

DDAS Accident Report

Accident details

Report date: 04/03/2011	Accident number: 604
Accident time: 05:05	Accident Date: 02/07/2009
Where it occurred: MF 387, Al SHajarah Village, Alramtha Province	Country: Jordan
Primary cause: Victim inattention (?)	Secondary cause: Unavoidable (?)
Class: Excavation accident	Date of main report:
ID original source:	Name of source: Demining group
Organisation: [Name removed]	
Mine/device: M14 AP blast	Ground condition: grass/grazing area soft
Date record created:	Date last modified: 04/03/2011
No of victims: 1	No of documents: 2

Map details

Longitude:	Latitude:
Alt. coord. system:	Coordinates fixed by:
Map east: 35.956630 E	Map north: 32.673870 N
Map scale:	Map series:
Map edition:	Map sheet:
Map name:	

Accident Notes

no independent investigation available (?)
standing to excavate (?)
use of rake (?)
non injurious accident (?)
Inadequate detector pinpointing

Accident report

An internal demining group accident report was made available. The conversion into a DDAS file has led to some of the original formatting being lost. Text in square brackets [] is editorial.

The internal report is reproduced below, edited for anonymity.

INCIDENT INVESTIGATION [Demining group] – MINE ACTION TEAM - JORDAN

GRID REF: 32.673870 N, 35.956630 E

MINEFIELD NO – 387, MINEFIELD TASK ID - E 387 AL SHAJARAH 1

INVESTIGATION CONDUCTED BY – [Demining group], [Name removed].

DEMINER: [The Victim]. Date of Birth: 16/09/1968 NIC NO (ID NUMBER): [Removed]

SECTION COMMANDER: [Name removed]. TEAM LEADER: [Name removed].

TEAM: METAL DETECTOR 10.

TIME OF INCIDENT: 05:05 PM. DATE OF INCIDENT: 2 JULY 2009

NATURE OF INJURY: No Injury. TYPE OF MINE: Anti Personnel M 14

IMSMA DETAILED REPORT FOR MINE INCIDENT Thursday, 2 July 2009

Part 1 – Description of the incident

1. Organisation name: [Demining group], JORDAN. Team No: Metal Detector 10.
2. Incident date: 02/07/2009. Time: 05:05 PM
3. Location of incident: EAST SECTOR, Province: ALRAMTHA, Village: AL SHAJARAH. Project or task No: E 387 ALSHAJARAH 1
4. Name of site manager or team leader: [Name removed].
5. Type of incident: M14 AP MINE, uncontrolled detonation of a mine.
6. Device was detonated by: deminer team leader
7. Device detonated while: Raking with Heavy Rake, Investigating
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 in lane 15 (12 O'clock mine) he didn't approached the mine in the proper procedure which caused the deminer to hit the mine from the top of the pressure plate and initiate the mine 2.2 m away from the deminer (the distance of the heavy RAKE).

Part 2 – Injuries

10. Did the incident result in any injuries? No
11. List people injured and nature of injury [None]

Part 3 – Equipment damages

12. Did the incident result in any damage to equipment or property? No
13. List any mine action equipment or property damage: [None]
14. List damage to equipment or property owned by a member of the public or the government. [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): M 14 AP MINE

17. Comments (include measurements of any crater resulting from the explosion): Crater
Depth: approx. 15 cm / Width: approx. 40 cm.

Part 5 - Site conditions

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

Ground/Terrain: Soft, Flat

Weather: Clear, Hot

Vegetation: Medium, Bush



[The accident site.]

Part 6 – Team and task details

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

Name	Position in Location	Occupation
[The Victim]	Deminer	Metal Detector 10

21. How long had this team been?

- a. At this site? 1 month
- b. working on this task? 2 months
- c. working on the day? 4 hours

22. Detector type: N/A. 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, Safety Vehicle, 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: (03) minutes

b. Time spent at site administering treatment: nil minutes

c. Time from evacuation FROM to arrival King Abdullah Hospital: nil minutes

Part 8 – Reporting procedures

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

Investigation conducted by: [Name removed], [Name removed]

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

Verified by: [Name removed]

Observations and Recommendations

According to the preliminary investigation the incident happened due to individual mistake. The area very loose and the depth of the mine (based on the crater) no more than 18 cm.

Signed: Operations Coordinator, 2 July 2009

Attachments:

Statements by Injured Members

Statements by Witnesses

Photograph of accident site

Copy of Incident Report

Victim Report

Victim number: 787	Name: [Name removed]
Age: 40	Gender: Male
Status: deminer	Fit for work: yes
Compensation: N/A	Time to hospital: N/A
Protection issued: Frontal apron	Protection used: Frontal apron, Mask Visor, Blast boots

Mask Visor

blast boots

Summary of injuries:

COMMENT: No injuries were recorded. No Medical report was made available. See Medic's statement.

Statements

Statement 1: the Victim

At 12:45 pm I went to the field entered the lane, opened the fence and headed to the cluster I'm working on, I put a base stick then entered the cluster and found the center mine and removed it then went to 12 o'clock mine and found a fuse, I informed the section commander and he ordered me to work on 9 m² to search for the missing mine, I went to the 3 o'clock mine and it was near to the surface so I removed it, then to 9 o'clock mine it was on the surface and very near, I went back to 12 o'clock mine to search for the missing mine so I entered 3 metres then got back, and started in the 2nd metre; the detector gave a signal and while I was improving in my search following all the instructions a mine blasted.

Statement 2: Section Commander

On Thursday the 2nd of July 2009 I checked on the deminer [the Victim] work and I ordered him to work on 9 m² after he told me that he found a fuse without a mine, and he started searching then I headed to lane 14 to the deminer [Name removed]'s site then I heard a sound of explosion from lane 15 then I went there and we evacuated the deminer but he was in a good condition.

Statement 3: Team leader

While I was making my round on the 2nd of July 2009 at 05:04 pm I heard a sound of explosion I was in lane 17 and saw a smoke from lane 15 at the deminer [the Victim's] site, I informed the medic team and they immediately came within minutes and I informed the sector coordinator while am walking to the accident site, the injured deminer was evacuated walking without feeling any pain and he was put in the ambulance to be observed till the end of the working hours, we stopped work on that task immediately and I called several times to check on the injured deminer but he was fine and I closed the lane for investigation.

Statement 4: Witness Deminer

On Thursday the 2nd of July 2009 at 05:04 pm we were informed about an accident in lane 15 at the deminer [the Victim's] site then I shouted that there is an accident happened; I looked at the injured deminer and found him standing on his legs.

Analysis

The primary cause of this accident is listed as *Victim Inattention* because the investigators seemed to believe that the Victim made a “mistake”, presumably by not pinpointing the detector reading accurately and so avoiding raking on top of the mine. The secondary cause is listed as *Unavoidable* because it is possible that the Victim was working as directed when the detonation occurred. The long tool, the procedure for using it, and the PPE combined to prevent injury.

The demining group who made this report available is thanked for its transparency and its professional concern to share lessons that can be learned from accidents. This record, along with several other records where rakes were used, provide compelling evidence that the controlled use of rakes can be both effective and tolerably safe (reducing risk of injury to tolerable levels).