

5-31-2009

DDASaccident706

Humanitarian Demining Accident and Incident Database
AID

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Recommended Citation

Database, Humanitarian Demining Accident and Incident, "DDASaccident706" (2009). *Global CWD Repository*. 905.
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DDAS Accident Report

Accident details

Report date: 07/03/2011	Accident number: 706
Accident time: 10:50	Accident Date: 31/05/2009
Where it occurred: E 399 SABHA 8, Umal Quittain Village, Almafraq Province	Country: Jordan
Primary cause: Unavoidable (?)	Secondary cause: Field 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: bushes/scrub hard rocks/stones
Date record created:	Date last modified: 07/03/2011
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

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 8 (399), NORTH BORDER PROJECT, EAST SECTOR

GRID REF: [Not recorded]

MINEFIELD NO: - 399, MINEFIELD TASK ID: - E 399 SABHA 8

INVESTIGATION CONDUCTED BY – [Name removed].

DEMINER: [The Victim]. DATE OF BIRTH: 12/09/1967.

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

TIME OF INCIDENT : 10:50 AM. DATE OF INCIDENT: 31 MAY 2009

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

IMSMA DETAILED REPORT FOR MINE INCIDENT Thursday, 31 May 2009,

Part 1 – Description of the incident

1. Organisation name [Demining group], JORDAN Team No: Metal Detector 1
2. Incident date: 31/05/2009, Time: 10:50 AM
3. Location of incident: EAST SECTOR, Province: ALMAFRAQ. Village: UM AL QUTTAIN, Project or task No: E 399 SABHA 8
4. Name of site manager or team leader: [Name removed].
5. Type of incident: M14 AP MINE uncontrolled detonation of a mine/UXO
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 recover one missing AP mine (M14) assigned for him by the team leader after grapping 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: Nil

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): Anti-Personal Mine 01,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: Hard, flat

Weather: Clear

Vegetation: Medium, bush

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? 1 month

b. working on this task? Week 4

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 shown in photograph]

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: (01) minute

b. Time spent at site administering treatment: (01) minute

c. Time from evacuation FROM to arrival King Abdullah Hospital: 50 minutes

Part 8 – Reporting procedures

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

Investigation conducted by: [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.

Operations Coordinator [Name removed] 31 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: 892	Name: [Name removed]
Age: 42	Gender: Male
Status: deminer	Fit for work: yes
Compensation: N/A	Time to hospital: 50 minutes
Protection issued: Frontal apron Mask Visor blast boots	Protection used: Frontal apron, Mask visor, blast boots

Summary of injuries:

COMMENT: No injuries. No Medical report was made available. A photograph showed the deminer with no injuries.

Statements

Statement 1: the Victim

In the morning I started my work in section 8 but because of the safe distance we couldn't complete work there so I went to section 9 (IOEB) I marked the mine place using the metal detector I put the mark 10 cm far from the mine place after that I used the light rake and started getting near the mine 20 cm far then I used the heavy rake to make a 10 cm depth 20 cm far trench then while I'm working I found a buried stone, I completed working using the heavy rake near the stone but the rake hit the stone and fell down on the mine which made it blow (notice: the mine was unseen).

Answers to Investigator Questions:

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

Yes, before the accident the team leader came and made a QC on my work and gave me some safety instructions.

No, I couldn't use the light rake because of the hard ground.

No, thank god I wasn't hurt.

Statement 2: team Leader

In the 31st of May 2009 at 10:50 am an accident happened, I went to check on the de-miner [The Victim]'s work he marked the mine place and left a 20 cm space between him and the mine and started working, I went to bring a blue stick to mark the mine place after removing it after 10 m from leaving his site I heard a sound of explosion from his direction and then I reported about the accident according to the instructions and went to the de-miner and evacuated him to a safe place, the medic team came they checked on him he was fine and in a good condition.

Answers to Investigator Questions:

Yes, he was wearing his demining uniform and all the safety stuff.

Yes, I made a QC on his work before the accident and he was doing well.

Yes, the mine was buried 5-10 cm depth and there were a stone near it.

Yes, the area is hard and has lots of bushes.

Yes, the accident happened while using the heavy rake and because of the existence of a buried stone which was hit by the rake and fell on the mine which made the accident.

Yes, he used the light rake until the area became very hard for it then he had to use the heavy rake.

Analysis

The primary cause of this accident is listed as *Unavoidable* because it seems that Victim may have been working correctly when the accident occurred. The Secondary cause is listed as a *Field Control Inadequacy* because the investigators decided that the Victim was not working correctly and his error was not corrected. His digging on top of a metal detector signal may indicate poor training on metal detector pinpointing.

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.