DDAS Accident Report

Accident details

Report date:	15/03/2004	**Accident number:**	400
Accident time:	10:05	**Accident Date:**	22/06/2001
Where it occurred:	Rasha Koshare MF	**Country:**	Kosovo
Primary cause:	Unavoidable (?)	**Secondary cause:**	Inadequate equipment (?)
Class:	Excavation accident	**Date of main report:**	21/07/2001
ID original source:	BoI: 008/2001: TKG	**Name of source:**	KMACC
Organisation:	Name removed		
Mine/device:	PMA-2 AP blast	**Ground condition:**	bushes/scrub electromagnetic rocks/stones sparse trees wet
Date record created:	04/03/2004	**Date last modified:**	04/03/2004
No of victims:	1	**No of documents:**	1

Map details

Longitude:		**Latitude:**	
Alt. coord. system:	DN 35021 01714	**Coordinates fixed by:**	
Map east:		**Map north:**	
Map scale:		**Map series:**	
Map edition:		**Map sheet:**	
Map name:			

Accident Notes

inadequate metal-detector (?)

visor not worn or worn raised (?)

inadequate equipment (?)

use of shovel (?)

metal-detector not used (?)

Accident report

What follows is the original KMACC Board of Inquiry, edited for anonymity and with excess pictures removed.

REPORT FOR ACCIDENT INVESTIGATION BOARD OF INQUIRY – No 008/2001

Mine Accident that occurred in MNB West on Friday 22 June 2001 in which [Demining group] deminer [the Victim] was injured.

Introduction

1. In accordance with the Mine Action Co-ordination Center (MACC) Standard Working Procedure No 4, this mine accident was investigated. This accident was not reported by [Demining group] as it should have in accordance with the MACC Guidelines and Technical Standards. The accident occurred on Friday 22 June 2001 at 10:05 hours and it was not reported to the MACC by [Demining group] until Friday 13 July 2001. Based upon the investigation and interviews conducted, this mine accident is considered to be preventable.
2. This finding is based on the fact that the mine detonated, followed the clear pattern of mines preceding this mine. The previous mines found were at an angle with the tops facing toward the direction of clearance. The lane had changed direction to head toward an identified PMR2A approximately five meters to the front. With the pattern and posture of the mines established this mine should have been expected. It is also believed the deminer may have been distracted by the PMR2A that was to his front.
3. In the days following 22 June 2001, staff within the MACC heard rumors of [Demining group] having a mine accident. However as no notification or report was received of an accident, these rumors were dismissed as being incorrect. During the investigation of a subsequent [Demining group] mine accident on Tuesday 10 July 2001, the MACC QA Officer asked the [Demining group] Operations Officer [Demining group ops officer] if they had a mine accident in the past weeks without reporting it. The reply from [him] was that they had not had a mine accident.
4. One of the [Demining group] casualties (the section leader) from the 10 July 2001 mine accident was admitted to Gjakova Hospital with minor blast injuries to his legs. It was when the MACC QA Medical Officer was visiting this casualty that he received the name of [the Victim] from the hospital. This person was reported by the hospital as being a deminer from [Demining group] who had been admitted on 22 June 2001, and had received blast injuries to his eyes. The hospital had said that he had been released on 6 July 2001.
5. [Demining group ops officer] and [name excised] ([Demining group] International Supervisor) both came to the MACC with their Investigation Report of the mine accident of 10 July 2001. The MACC QA Officer and the Chief of Operations questioned them both. They were asked if [Demining group] had an accident in the previous weeks without reporting it. They both categorically denied that [Demining group] had a mine accident and had not reported it. They indicated that there was a 'witch hunt' and that the accusations of a mine accident were false. They were given the name of [the Victim] and asked if this person was a deminer from [Demining group]. It was explained that he was admitted to Gjakova Hospital with blast injuries to his eyes and it is believed that he is a member of [Demining group]. They stated they were not sure if he was or not, but would check their nominal roll on returning to their HQ and inform the MACC.
6. The following day, 13 July 2001, [Demining group international supervisor] returned to the MACC and finally admitted that [Demining group] did have a mine accident on Friday 22 June 2001, that they had failed to report it, and that [the Victim] was the deminer involved. The reasons given for not reporting this accident was that the injuries received by the deminer were not serious. They also perceived that their HQ in Copenhagen were very nervous with the frequency of mine accidents that were occurring (two in the previous month) and could possibly close their program in Kosovo. Therefore they decided to not

report this mine accident, and were confident that they would not be 'found out.' The [Demining group] Kosovo Programme Manager was not informed of this mine accident until 16 July 2001.

