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Humanitarian Demining Accident and Incident Database

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DDAS Accident Report

Accident details

Report date: 06/03/2011	Accident number: 683
Accident time: 09:55	Accident Date: 21/05/2009
Where it occurred: MF: E 394 SABHA 7, Um Al Quittain Village, Almafraq Province	Country: Jordan
Primary cause: Victim inattention (?)	Secondary cause: Unavoidable (?)
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
Date record created:	Date last modified: 06/03/2011
No of victims: 1	No of documents: 2

Map details

Longitude:	Latitude:
Alt. coord. system: Not recorded	Coordinates fixed by:
Map east:	Map north:
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 (?)
Inadequate detector pinpointing
non injurious accident (?)

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

TASK NAME SABHA 7 (394). GRID REF: [None]

MINEFIELD NO:- 394, MINEFIELD TASK ID: - E 394 SABHA 7

INVESTIGATION CONDUCTED BY – [Names removed].

DEMINER: [The Victim]. DATE OF BIRTH: 01/01/1957.

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

TEAM: METAL DETECTOR 1.

TIME OF INCIDENT: 09:55 AM, DATE OF INCIDENT: 21 MAY 2009

NATURE OF INJURY: No Injury

TYPE OF MINE: Anti Personnel M 14

IMSMA DETAILED REPORT FOR MINE INCIDENT Thursday, 21 May 2009

Part 1 – Description of the incident

1. Organisation name: [Demining group], JORDAN Team No: Metal Detector 1
2. Incident date: 21/05/2009. Time: 09:55 AM
3. Location of incident: EAST SECTOR, Province: ALMAFRAQ, Village: UM AL QUTTAIN. Project or task No: E 394 SABHA 7
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
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 recover one missing AP mine (M14) assigned for him by the team leader after grabbing all the visible APs in the cluster and the central AT the mine blasted 2.2 metres away from the deminer while searching the area with the heavy RAKE after pinpointing a signal using the metal detector.

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

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: Hard, flat

Weather: Clear

Vegetation: Medium, bush



[A photograph of the accident site shows no “bush” and dry grass.]

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 1

21. How long had this team been?

- a. At this site? 4 weeks
- b. working on this task? 2 months
- c. working on the day? 2:55 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: (02) 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], [Name removed]

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

Verified by: [Name removed], [Name removed]

Observations and Recommendations

According to the preliminary investigation the incident is caused due to an individual mistake while investigated the MD signal.

Signed: Operations Coordinator, 21 May 2009

Attachments:

Statements by Injured Members

Statements by Witnesses

Photographs of Injuries

Photographs of Incident Site

Copy of Incident Report

Victim Report

Victim number: 867

Age: 52

Status: deminer

Compensation: N/A

Protection issued: Frontal apron

Mask Visor

blast boots

Name: [Name removed]

Gender: Male

Fit for work: yes

Time to hospital: N/A

Protection used: Frontal apron, Mask visor, blast boots

Summary of injuries: None

COMMENT:A photograph showed no injuries. No Medical report was made available. See Medic's statement.

Statements

Statement 1: the Victim

While I was searching for missing mines I used the metal detector and located the target and put a mark 15 cm far, I used the light rake at the beginning but because of the hard ground I had to use the heavy rake from the right of the found mine, and while trying to remove the mine the accident happened, the mine was in a very hard area that's what caused the accident then the team leader came and checked on me I was in a good health thank god.

Answers to Investigator Questions:

Yes, I took a safety brief before starting the work.

Yes, the team leader made a QA before the accident 3 times.

Yes, the ambulance came after the accident in a few minutes and I didn't need any medication.

Statement 2: Team leader

While I was checking and supervising in section 13 I heard a sound of explosion and I saw it in front of me, immediately I reported to the medic team and saw the nearest de-miner to the accident [Name removed] heading to the accident place, I went there and found the deminer [the Victim] standing in a good condition with no injuries we evacuated him to the ambulance which was at a lane near to the accident cause the missing mines are not in their expected places.

Answers to Investigator Questions:

Yes, I was checking on the working groups all the time.

The last check I made on that section was at the beginning of the 3rd round.

Yes, the sector coordinator gave us the morning safety brief.

Statement 3: Witness Deminer

While I was working at the beginning of section 12 I heard a sound of explosion from the IOE area at the same section where the de-miner [the Victim] was working, I headed there and found him standing near the explosion with no injuries, then the team leader came and we evacuated him to the ambulance which was near the safe lane.

Answers to Investigator Questions:

Yes, we were given the safety brief from the team leader.

Yes, the nature of the ground is very hard there.

Statement 4: Medic

We were informed about an accident in section 12 Sabha 7 with the deminer [the Victim], he was in a good condition not injured, he was evacuated normally, but we noticed a high blood pressure on average 100/160 within 2 hours.

Analysis

The primary cause of this accident is listed as *Unavoidable* because, when using rakes, if the Light rake would not move a rock, it is normal to use the Heavy rake. Certainly, raking could be safer than reaching into an area not yet searching to try to pull a rock from the ground. The length of the rake, the way it was used and the wearing of effective PPE meant that the Victim avoided injury. The secondary cause of this accident is listed as *Victim inattention* because the Victim may have been working incorrectly (as the investigators indicated).

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 safe.