6-5-2000

DDASaccident269

HD-AID
Humanitarian DeminingAccident and Incident Database

DDAS Accident Report

Accident details

Report date:	15/03/2004	**Accident number:**	269
Accident time:	10:20	**Accident Date:**	05/06/2000
Where it occurred:	Petrol refinery, Prizren district. MNB(S)	**Country:**	Kosovo
Primary cause:	Unavoidable (?)	**Secondary cause:**	Inadequate training (?)
Class:	Excavation accident	**Date of main report:**	12/06/2000
ID original source:	KC/MD/JF	**Name of source:**	KMACC
Organisation:	Name removed		
Mine/device:	Fuze	**Ground condition:**	grass/grazing area rocks/stones
Date record created:	18/02/2004	**Date last modified:**	15/03/2004
No of victims:	1	**No of documents:**	2

Map details

Longitude:	47° 21' 88"	**Latitude:**	46° 83' 09"
Alt. coord. system:		**Coordinates fixed by:**	GPS
Map east:		**Map north:**	
Map scale:	KFOR Misc	**Map series:**	UTM/WGS 84
Map edition:	8	**Map sheet:**	19 & 20
Map name:	1:50,000		

Accident Notes

inadequate training (?)

mine/device found in "cleared" area (?)

inadequate communications (?)

Accident report

A Mine Accident Report was prepared for the country MACC and made available in August 2000. The following summarises its content.

The victim has nine months experience working as a Battle Area Clearance team member. The deminers were working at a petrol refinery that had been "a NATO target during the bombing campaign" and "cluster strikes" had been recorded. "Other clearance agencies and KFOR [had] previously conducted clearance and demolition on [the] site". The weather on the

day was clear and sunny with the temperature above 25 degrees C. The site was last visited by MACC QA five days before the accident.

The communications system in place was not working well on the day of the accident. As a result the demining group's HQ was not told of the accident for seven hours and the MACC was not informed until the following day.

At 10:20 The victim was using a "Schonstedt GA 72-cd Locator in his "clearance area" and got a signal. He moved the grass from the area and "noticed a silver coloured metallic object visible on the surface". He was moving a stone to investigate this "suspected part of a BLU 97" when at 10:20 it detonated. He suffered injury to the index finger of his right hand. He was wearing his PPE according to SOPs. [The PPE was not described or photographed but would have included a visor and flak-jacket as required in that theatre.]

Work at the site was halted. The site medic gave first aid within three minutes of the accident. The victim walked from the accident site. Despite the apparently minor nature of the injury, the Team Leader decided that the victim should be checked in hospital. The victim was "stabilised" and taken to the Argentine KFOR hospital, arriving 40 minutes after the accident.

On arrival at the hospital the victim's hand was x-rayed. It was decided that there were no fractures and that no stitches were needed. "His cut was cleaned and dressed", antibiotics were prescribed and he was told to return two days later to the outpatients' department to have it checked.

The investigators decided that the device involved was "most likely the detonator from a BLU-97 previously destroyed".

Conclusion

The investigators concluded that if the victim had more experience he might have been more cautious "before removing stones", but that the accident was unavoidable.

Recommendations

The investigators recommended that the demining group carry out a CASEVAC exercise and that the MACC should be informed of all accidents no matter how minor within two hours (as required in the MACC Technical Standards).

Victim Report

Victim number: 343 **Name:** **Name removed**

Age: 19 **Gender:** Male

Status: deminer **Fit for work:** yes

Compensation: not made available **Time to hospital:** 40 minutes

Protection issued: Not recorded **Protection used:** not recorded

Summary of injuries:

INJURIES

minor Hand

COMMENT

See medical report.

Medical report

This unsigned report is based on the statements of the Medic, BAC Searchers and the Victim.

At the time of the accident,(approx. 10.20) There were one fully equipped ambulance with a driver and one Medic at the resting area.

When they heard the explosion and the whistles they immediately went to the place of the accident.

They arrived at the place of the accident in 2 minutes. The victim was standing up in safe area and had already been taken care of by [a deminer] who is also a medic.

The victim had sustained a laceration to his right forefinger, about 3cm long, and he was bleeding, this was only a minor injury and he was feeling OK.

The medic examined him and no other injury was found.

The finger was cleaned and bandaged and the victim was placed in the ambulance.

After contacting the [demining group] office in Gjakova, the victim was transported to KFOR hospital in Gjakova where he arrived at 10.50

At the hospital he was examined, x-rayed and his wound cleaned and dressed. No other treatment was required and there was no need to stay at the hospital.

The medic filled in the Emergency journal and they all went to the [demining group] office for debriefing.

Conclusions

The medical treatment was accurate according to the type of injury.

From the time of the accident till the time of arrival at the hospital was only 30 minutes.

The CASEVAC was performed to SOPs

Analysis

This accident could be classed as a “Missed-mine accident” because the area had been cleared before and it seems likely that the device involved had been thrown out of a previous (inadequate) detonation. The poor quality of the previous clearance had been recognised, which explains why it was being cleared again. However, given that the area was being recleared and the accident occurred during excavation, it is classed as an “Excavation accident”.

The primary cause of this accident is listed as *"Unavoidable"* because it seems that the victim was working as directed when the accident occurred. His failure to recognise the device that he picked up leads to the secondary cause being listed as *“Inadequate training”*. This failing was recognised by the demining group management – see Related papers.

The fact that the area had been cleared at least once previously lends weight to the view that the device involved was a remnant of a previous incomplete destruction. But whether the part was from a BLU-97 is not at all clear.

The accident report demonstrates an unusually thorough and critical approach to accident investigation. The Mine Action Co-ordination Centre that carried out the investigation was not engaged in demining, and this may (in part) explain the unusually objective nature of their investigations.

Related papers

An investigation report by the Operations Manager of the demining group recorded that communications between himself and the accident site were successful and that he was

informed of the accident at 10:35 on the day it occurred. His attempt to "stand down" his operatives was complicated by an inability to contact them all, and his inability to reach his group's HQ meant that they were not informed until 17:15.

The Operations Manager and Team Leader examined the accident site and could find no evidence of "disturbed ground" or any parts of the device. This was taken as evidence that the device was a "kick-out" from a previous demolition at the site. The victim's PPE was intact with no evidence of fragment impact or damage.

The operations Manager decided to increase training on component parts of sub-munitions. He explained that the "broken" communications meant that he did not want to risk being misunderstood and provoking unnecessary activity by trying to report the minor accident sooner.