DDAS Accident Report

Accident details

Report date: 05/03/2011

Accident number: 653

Accident time: 12:45

Accident Date: 14/02/2010

Where it occurred: Jabir E 396b, Almafraq Province

Country: Jordan

Primary cause: Field control inadequacy (?)

Secondary cause: Inadequate training (?)

Class: Vegetation removal accident

Date of main report: 22/02/2010

ID original source: None

Name of source: Demining group

Organisation: **[Name removed]**

Mine/device: M14 AP blast

Ground condition: grass/grazing area
hard
rocks/stones

Date record created:

Date last modified: 05/03/2011

No of victims: 1

No of documents: 2

Map details

Longitude:

Latitude:

Alt. coord. system:

Coordinates fixed by:

Map east: 36.20588 E

Map north: 32.50419 N

Map scale:

Map series:

Map edition:

Map sheet:

Map name:

Accident Notes

no independent investigation available (?)

disciplinary action against victim (?)

vegetation clearance problem (?)

inadequate training (?)

Accident report

A PDF 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

GRID REF: 32.50419 N: 36.20588 E

MINEFIELD NO: - 369 B, MINEFIELD TASK ID: - E 369 JABI R 3

SECTOR – EAST, PLACE – JABIR, REGION - JABIR

INVESTIGATION CONDUCTED BY – [Name removed]

OFFICIATED TEAM LEADER: [the Victim]. DATE OF BIRTH: 12/02/1971. NIC NO (ID NUMBER): [removed]

TEAM LEADER: [Name removed].

TIME OF INCIDENT: 12:45 PM. DATE OF INCIDENT: 14 FEBRUARY 2010

NATURE OF INJURY: Multi wounds in the Face and Hand

TYPE OF MINE: Anti Personnel M 14

IMSMA DETAILED REPORT FOR MINE INCIDENT Sunday, 14 FEBRUARY 2010,

EAST SECTOR, JABIR

Part 1 - Description of the incident

1. Organisation name: [Demining group], JORDAN Team No: Bravo.

2. Incident date: 14/02/2010. Time: 12:45 PM

3. Location of incident: EAST SECTOR, Province: ALMAFRAQ, Village: Jabir, Project or task No: E 369 B Jabir 3

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: officiated team leader

7a. Device detonated while: Cutting grass with grass cutter

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):

The Deminer today was officiated as a team leader due to the absence of the team leader. He took one deminer tools and started to work himself in one of the remaining cluster in his section. While he was using the grass cutter to cut the grass in front of the base stick he hit the barely covered M14 mine by the grass cutter which caused the mine to initiate.

[The accident site, showing the grass shears in use at the time.]

Part 2 — Injuries

10. Did the incident result in any injuries? Yes.

11. List people injured and nature of injury

Name	Occupation	Injury
[The Victim],	Officiated Team Leader,	Multi wounds in the Face and Hand

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: Grass Cutter, Damaged (not reusable)

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	Cutting Grass

16. State specific device (if known): M14 AP MINE

17. Comments (include measurements of any crater resulting from the explosion): Crater Depth: approx. 15 cm / Width: approx. 30 cm

Part 5 - Site conditions

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

Ground/Terrain: medium, flat

Weather: cloudy

Vegetation: heavy, grass

Part 6 — Team and task details

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

[The Victim] Officiated Team Leader, Team Bravo

21. How long had this team been?

a. at the Site: 2 months

b. at the Task: 2 months

c. working on the day? 6 Hours 30 minutes

22. Detector type: F3, Serial Number: 14674: Detector status: Functional: Passed to [Name removed] for technical inspection at Jabir 3 site (location) on 14 Feb 2010. Tripwire feeler used? No

23. Hand tool: GRASS CUTTER

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

25.Comments: [None]

Part 7 - Medical & First Aid

Medical treatment required? yes

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: (02) minute

b. Time spent at site administering treatment: (03) minutes

c. Time from evacuation to arrival King Abdullah Hospital: 20 minutes

Part 8 – Reporting procedures

Reported by: Ops Manager to: [Demining group] Offices & NCDR

Investigation conducted by: [Name removed] (clearance coordinator)

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

Verified by: [Name removed]

Findings of the Investigation Officer

Through my visit for the incident site I found the following:

1- The officiated team leader didn't carry out visual check before using the grass cutter because I found some stones in the clearance box.

2- There is no proper drill has been carried out in the nine / twelve o'clock mine. "no grass cutting".

3- He didn't apply the correct procedure to approach the mine.

4- Base stick has been placed and the box marked correctly.

5- He didn't use the rakes for investigating the signal, straight away recovered the mine and marked.

6- He didn’t take any precautions during the use of grass cutter & also not followed the correct vegetation cutting drill.

7- He collected stones from the AP clusters and dumped them near to the AT mine recovered place.

8- The nine / twelve o’clock mines was recovered within five minutes “12:40 hours – 12:45 hours”, because he has not followed the correct procedures hence resulted in the mine blast incident.

9- He didn’t wear the full face visor, and also he worked as a deminer in his AOR, this is violation to the SOP and safety regulation.

[Name removed] Investigation Officer 15 of Feb 2010

Observations and Recommendations

1- The Officiated team Leader has not followed the instruction while deminers are nominated as a officiating team leaders.

