

DDAS Accident Report

Accident details

Report date: 07/02/2008	Accident number: 560
Accident time: 12:30	Accident Date: 25/07/2007
Where it occurred: Between Shama and Naqoura, 370m from gravel road	Country: Lebanon
Primary cause: Inadequate training (?)	Secondary cause: Management/control inadequacy (?)
Class: Handling accident	Date of main report: Not recorded
ID original source: DTG 252130CJUL07	Name of source: UNMAS
Organisation: [Name removed]	
Mine/device: DPICM M77 submunition	Ground condition: bushes/scrub leaf litter trees
Date record created:	Date last modified: 07/02/2008
No of victims: 1	No of documents: 1

Map details

Longitude:	Latitude:
Alt. coord. system: UTM 704664-668268	Coordinates fixed by:
Map east:	Map north:
Map scale:	Map series:
Map edition:	Map sheet:
Map name:	

Accident Notes

inadequate medical provision (?)
inadequate training (?)
metal-detector not used (?)
protective equipment not worn (?)
visor not worn or worn raised (?)

Accident report

The report of this accident was made available in February 2008 as a collection of files and pictures. Its conversion to a DDAS file means that some of the original formatting has been lost. The substance of the report is reproduced below, edited for anonymity. The original files are held on record. Text in [] is editorial.

REPORT

DTG 252130CJUL07

To: Force Commander UN INTERIM FORCE IN LEBANON

From: DCOS OPS

Through: COS

Subject: REPORT ON [foreign] EOD TEAM ACCIDENT 25-07-2007

Reference: A JOC summary of OPS brief dated 25 JUL 07

On the 25th July 07 a [European] EOD team suffered an explosion in the vicinity of Shama at UTM 704664-668268, resulting in the death of one [European] NCO. After receipt of initial reports to JOC, the incident was investigated. This report outlines the results of that investigation.

Chronology of Events

The chronology of events for the incident is as follows:

On 25th July at 1300 hours, it was reported to JOC that one [European] Combat Engineer was injured by an explosion while carrying out EOD activities in the vicinity of Shama at UTM 704664-668268, and an ambulance was required for his medical evacuation.



[The Victim's sunglasses were photographed later.]

JOC immediately dispatched an ambulance from Naqoura Level 1 hospital to the area of the incident accompanied by the FMO and one additional doctor from the [European] Component. In addition Maj [Name removed] from J3 Combat Engineer went to the scene to provide technical assistance, (he arrived at 1347 hours). At 1355 hours Maj [Name removed] reported that the accident took place at about 1230 hours and identified the injured person as [the Victim] (EU ENG COY). Later the doctors on the spot pronounced [the Victim] dead, the

corpse was evacuated to Naqoura Hospital at 1534 hours along with one soldier who was lightly injured during the evacuation (he has since recovered).

At 1430 hours a helicopter was sent to the area with DCOS OPS, MA to FC and a J3 representative to carry out an aerial recce of the area.

Two EOD teams from Sector West arrived at the scene of the incident (at 1520 and 1600 hours respectively) in order to support the investigation team and to clear a path to the location of the explosion.

At 1600 hours a FHQ investigation team comprised of Maj [Name removed] (J3), Maj [Name removed] (J3), LTC [Name removed] (J2) and WO [Name removed] (GIS) were sent to the incident scene.

The investigation team arrived on the spot at 1620 hours, and liaised with the chief of Sector West EOD. They were conducted to the incident scene by a secure path. The area was secured by a Sector West patrol, in addition there was a MP patrol (Tanzanian), a representative of J3 CBTENG, one member of UNMACC and the Commander of the LAF 62 Battalion present. The investigation team ascertained the following:

The [European] EOD team was carrying out a recce of the area. The area is located in an isolated deep narrow valley which was very difficult to access, the approach being through a narrow footpath 370 meters away from the main track. This area is dangerous, according to the information provided by the representative of J3 CBTENG (ANNEX C) [Not provided] it was attacked by cluster bombs during last summer's war. In fact, during the investigation it was observed that the area was heavily contaminated with unexploded cluster bombs and other war debris.



[An M77 ribbon can be seen on the right. The presence of this in the area implies that the same device killed the Victim.]

The path used by the investigation team was visually checked by a Sector West EOD team, it also had improvised markings made by the [European] EOD team during the evacuation of the corpse.

When the team arrived at the spot where the explosion took place, they found small parts of the cluster bomb that caused the death of the [European] NCO. No crater or signs of the explosion were found on the ground. There were blood stains in the area where the explosion took place and also 2.7 meters away, where the deceased's body was found. The area was surrounded by several unexploded cluster bombs.

