

7-30-2009

DDASaccident705

Humanitarian Demining Accident and Incident Database
AID

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Recommended Citation

Database, Humanitarian Demining Accident and Incident, "DDASaccident705" (2009). *Global CWD Repository*. 904.
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DDAS Accident Report

Accident details

| | |
|---|--|
| Report date: 07/03/2011 | Accident number: 705 |
| Accident time: 10:40 | Accident Date: 30/07/2009 |
| Where it occurred: MF 406, East Sector, Alramtha Village, Al Turrah Province | Country: Jordan |
| Primary cause: Field control inadequacy (?) | Secondary cause: Unavoidable (?) |
| Class: Excavation accident | Date of main report: Not recorded |
| ID original source: None | Name of source: Demining group |
| Organisation: NPA | |
| Mine/device: M14 AP blast | Ground condition: hard |
| Date record created: | Date last modified: 07/03/2011 |
| No of victims: 1 | No of documents: 2 |

Map details

| | |
|------------------------------|-------------------------------|
| Longitude: | Latitude: |
| Alt. coord. system: | Coordinates fixed by: |
| Map east: 36.028240 E | Map north: 32.640218 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 (?)
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

TASK NAME AL TURRAH 2 (406), NORTH BORDER PROJECT, EAST SECTOR

GRID REF: 32.640218 N, 36.028240 E: AL TURRAH 2

MINEFIELD NO:- 406, MINEFIELD TASK ID: - E 406 AL TURRAH 2

INVESTIGATION CONDUCTED BY – [Name removed].

DEMINER: [Name removed].

NIC NO (ID NUMBER): [Removed]

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

TIME OF INCIDENT : 10:40 AM, DATE OF INCIDENT: 30 JULY 2009

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

IMSMA DETAILED REPORT FOR MINE INCIDENT Thursday, 30 July 2009

Part 1 – Description of the incident

1. Organisation name: [Demining group], JORDAN Team No: Metal Detector 9.
2. Incident date: 30/07/2009: Time: 10:40 AM
3. Location of incident: NORTH EAST SECTOR Province: ALRAMTHA, Village: AL TURRAH: Project or task No: E 406 AL-TURRAH 2
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 investigate a signal using the heavy RAKE after pinpointing it and finished with the light RAKE the deminer hit the non visible AP mine (M14) on the pressure plate which initiated the mine 2.2 metres away from the deminer.

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, Hot

Vegetation: Bush, Medium

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 9 |

21. How long had this team been?

- a. At this site? 2 months
- b. working on this task? 2 months
- c. working on the day? 3:40 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 No

28. Time and distance data

- a. Time from incident to SECTION MEDICAL POINT: (01) minute
- 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

The deminer was looking for a missing mine (M14) in the cluster and the metal detector indicated a very weak signal, the deminer started to investigate that signal then the mine initiated that the deminer wasn't following the proper procedure to approach the mine (approaching from the top instead of the side), according to the site investigation the mine was deeply buried about 40 cm.

Signed: Operations Coordinator, 30 JULY 2009

Attachments:

Statements by Injured Members

Statements by Witnesses

Copy of Incident Report

Victim Report

| | |
|--|--|
| Victim number: 891 | 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. No Medical Report was made available.

Statements

Statement 1: the Victim

While I'm searching for a missing mine from the cluster and after I used the detector in my search for the second time a small signal appeared which made me to recheck directly as I took the right distance from the center of the signal then I dig to more than 20 cm depth when the signal became clearer, I continue digging when the accident happened.

Statement 2: Team Leader

At 10:40am while I was checking on the de-miners on lane 32 after NCDR left the site, I heard a sound of explosion from the north side and saw the injured near the explosion inside the

center lane, I informed about the accident and evacuated the team and after less than a minute I was at the injured site and checked on him he was in a good condition then medic team came and they first aided him.

Statement 3: Section Commander

Before the accident I went to the injured to find him using the heavy rake and searching for a missing mine, I told him the digging he is doing is wrong, and that he should use the light rake if he had to dig for this deep signal, he continued working using the heavy rake when the accident happened with no injuries, then I informed the team leader and medic team and we made the needed procedures.

Analysis

The primary cause of this accident is listed as a *Field Control Inadequacy* because the Section Commander made a statement that he had told the Victim to work in a different manner and was ignored. This raises questions about the authority that field supervisors have in the field. The secondary cause is listed as *Unavoidable* because it is possible that, in hard ground, the Victim was working in the only way possible to achieve the required end. The demining group's use of PPE and long tools meant that no injury resulted.

The Victim had used his metal detector to pinpoint the mine before using the heavy rake on top of it, which implies that there may have been a detector pinpointing inadequacy.

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.