7. Although a very serious breach of procedures, and in no way condoned, it is somewhat understandable given the circumstances. However to then blatantly lie about it when questioned on at least two separate occasions cannot be overlooked. It displays a complete lack of integrity and honesty, and calls into question the character of the two persons involved.

8. Demining is inherently a dangerous occupation. The safety of all persons concerned relies on tried and recognised standards that are in place to minimise the risks involved. he International supervisors that are employed in this business are engaged for their knowledge and experience, and most importantly their ability to solve problems and make sound decisions. The qualities of honesty and integrity are fundamental basic human traits that are expected of all persons, whether they are International or National. Without these qualities, then there is no trust.

9. The MACC is the authority that sets and maintains the standards within the demining program, and has to be seen as being unbiased and having one standard that applies to all organisations. It is expected that the same methodology is applied by the individual demining organisations with their staff, whether they are deminer or supervisor, or International or National. Therefore if a deminer is released due to a serious breach of procedures then the same should apply to an International.

Events leading up to the Accident

10. The QA Officer investigated this mine accident on Monday 16 July 2001, which is 24 days after the event. The accident occurred in one of the Rasha Koshare minefields, number 315 at grid reference DN 35021 01714 on Friday 22 June 2001 at 1005 hours.

11. The [Demining group] clearance drill for all the minefields in the Rasha Koshare area is to clear by prodding and excavation drill. This is due to the high metal content in the soil. The deminer [the Victim] whilst excavating in a clearance lane, detonated a PMA3 anti-personnel blast mine. At the time of the accident he was using his excavating tool, and in the process of using this tool he detonated the mine. There is no evidence to suggest that he was not using his excavation tool in the approved manner. He was wearing his personal protective equipment, and as a result of the blast he received mud and some particles in his right eye. There were no other injuries to his face or to the rest of his body.

12. Immediately after the uncontrolled explosion he stood up and walked out of the lane to a small stream and proceeded to wash his eyes. The section leader [name excised] was the first person to his aid and she took him out of the minefield to the road where the medics then administered treatment. They bandaged his eyes and then took him by ambulance to Gjakova Hospital.

13. [Demining group ops officer] was on the site when the first aid treatment was given to [the Victim]. It was at this time that the decision was made to not report this accident. [the Victim] was admitted to Gjakova Hospital and given further treatment. He was kept in hospital until Friday 6 July 2001, to continue removing the particles from his eye.

14. The clearance lane that [the Victim] had been working was in wet swampy ground. The clearance for this particular lane was to excavate the soil and mud down to the rock, which was approximately 20cm below the dirt and mud. There was a pattern of PMA3 mines that had been located in this lane and they were spaced at approximately 1.5m spacing. The previous two mines that had been found were apparently not lying flat, but were on an angle with the face of the mine facing toward the excavating deminer. The deminers had located a PMR2 fragmentation mine approximately five meters to the front of the lane and had therefore changed the direction of the clearance lane towards this mine. The location of the mine that was detonated by [the Victim] was consistent with the pattern of the previous two PMA3 mines located in this lane.

VIEWS OF ACCIDENT LANE

The Victim's protective equipment and handtool

[Note that the mud-spatter on the armour apron goes right up to the collar and would probably have struck the victim's lower face even if the visor were being worn in the down position.]

Work History of the Casualty

15. [The Victim] has been working for [Demining group] as a deminer since May 2000.

Past History of the Area

16. The accident site is Task Dossier W02 – 37, at minefield number 315. The minefields in this task dossier are all in the Rasa Koshare area, which is on the Kosovo – Albanian border. There was heavy fighting in this location during the war and there are numerous minefields along this border area.

