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DDAS Accident Report

Accident details

Report date: 15/03/2004	Accident number: 323
Accident time: 12:50	Accident Date: 30/05/2001
Where it occurred: Rasa Koshare minefield No.358	Country: Kosovo
Primary cause: Field control inadequacy (?)	Secondary cause: Inadequate training (?)
Class: Missed-mine accident (survey)	Date of main report: 11/06/2001
ID original source: TG/CC/JF No 006/2001	Name of source: KMACC
Organisation: Name removed	
Mine/device: PMA-3 AP blast	Ground condition: bushes/scrub electromagnetic woodland
Date record created: 20/02/2004	Date last modified: 21/02/2004
No of victims: 1	No of documents: 2

Map details

Longitude:	Latitude:
Alt. coord. system: GR 34T DN 3503 0246	Coordinates fixed by:
Map east:	Map north:
Map scale:	Map series:
Map edition:	Map sheet:
Map name:	

Accident Notes

inadequate training (?)
protective equipment not worn (?)
inadequate area marking (?)
inadequate metal-detector (?)
metal-detector not used (?)

Accident report

The following is the MACC accident report, edited for anonymity.

Introduction

In accordance with the Mine Action Co-ordination Centre (MACC) Standard Working Procedure No 4, the MACC Programme Manager issued a Convening Order on Wednesday 30 May 2001 for an accident Investigation Board of Inquiry. Annex A details the Convening Order.

This is a comprehensive report by the Board of Inquiry into the mine accident that occurred on Wednesday 30 May 2001. Based on the investigation, interviews, statements from the demining NGOs (a collaboration between two NGOs) personnel involved in the accident, visits and photos of the accident site, this mine accident is considered to be preventable. This finding is based on the fact that an International Supervisor had conducted improper clearance procedures whilst conducting a level two survey. This clearance was not in accordance with the demining NGO's SOPs or to a recognised standard. The deminer [the victim] was permitted to enter this area without personal protective equipment and was therefore placed in a dangerous situation that ultimately led to him stepping on a PMA-3 mine and sustaining injuries. Notwithstanding the fact that the deminer should not have been permitted to enter this area, his injuries would have been significantly reduced had he been wearing personal safety equipment.

The accident occurred at one of the Rasa Koshare minefield's, Task Dossier Number W02-37, minefield number 358, GR 34T DN 3503 0246 on 30 May 2001 at 12:50.

Events leading up to the Accident

The demining NGO have been conducting clearance operations in the Koshare area since March of this year. This organisation has had resounding success in locating and clearing a large proportion of the minefields in the Koshare area. The terrain is very difficult with thick vegetation and the density of mines is high. The strategy employed by the demining NGO to employ a survey capacity to locate and identify the minefields and then the actual mine rows has been effective. It has allowed the demining teams to move into a minefield and conduct clearance immediately without having to waste time searching for the mine rows. The demining NGO have one Level Two Survey Team conducting operations at minefield number 358. According to the Vojska Jugoslavije (VJ) record for this minefield, there are two rows of mines that contain PMR-2A fragmentation mines and PMA-3 blast mines as keepers. This minefield is bisected by a dirt road that has been utilised as a base lane for both rows on either side of the road.

An International Supervisor for the demining NGO worked alone in mine rows on the East of the road, and the West side of the road was worked in by the remainder of the survey team. Due to the complexity of the mine rows on the Eastern side it was decided by the demining NGO Operations Manager to employ the International Supervisor to locate and then identify the pattern of the two mine rows. The International Supervisor was the only person up until the accident to have conducted clearance and walked in this area. He had located the two mine rows and was able to determine the pattern on his side of the road. The mine clusters he had located contained one PMR-2 mine and two PMA-3 keepers in these two rows. One of these clusters was in very close proximity to the mine that the victim stepped on. The two PMA-3 mines in this particular cluster that the International Supervisor had located were not armed.

The method the International Supervisor employed to locate the mine rows and then identify the pattern of the mines was not in accordance with the demining NGO SOPs or to a recognised standard. He did not use a base stick to clear, and therefore the width of clearance lane was not to the full 100cm width with the 10cm safety overlap either side. He was not using a metal detector as all minefields in this task dossier are cleared by excavation due to the very high metal content in the soil. Therefore he was conducting excavation and

prodding drills to clear, however as he was not using a base stick, the reliability and consistency of this clearance was questionable.

The International Supervisor was about to conduct marking in his area and he called the Survey Section Leader and enquired if there were marking sticks at his site. The SL then sent one of the deminers, [the victim] down to the International Supervisor's location with the marking sticks. The International Supervisor met the victim up on the road and it was his intention to take the sticks from him and continue into the mine row and conduct his marking. The victim insisted that he help the International Supervisor with carrying the sticks into the mine rows and assist him with the marking. The International Supervisor then agreed and he and the victim entered the mine row and commenced marking.

