

5-3-2000

# DDASaccident307

Humanitarian Demining Accident and Incident Database  
*AID*

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# DDAS Accident Report

## Accident details

<b>Report date:</b> 19/05/2006	<b>Accident number:</b> 307
<b>Accident time:</b> 08:40	<b>Accident Date:</b> 03/05/2000
<b>Where it occurred:</b> MAG/E/0072	<b>Country:</b> Iraq
<b>Primary cause:</b> Management/control inadequacy (?)	<b>Secondary cause:</b> Inadequate training (?)
<b>Class:</b> Missed-mine accident	<b>Date of main report:</b> 05/05/2000
<b>ID original source:</b> JJ	<b>Name of source:</b> UN/JJ/AVS 2001:KI04
<b>Organisation:</b> Name removed	
<b>Mine/device:</b> Valmara 69 AP Bfrag	<b>Ground condition:</b> grass/grazing area
<b>Date record created:</b> 19/02/2004	<b>Date last modified:</b> 19/02/2004
<b>No of victims:</b> 1	<b>No of documents:</b> 1

## Map details

<b>Longitude:</b>	<b>Latitude:</b>
<b>Alt. coord. system:</b> MAG/E/0072	<b>Coordinates fixed by:</b>
<b>Map east:</b>	<b>Map north:</b>
<b>Map scale:</b>	<b>Map series:</b>
<b>Map edition:</b>	<b>Map sheet:</b>
<b>Map name:</b>	

## Accident Notes

vegetation clearance problem (?)  
mine/device found in "cleared" area (?)  
dog missed mine (?)  
inadequate training (?)  
inadequate investigation (?)

## Accident report

A UNOPS MAP Board of Inquiry was instigated and the following BOI report provided. The date of the report was one day before the date of the site visit, so the date of the site visit has been adopted. That was two days after the accident on 5<sup>th</sup> May 2000. Apparently for "political" reasons (unexplained), the original report was not provided. No details of the demining group involved or the victim's identity were provided. The following is edited to allow it to be read smoothly.

The victim had been employed since 01/12/99, five months and two days prior to the accident. "The last official stand-down or leave period for the deminers was 15/12/99 – 15/01/00. Apart from that, the deminers had the usual weekend days off, and had just finished a long weekend leave period prior to the accident. Mine Detection Dog Contractor personnel were scheduled to depart on leave on 03/05/00 after a deployment of 10 weeks."

The accident site was approximately 110m from the task site control point. A safe lane was being established parallel to a track. A discernable pathway was about three metres to the left of the accident site. "The grass was fairly dense and this made the task of looking for mines very difficult."

"Mine Detection Dogs" and Manual Clearance were used at the site. The casualty was the first deminer to start work that day (at approximately 08:40) with his No. 2, monitoring him and the Section Leader monitoring the pair. The victim was wearing a "vest" and "visor" at the time. Because the area had been "verified", and was therefore considered by all to be "safe", the casualty walked straight out from the perimeter towards the indication box he was going to clear. Approximately 3.5 metres from his assigned work area he stepped on a V-69 bounding fragmentation mine.

The casualty suffered minor abdominal and groin injuries, probably as a result of the impact and shock of the mine bounding out of its pot and hitting him in the abdominal region, which lifted him up and threw him "some distance". "He was thrown into the air by the bounding action of the mine, landing on his back."

The team leader was arranging his site folder and the rest of the team were "preparing the sticks" when they heard the explosion. A 'STOP, STAND STILL' order was given and all other deminers returned to the admin area.

The casualty was evacuated to the Sub - District Hospital to be stabilized at 08:50. He was evacuated on to Main Emergency Hospital at 13:00.

### **Conclusion**

It is the opinion of the Board of Inquiry that the accident cannot be ascribed to any neglect, carelessness nor misconduct of any individual or group.

The BOI found no evidence of misuse of drugs, alcohol or medication. All personnel involved, UN, Manual Clearance Contractor and Mine Detection Dog Contractor complied with all applicable orders, instructions and safety precautions.

