

DDAS Accident Report

Accident details

Report date: 06/07/2005	Accident number: 412
Accident time: 08:55	Accident Date: 08/06/2004
Where it occurred: Vanankerny Village, Kilinochi District	Country: Sri Lanka
Primary cause: Unavoidable (?)	Secondary cause: Victim inattention (?)
Class: Excavation accident	Date of main report: 09/06/2004
ID original source: [Name removed]	Name of source: [Name removed]
Organisation: [Name removed]	
Mine/device: P4Mk2 P4Mk1 AP blast	Ground condition: grass/grazing area soft
Date record created: 06/07/2005	Date last modified: 06/07/2005
No of victims: 1	No of documents: 2

Map details

Longitude:	Latitude:
Alt. coord. system: See map under "Other documents"	Coordinates fixed by:
Map east:	Map north:
Map scale: MF HDU 486	Map series:
Map edition:	Map sheet:
Map name:	

Accident Notes

disciplinary action against victim (?)
long handtool may have reduced injury (?)
inadequate equipment (?)
non injurious accident (?)
use of rake (?)
no independent investigation available (?)

Accident report

The picture below shows the accident site and the blast crater.



An IMSMA Mine Accident Report was made available in October 2004. The Demining group also made available its own report which follows the summary from IMSMA reproduced below. The internal investigation includes witness statements.

Summarised from the IMSMA forms:

“The deminer was working in his clearance lane using a heavy rake to excavate the ground. The ground was very hard and use of the light rake was limited. At approximately 08:55hrs an explosion occurred under the rake.”

The deminer suffered “no injuries”. The “metal prongs [of the rake] were broken in two.”



[The picture above shows the rake head with a separated tine.]

The Victim was wearing a Frag jacket and Short visor on a plastic helmet) which were undamaged.

The last QA visit had occurred within 8 days of the accident (the IMSMA date field does not require a day, merely a month and year).

The demining group had been working at the site for 3 months and 3 weeks. Work had been progressing on the day for 30 minutes when the initiation occurred.

The accident was reported to the demining group HQ on 08/06/2004 at 14:00. The IMSMA report was dated 09/06/2004.

Statements taken by [Demining group] OPS Room manager [name excised]

Statement of deminer [the Victim]

I am [the Victim] while I using heavy rake heard an explosion and I stopped my worked and realized the accident was happened in my lane looked my self at the same time section leader and team leader came to me and asked what was gone. I explained everything that following here.

- Normally I use heavy rake, because of the grass which has heavy long roots so light rake which was not possible for grass. In this lane I found three mines all those were found in the same method and this was fourth one. This was happened at 8.55 we came after the breakfast and it was happened before the breakfast also I found three mines that is all.

Statement Of Team Leader [Name excised]

I am the team leader of Team 03 Northern Group at 8.55 I was watching on one of the clearance lane on section two and everything was in order but suddenly I heard an explosion and saw smoke coming from a section two lane. At once I went to the site of the explosion of the spot and I found the section leader standing with the deminer I went through the deminers body with section leader fortunately the man had no injury. I instructed to the sec leader to close the lane and sent the deminer to cp and I spoken to him.

Team leaders additional comments: I believe that the deminer has used the heavy rake sideward because of the root of the grass was heavy so almost all the deminers are the same way. But this deminer has removed three mines in the past on the same way and in this time unfortunately the mine was activated.

Statement of Section leader [name excised]

I am the section leader of 2 section team three and have been working for the last seven months in that position. 10 minutes before to the accident we came from our breakfast and I came through all the deminers and coming towards this deminer suddenly I heard an explosion and realized something wrong and rushed to the and I found no injuries on him. At the same time team leader had a look and instructed to close the lane and sent to the deminer to cp

Additional comments: The command and control of my section is good no more faults on tool kit and applying rakes but this was caused by the heavy root grass and I believe while he use his heavy rake he applied sideward and mine was activated in the same pattern he found three mine here so unfortunately this was activated

Preliminary conclusions and recommendations

After finishing breakfast the team started work at 08:45 hrs. At around 0855 hrs While the team leader and the section leaders were observing the de-miners– [the Victim] activated a mine. During this time the section leader was 5 meter away walking towards this man. Fortunately there was no injury. At once the team leader followed these procedures:

- 1) Took the deminer to the Control Point
- 2) Closed the lane
- 3) Informed HDU headquarters

After having the information from the team, Ops Room Manager [name excised] and Northern Ops Officer visited the site to conduct an investigation and documentation according to the decision taken by PM and Director [Demining group]. I had a visit today.

I believe and confirm the deminer activated the mine. He applied the heavy rake with pressure over 3.5kg pressure. I had a deep look on the ground. According the land type the grass had heavy long root and he used heavy rake to take off it. I instructed Northern Ops officer [name excised] train this team on how to use the tools according to the grass type for half a day. I warned the deminer that this happened by careless heavy rake use. I recommend that we immediately suspend the deminer and discipline him.

This is my decision.

Signed: Operations Manager [demining group]

Programme manager [Demining group]

Signed as read by: TA south, STA, director National authority.

Victim Report

Victim number: 540	Name: [Name removed]
Age:	Gender: Male
Status: deminer	Fit for work: yes
Compensation: not appropriate	Time to hospital: not appropriate
Protection issued: Frag jacket Short visor	Protection used: Frag jacket, Short visor

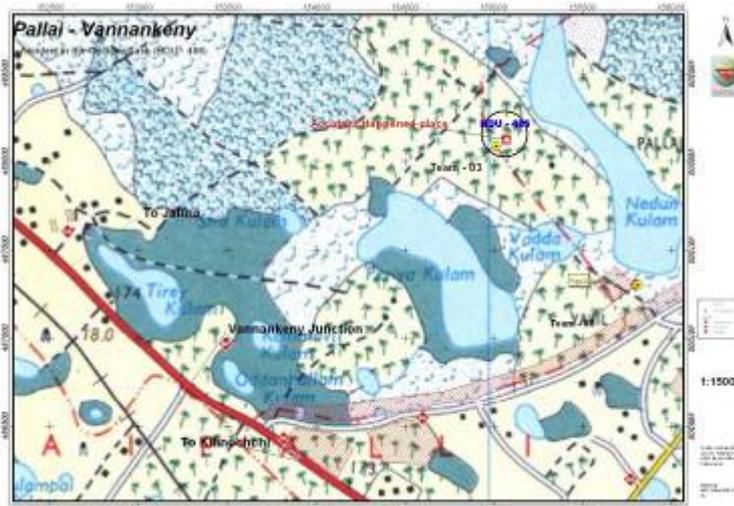
Summary of injuries:

COMMENT

The Victim suffered no injuries.

Maps

A map of the accident site is reproduced below.



Analysis

The primary cause of this accident is listed as “*Unavoidable*” because the deminer appears to have been working in an approved and effective way (having found three mines already that day) at the time of the initiation. The use of the rake amid thin roots without pausing to cut roots with another tool was commonly observed during a 2005 study. The secondary cause is listed as “*Victim inattention*” because it is likely that the deminer used his tool carelessly and applied pressure in a careless manner. The internal investigator called for the Victim to be disciplined for his incorrect use of the tool.

The mine involved was small (30g Tetryl main charge) and the distance between the deminer and the initiation coupled with his wearing of PPE probably prevented injury. The long-handle of the rake is a significant safety advantage over other hand-tools.

The inadequate equipment referenced in the "Notes" is the rake-head which broke. Locally made, the quality of the welding is varied and welds sometimes break in normal use. The demining group began work on improved rake-head manufacture and design during 2005.