The EOD on the spot confirmed that the explosion had injured [the Victim] in the right thigh, both hands and also in the face. This was confirmed later by [European] medical personnel who concluded that death probably occurred immediately.

The Commander of [Name removed] Battalion requested to observe the scene of the explosion, he was guided to the spot by SEC WEST EOD personnel at approx 1700 hours.

The investigation team concluded its work and arrived back in Naqoura at 1830 hours.

Summary

The GIS team ascertained the exact location of the explosion, the location of the body and the location of the closest vehicle to the area. UNMACC provided the UTM grids of the centre of the area attacked by cluster bombs (CBU) during the last summer war. The EOD team could determine that the explosion of the CBU did not take place on the ground since no crater was created as a consequence of the explosion.

The area of the incident was littered with CBUs, improvised Katyusha-style rocket, the remains of telephone cables and other war debris, showing evidence that this is a very dangerous area most probably used by Hezbollah as a firing position during last years war, the position was destroyed by an Israeli strike which accounts for the numerous UXO in the area.

Conclusions

According to the evidence found by the investigation team it can be concluded that:

The [European] EOD team was carrying out a recce in the area close to the AE position.

The explosion took place by accident most probably while [the Victim] was handling the CBU.

[The Victim] was injured in the right thigh, both hands and also in the face, death probably occurred immediately.

Recommendations

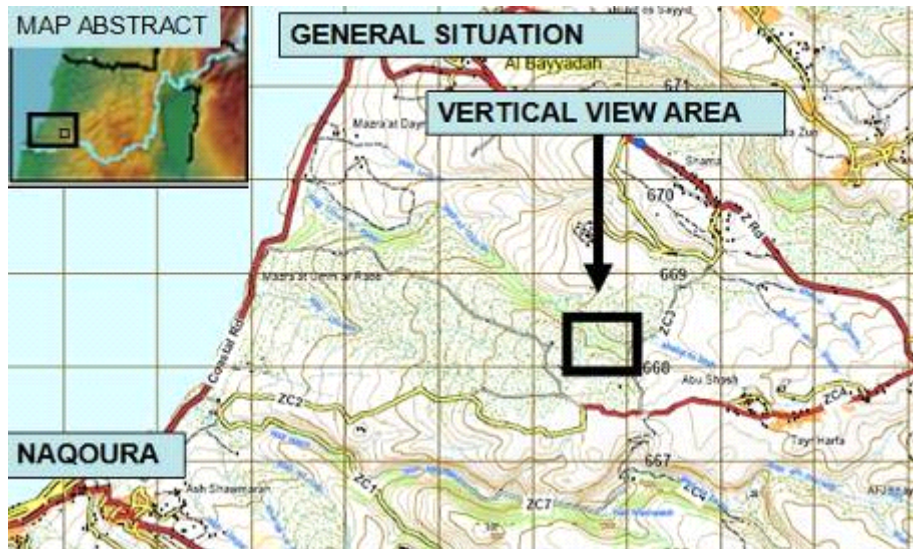
The investigation has prompted the following recommendations:

If a known dangerous area is accessed, the International Mine Action Standard (IMAS) methodology should be used in operational tasks.

Prior to conducting a recce of an area suspected to have been affected by CBU strikes, Units should first consult J3 CBT ENG.

Annexes

Annex A: UNIFIL GIS report on incident [This comprises four maps and no text. One map is reproduced below.]



Annex B: Scene of Incident

[This comprises a brief PowerPoint presentation that includes a picture of the investigators at the scene: at least one is not wearing any PPE – look for the floppy sunhat.]



Annex C: UNMACC Dangerous Area Report [Not made available.]

Victim Report

Victim number: 734

Name: [Name removed]

Age:

Gender: Male

Status: surveyor

Fit for work: DECEASED

Compensation: Not made available

Time to hospital: Three hours 4 minutes

Protection issued: Not recorded

Protection used: None

Summary of injuries:

severe Eyes

severe Face

severe Hands

severe Head

severe Leg

FATAL

COMMENT: "Death probably occurred immediately". No Medical report was made available.

Analysis

The primary cause of this accident is listed as "Inadequate training" because it seems that an unauthorized reconnaissance was being carried out by an ex-patriot EOD specialist who picked up a DPICM M77 and it detonated in his hands. The Victim wore no protective equipment and seems not to have obeyed basic safety rules.

The secondary cause is listed as a "Management control inadequacy" because the Victim was presumably instructed or permitted to carry out his "survey" by his superiors. It was a failure of management to send anyone out without the required equipment, medical support or the appropriate knowledge to avoid the threats that might be encountered.