"The Board does, however, acknowledge that wind speed and direction could have been a factor in the cause of the accident in regard to dog indications. This is because the prevailing wind at the time was blowing toward the road, thus possibly allowing for the dogs to indicate a mine upwind of the actual mine itself."

The indication box in question, 3.5 metres away from the mine had not been investigated at the time of the BOI report.

### **Recommendations**

The Board of Inquiry recommended the following:

- a) "That no disciplinary action is taken against any member of the contractor staff.
- b) That no disciplinary action is taken against any member of UNOPS staff.
- c) That the verification drill should never be allocated to any area within a demarcated area unless there is extensive evidence of use e.g. cultivation, grazing etc.
- d) That the "panel search" method of search by dogs is always applied as a minimum search method within a demarcated area and that no deviation from this method is allowed (provided sub-para "c" above does not apply.
- e) That the whole minefield classification system as it is now, in current SOPs, be revisited and amended to include any new classifications as appropriate.

f) That a review of Manual Clearance Contractor and Mine Detection Dog Contractor SOPs take place (if not already done so) and clarify then amend areas where poor or wrong judgment may cause a repeat of this accident, then retrain all personnel in the conduct of joint operations as per the revised SOP.

g) That better supervision of teams is catered for, and where possible more senior management personnel are involved in the planning phase of the work (for advice and guidance).

h) That as soon as a dog makes an indication, the Dog Handler should note wind direction and strength so as to allow deminers to assess the best direction in which to approach the indication box. The size of the box also requires further discussion.

i) That dog indication is followed up the same day, by manual deminers. Where this is not possible, then the area must be re-done by dogs or the dog handlers must be present to indicate to the manual deminers where their search areas both to and around the indications should be.

j) That reclassification by Dog Handlers must be an ongoing process e.g. every 5 – 10 metres of advancement, and

k) It is recommended that manual deminers always verify ahead of themselves visually and with a mine detector before advancing into any area.

Statements referenced in the BOI report from the Team Leader, Site Commander, Witnesses and the victim were not made available.

## Victim Report

<b>Victim number:</b> 387	<b>Name:</b> Name removed
<b>Age:</b>	<b>Gender:</b> Male
<b>Status:</b> deminer	<b>Fit for work:</b> not known
<b>Compensation:</b> not made available	<b>Time to hospital:</b> 4 hours 10 minutes
<b>Protection issued:</b> Long visor Vest	<b>Protection used:</b> Long visor; Vest

### Summary of injuries:

#### INJURIES

minor Abdomen

minor Genitals

#### COMMENT

No formal medical report was made available. Victim's injuries may have been more severe.

### Analysis

The censored BOI report is confusing. Two commercial clearance groups worked in co-operation at the site. One was operating dogs, the other manual clearance. The mine was missed during area reduction prior to determining where to run dogs. If the undergrowth in the area had been adequately cleared (which it was not – “the grass was fairly dense and this made the task of looking for mines very difficult”) it would probably have been possible to see the V-69 because all bounding fragmentation mines are laid partly exposed. If a detector had been passed over the area, it would certainly have found the large metal signature of a V-69.

The analysis of this accident is hampered by the fact that the full report of the Board of Inquiry, including statements of witnesses, was not made available.

The recommendations of the BOI begin by stating:

- a) That no disciplinary action is taken against any member of the contractor staff.
- b) That no disciplinary action is taken against any member of UNOPS staff.

This is strange. Someone made a serious mistake in deciding what was an acceptable means of area reduction and it is incredible good-fortune that the mistake did not lead to a fatality in this accident.

The primary cause of this accident is listed as a "*Management/control inadequacy*" because management had approved patently inadequate area-reduction methods. The secondary cause is listed as "*Inadequate training*" because it seems that some people did not know what they were doing. The recommendation exonerating UNOPS staff may be taken to imply that they could have been held in part responsible.

The failure of the BOI to investigate the circumstances thoroughly is a serious "*Management Control Inadequacy*" meaning that an opportunity to correct dangerous practise was missed.