17. The [Other demining group] conducted clearance operations in the Rasha Koshare minefields from July – November 2000.

Sequence, Documentation and Procedure of Tasking

18. The Task Dossier No W02-37 was issued to [Demining group] on 17 February 2001. As stated this was a minefield that [another demining group] had previously conducted clearance in, although had not completed.

Geography and Weather

19. The area in general is the Kosovo – Albanian Border approximately 25km NW from Gjakova. The border region around this area is mountainous and covered with forest and bush. The road access to this site is through the village of Junik. The route from here is a 12km very uneven gravel road which winds its' way up to the minefield. The weather at the time of the accident was fine.

Site Layout and Marking

20. The site layout and marking at the site was in accordance with the [Demining group] SOPs for mineclearance. The mine row that this particular lane follows is through a swampy area, on relatively flat ground. According to the Vojska Jugoslavije (VJ) minefield record there are five mine rows containing PMR 2A fragmentation mines with PMA 3 blast mines as keepers. Both PMR2A and PMA3 mines have been found in this clearance lane.

Management Supervision and Discipline

21. The section leader [name excised] directly supervised the deminer [the Victim], and at the time of the accident the supervision on site was adequate. There is also a Team Site Leader for this site, as well as a Senior Demining Supervisor, Mr [name excised] that over-see's the supervision of all demining sites. Managing all [Demining group] clearance operations is Mr [Demining group ops officer], the Operations Officer.

Quality Assurance and Quality Control

22. [Demining group] Quality Control is achieved through a system of on-site checks by the Section Leaders and Team Leaders to ensure adherence to the mineclearance SOPs. The MACC QA teams conduct external Quality Assurance on a regular basis, normally each site is visited a minimum of once per week.

Communications and Reporting

23. This mine accident was not reported until 13 July 2001.

Medical Details

24. [The Victim] suffered injury to his right eye from mud as a result of the explosion. See the attached [Demining group] medical brief. [Not made available.]

Dress and Personal Protective Equipment (PPE)

25. At the time of the accident the deminer [the Victim] was wearing personal protective equipment in accordance with [Demining group] SOPs.

Tools and Equipment

26. [the Victim] was using an excavation tool at the time of the accident. There was very minor damage to the tool.

Details of Mine Involved

27. [Large picture removed.]

Insurance Details

28. [The Victim] is covered by the [Demining group] personal insurance it has for all staff. All insurance policies for [Demining group] are through Willis Insurance Group of London. A copy of the insurance detail is kept in the MACC QA Office.

Conclusions

29. Based on the investigation, interviews, and visits to the site, the Board of Inquiry concludes the following:

- This mine accident was not reported to the MACC until 21 days after the accident, and this was only because evidence had come to hand naming the injured deminer.
- There was a deliberate and calculated decision to conceal this accident from the MACC, the [Demining group] Programme Manager and [Demining group] HQ in Copenhagen by [Demining group ops officer] the [Demining group] Operations Officer. This is a very serious breach of procedures.
- [Demining group ops officer] and [Demining group international supervisor] both demonstrated a lack of honesty and integrity when questioned about the accident, by denying any knowledge of it. Through their actions they have now suffered a significant loss of trust and confidence with the MACC, as well as a loss of credibility within their organisation and other organisations within the Programme.
- The reasons given why this accident was not reported, was that the injuries suffered by the deminer were not considered serious, and the perception by [Demining group ops officer] that [Demining group] HQ in Copenhagen were very nervous about the number of accidents that [Demining group] had sustained this year.
- The MACC as the demining authority in Kosovo has to be seen to be unbiased, and the enforcer of recognised standards, in order to maintain credibility within the demining community.
- [Demining group] have indicated that [Demining group ops officer] is a valuable member of their organisation and is integral to maintaining their time-line of completing their allocated minefields. As an organisation they have demonstrated a willingness to enforce standards. The section leader from the last mine accident on 10 July 2001 has been administratively released because of a serious breach of procedures. This same methodology should also be considered in this instance.
- The [Demining group] deminers have seen a national colleague released from their team. If [Demining group ops officer] did not suffer the same fate for a more serious

breach of procedures and dishonesty, then they would perceive that there are two standards within the program, and that compromises will be made because of the person's nationality and/or position.