2- He is not wearing the full face Visor while recovering mines from the cluster.

3- The mine blast incident happened due to the gross violation of SOP and safety regulations.

4- It is strongly recommended to terminate his contract on the ground of “GROSS VIOLATION OF SOP AND SAFETY REGULATIONS”

Signed: Operations Manager, 22 FEBRUARY 2010

Attachments:

Statements by Injured Members

Statements by Witnesses

Photographs of Injuries

Photographs of Incident Site

Copy of Incident Report

Copy of Medical Report

Victim Report

Victim number: 836

Name: [Name removed]

Age: 39

Gender: Male

Status: supervisory

Fit for work: yes

Compensation: Not made available

Time to hospital: 25 minutes

Protection issued: Frontal apron
Goggles
Mask Visor
blast boots

Protection used: Frontal apron, goggles, blast boots

Summary of injuries:

INJURIES: minor Arm. minor Face

COMMENT: See Medical report.

Medical report

Photographs showed a heavily bandaged right forearm and hand and the Victim’s face with light fragmentation wounds on chin, nose and cheeks.

A photograph of a page of medical report (Time 13:54) showed:

Procedure: Skin cleaning using brush

Diagnosis: plast injury to face and rt arm

Findings: Multiple skin lesions on the face and rt arm

Procedure: supine GA, LARY MASK

Painting and Towelling

Cleaning of skin using brush

Dressing with mebo

Statements

Statement 1: the Victim

When I was checking the de-miners at around 12:40 hours in lane 8 the deminer [Name removed] told me that he feels tired and wants to take some rest outside the mine field, I checked his cluster then took the detector from him and went to the other clusters in my AOR. This area has lots of bushes and stones, I worked as a deminer in my AOR searching for AP mines, I recovered an M14 AP mine from the same cluster (9 o’clock mine) and then I searching the 12 o’clock mine and at 40 cm distance I heard a detector signal through the heavy bushes and I started to cut the grass following the procedures and when the area was ready I put the white triangle marker and continued cutting the grass. During this process I touched the mine pressure plate with the grass cutter, hence mine blast incident happened. After the incident I went out of the field by walking.

Answers to Investigator's Questions:

Yes, the original team leader told me to replace him that day.

Yes, he gave me all the necessary documents that concerns work.

Yes, I gave the team the morning brief before work started.

Yes, I knew I shouldn’t work as a deminer while am replacing the team leader.

Yes, I marked the cluster I was working at according to the SOP procedures.

Yes, I was wearing all the safety PPE’s while working.

Yes, I didn’t order the deminer [Name removed] to get out or stay in the mine field.

Yes, I made visual check before I started to work.

Yes, I removed all the stones near the mine location.

Yes, the mine I recovered was behind me in a box and the fuse in another box.

Statement 2: Witness deminer

I informed the team leader that I finished my work in searching for a missing M14 mine and I didn't find it, at 12:40 hours I was tired and asked him to go out of the field but he didn't reply. Then he took the detector from me to check the area I was working, then I went away to check the clusters I recovered according to the marking system, I was 20 meters away from the team leader site when I heard a sound of explosion, I turned around to find that the accident happened with the team leader he was standing I went to him and took the radio and informed about the accident then I evacuated him with the other deminers.

Answers to Investigator Questions:

Yes, the area I was working at before he came was marked according to the SOP and he checked it.

Yes, I went to check on other clusters within my AOR I didn't clear it before.

Yes, the cluster that the team leader worked AP mines not recovered.

Yes, when I came to the injured team leader I saw an AP mine recovered before the accident happen.

Yes, after we evacuated the injured I came back with the clearance coordinator [Name removed] to the area and noticed that it was marked correctly.

Yes, there were lots of stones and bushes in the area.

Yes, we took the morning safety brief before we started to work.

No, I didn't see the white triangle Marker at the accident site.

Statement 3: Witness deminer 2

The team leader came to my AOR and checked on the clusters I recovered and it was 12:35 hours, then he left my location to check on other deminers who is working next to me, after a while I heard a sound of explosion, turned around and seen mine blasted at 70 meters away from my site and heard the deminer [Name removed] shouting that an accident happened then we went to the injured area to evacuate him to the safe area to find that the injured was the officiated team leader.

Answers to Investigator Questions:

Yes, the team leader gave us a safety brief before we started working.

No, I didn't reach the area of explosion to see if there was a mine recovered

No, we didn't use the foldable stretcher because the injured insisted to get out of the field by walking.

Yes, I was working on recovering AP mines.

Yes, we were near to each other because we were all working on recovering AP mines.

No, there are no AT mine in our AOR.

Yes I saw him wearing the protective goggles when I came to his site.

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the investigators found that the Victim was not working to his SOP and his errors were not corrected. He was a temporary field supervisor and seemed to be unaware of some of the requirements of the task, so the secondary cause is listed as *Inadequate training*. The appointment of someone unable to fulfill a supervisory role appropriately was a significant *Management Control inadequacy*. because the small mine appears to have been on the surface and rendered “invisible” by dust.

It is strange that the Operations Manager recommended that the Victim be dismissed for breach of SOPs, but did not recommend warning those who appointed him as temporary supervisor without ensuring that he was able to fill the role.

The demining group’s concern to investigate and share accident reports indicates a commendable professionalism.