q: Was the detector working well before the accident?

A: Yes, it was.

Q: Did the team leader check on your work before the accident?

A: Yes, he did.

Q: Were all the mines you cleared visible that day?

A: Some of them superficial and others on 10 cm depth nothing more.

Q: Were you having any problem at work that day?

A: No, but the land was so hard which made me to hacking while using the heavy rake.

Statement: Team Leader

At the beginning of that working day I gave the team the full safety brief, then distributed them to their sites, and I started checking on the injured deminer and he was working well and I didn't notice any mistake he made, I reminded him with the safety brief and headed to the other deminers, at 8:25 am I heard a sound of explosion when I was heading again to the injured I entered the lane to see what happened to find him walking outside the field to the ambulance area.

Q: Did you inform those responsible about the accident according to the SOP?

A: Yes, I did.

Q: Did you notice anything wrong with the injured that day?

A: No, he was working very well.

Q: How do you evaluate [the Victim's] work?

A: He works very well, his productivity is very good but maybe he pulled hard on the heavy rake because of the nature of the land there which is so hard which made the accident.

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the Victim was working without marking or a base stick and hacking at the ground with rake. Although the hard ground may have made the use of the rake correctly extremely slow, the marking errors should have been corrected. The secondary cause is listed as a *Management Control Inadequacy* because the group's management did not seem to recognise the failings of the field controllers.

The demining group's concern to investigate accidents, correct errors and share accident reports indicates a commendable professionalism.