- The clearance lane in which the accident occurred, followed a clear and consistent pattern of PMA3 mines. The mine row is laid in a swampy area on flat ground.
- The previous two PMA3 mines located in this lane were found buried at an angle with the tops facing toward the direction of clearance. With this information the deminer should have been conducting his excavation drill very cautiously, especially in the location he was working which was at the same interval as the previous mines.
- The clearance lane changed direction to head toward a PMR2A mine seen to the front of the clearance lane. This may have influenced the deminer by focusing him on this mine and not the immediate threat.
- The long-term prognosis for the injured deminer is good, and it is expected that he will not suffer any permanent disabilities.

Recommendations

30. The following are recommendations based on the Board of Inquiry conclusions:

- The dismissal of the section leader following the most recent accident on 10 July 2001 for a serious breach of procedures should be considered when the ramifications of this accident are assessed.
- If [Demining group ops officer] and [Demining group international supervisor] do not offer their resignations as a result of their actions, and/or [Demining group] are unwilling to release them from the Kosovo program, then the MACC should suspend their accreditation until they are replaced by suitable persons. If this is not enforced, then it is felt that the MACC has compromised its' position as the maintainer of standards and will lose credibility.
- It is understood that to get replacements will take time, however this has to be balanced with the requirement that the two concerned be removed from their positions as soon as possible. It is recommended that [Demining group] be given a period not longer than three weeks to have them replaced.
- All clearance in minefield number 315 be suspended until a re-assessment of the threat is made and a new plan prepared to take into consideration the swampy area within this minefield.
- This mine was detonated in a location consistent with the pattern of mines that were found within this lane. The previous two mines were found at an angle with the top facing toward the direction of clearance, and the lane had changed direction to go toward the PMR2A seen to the front. All demining organisations need to reinforce to their deminers that they maintain focus and concentration. They need to react on the information they gather as they clear along mine rows, and they should maintain their attention on the immediate threat, and not be distracted by outside influences such as another visible mine to their front.
- No further disciplinary action be taken against any National Staff that may have been involved with the non reporting of this mine accident.

Signed: UNMIK Mine Action Co-ordination Center, Quality Assurance Officer

Attachment: [Demining group] Medical Brief [Not made available.]

Comments by the MACC Operations Officer

31. The recommendations of the Quality Assurance Officer are fully concurred with. There has been a deliberate attempt by the [Demining group] Operations Manager in collusion

with one of his International Supervisors to deviate from the laid down procedures of the MACC Guidelines and Technical Standards as to the reporting of Mine Accidents.

32. What is more disturbing are the actions carried out by both men when asked by the MACC if there was any truth to the rumours circulating the “demining world”. Repeated inquiries by MACC personnel only resulted in both men lying in an attempt to extract themselves from the situation they found themselves, [Demining group ops officer] lying no less than twice. Their credibility has been fully compromised, to the point where they are no longer trusted by the Operations Branch of the MACC to competently or honestly continue in their current positions within the Kosovo Main Action Programme.

Signed: UNMIK Mine Action Co-ordination Center, Operations Officer

Comments by the MACC Programme Manager

The conclusions of this Board of Inquiry are concurred with, and in principle, so too the Recommendations. [Demining group ops officer], as the [Demining group] Operations Officer attempted to deliberately conceal the fact that the organisation suffered a mine accident, and then lied about the event when questioned by the MACC. [Demining group international supervisor] was also involved in attempting to cover up the accident, although ultimately the Operations Officer is responsible for such matters within the organisation.

The actions of both men have seriously damaged their personal credibility and standing within the MACC, as well as [Demining group]’s reputation as professional mine clearance organisation. In particular the decisions taken by [Demining group ops officer] cannot be condoned, and are not the decisions expected of an international Operations Officer, charged with the safety and supervision of a large number of mine clearance personnel.

The MACC Quality Assurance Officer has outlined the facts and the consequences clearly in this report. The reasons behind the decision being made were outlined, and from subsequent discussions with [Demining group], there also appears to be a misconception that the MACC expects accident-free mine clearance in Kosovo. The concerns about the loss of support from donors can be understood somewhat following two previous accidents involving [Demining group] personnel, however the idea that the MACC does not expect accidents to occur is incorrect. Indeed, the aim of the processes initiated by the MACC are to minimise the risk to deminers and to ensure that the causes of accidents are identified and not repeated. However it cannot realistically be expected that accidents will not happen, in the same way that industrial accidents occur in all occupations throughout the world. They are, to a certain extent a factor of the work that we do, albeit highly unfortunate and often tragic.

Should they be offered, the decision to accept the resignation of both men is up to the [Demining group] Organisation. This must be mitigated against the fact that [Demining group] personnel have cleared almost 6,000 mines to date under the supervision of [Demining group ops officer] and [Demining group international supervisor], which is an impressive total is such a short period. The success that they have achieved has been a major contributing factor towards the completion of the Programme by December 2001.

The detailed knowledge that both men have of the remaining minefields to be cleared by [Demining group] n 2001 must also be considered. The introduction of new personnel with no experience in these technically demanding minefields is not likely to increase the safety of the mine clearance personnel. Furthermore, it will not enable the two men to make amends for their actions, and to regain some of the lost credibility.

However, the conclusions of this inquiry have determined that the decision made by [Demining group ops officer] was not consistent with the requirements of position that he holds within the organisation, and this cannot be overlooked. It is therefore not possible to continue [Demining group]’s current accreditation with him in this position. Furthermore, the previous [Demining group] accident was attributed to incorrect decision making by [Demining group international supervisor], and the MACC recommended that some form of internal disciplinary action is taken against him, and this has occurred. Accordingly, there is little choice other than to suspend the accreditation of [Demining group], pending a satisfactory resolution of their operational management staffing. An acceptable solution will be for [Demining group] to employ a new Operations Manager, whilst retaining both [Demining

group ops officer] and [Demining group international supervisor] on probation, and in a reduced capacity.

Signed: UNMIK Mine Action Co-ordination Center, Programme Manager

Victim Report

Victim number:	515	**Name:**	**Name removed**
Age:		**Gender:**	Male
Status:	deminer	**Fit for work:**	presumed
Compensation:	not made available	**Time to hospital:**	not made available
Protection issued:	Frontal apron Helmet Short visor	**Protection used:**	frontal apron, helmet, Short visor

Summary of injuries:

INJURIES

severe Eye

COMMENT

See medical report.

Medical report

No medical report was made available.

The fact that the victim was held as a hospital in-patient for eye treatment for 14 days (inclusive) implies that his injuries were considered serious. The accident investigators report that the victim was expected to suffer no permanent disability and included a full face photograph of the victim in which slight injury and discolouration around the inside of the right eye (between eye and bridge of nose) was apparent.

Analysis

The primary cause of this accident is listed as *“Unavoidable”* because it seems that the victim was working properly to approved SOPs when the accident occurred. The secondary cause is listed as *“Inadequate equipment”* because his short visor that stands well away from the face may have allowed his eyes to be injured. It fails to interface with the body armour collar and stands so far out that it is possible that the victim could wear it properly and still look out beneath it while working. The visor was either worn raised, or provided inadequate protection that did not reach the requirements in the IMAS. The handtool used was also an example of inadequate equipment. It is not possible to “feel” delicately for a mine with such a tool. The basic design of the tool, with a steel head and wooden handle has also failed catastrophically when initiating blast mines in other accidents. The small size of the mine involved in this incident probably prevented this occurring.

The demining group’s pretence that no accident occurred and its dishonest attempts to cover it up are unusual only in so far as they were so incompetent. The researcher is aware that

many demining groups conceal “minor” accidents and believes that the funders bear some responsibility for this. However, the MACC felt that the deceit and lies constituted a serious *“Management/control inadequacy”* in this instance.