They had been in the lane for less than 10 minutes conducting marking, when the victim with a club hammer in his hand was bending down to pick up a marking stick. It was at this time that he stepped on a PMA-3 blast mine in what he thought to be the 10cm safety overlap.

According to the marking that was in place at the time of the accident this mine was just on the outside of the cleared area. There was mine marking tape fixed to the top of the danger sticks, however there was not any marking tape at the bottom of the sticks in the vicinity of the mine. The victim's foot must have only caught the very outside edge of the mine. The resultant blast caused injuries to the victim's face, chest, right arm and right foot.

As a consequence of the explosion the hammer was forced into the victim's chest causing bruising, and he then dropped the hammer [the photograph below shows a small hand axe, not a hammer: the red handled knife marks the crater].



The hammer has then fallen outside the marked area. The International Supervisor was standing approximately 2 metres from the victim, and facing in the opposite direction. The International Supervisor did not see the actual explosion or receive any injuries from the blast. Immediately after the explosion he moved to assist the victim and calm him. As the International Supervisor did not realise the victim had received injuries to his foot he attempted to guide him out of the lane and onto the road approximately 35 metres away. The victim was unable to walk and therefore the International Supervisor called to the SL to bring a stretcher to his site. The International Supervisor then called the demining NGO base and reported the accident and requested a helicopter casevac. When the SL arrived both he and the International Supervisor carried the victim out to the road on the stretcher where the medical team was waiting to provide first aid.

The victim was stabilised and from there he was then taken by ambulance to the HLS located approximately 1.5 km to the south. Further treatment was provided at the HLS whilst awaiting the arrival of the casevac helicopter. The helicopter arrived at 13:47 which was 50 minutes after the request for the helicopter was made and almost 60 minutes after the accident. The photograph below shows the victim in hospital on the day after the accident. The victim was conscious and able to talk whilst awaiting the arrival of the helicopter.



Work History of the victim

The victim has been working for the demining NGO as a deminer since May 2000.

History of the Area

The accident site is Task Dossier W02 – 37, at minefield number 358. 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. The majority of these minefields contain PMR-2 AP fragmentation mines with PMA-3 AP blast mines as keepers.

Sequence, Documentation and Procedure of Tasking

The Task Dossier No W02-37 was issued to the demining NGO on 17 February 2001.

Geography and Weather

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 uneven gravel road which winds its way up to the minefield. The weather at the time of the accident was fine with a temperature of approximately 25 degrees Celsius.

Site Layout and Marking

The site layout and marking at the site was in accordance with the demining NGO SOPs for mine-clearance, however the width of the lane was less than that prescribed in the SOPs. According to the VJ record this particular minefield has two mine rows which contain clusters of mines which contain one PMR-2 AP fragmentation mine with two PMA-3 AP blast mines as keepers. These mine rows have been laid in dense bush and trees.

Management Supervision and Discipline

The International supervisor for the site has a National section leader. Managing all the demining NGO clearance operations is the Operations Officer.

Quality Assurance and Quality Control

The demining NGO Quality Control is achieved through a system of on-site checks by the Section Leaders and Team Leaders to ensure adherence to the mine-clearance 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

At the time of the accident there was effective communication by VHF hand-held Motorola radios between the International Supervisor and his Section Leader on their internal net. There was further communication by hand-held VHF radios from the team site, and the demining NGO base situated in Hereq also on the demining NGO's internal net.

At the time of the accident the MACC QA Officer was in the region and monitored all radio traffic concerning the accident on the MNB (W) channel. There were no communications problems between any of the above callsigns during the period of the accident.

Medical Details

The victim received blast injuries to his face and eyes. He also received injuries to his chest and right arm and he has broken toes on his right foot. Annex D details the medical report from the MACC QA Medical Officer. [Annexes not made available.]

Personnel

A list of personnel and their duties is detailed at Annex D to the demining NGO's Preliminary Investigation Report. Written statements from the personnel involved in the accident form the Appendices to this Annex.

Dress and Personal Protective Equipment (PPE)

At the time of the accident the victim was not wearing personal protective equipment, which contravenes the demining NGO SOPs.

Tools and Equipment

The victim had a club hammer [axe] in his right hand at the time of the accident as he bent down to pick up a marking stick. However the accident was caused by the victim placing his right foot outside the cleared lane and not through the use of any tools or pieces of equipment.

Account of Activities

The following is a description of the events before and after the accident. The information from the investigation forms the basis of the description of events:

Wednesday 30 May 2001

12:40 – The International Supervisor calls by radio to the Survey SL to provide marking sticks for his site. The victim is sent by the SL to assist.

12:50 – The victim stands on PMA-3 whilst conducting marking, The International Supervisor is the first person to provide assistance. He calls the SL to come to his lane and assist, and they then carry the victim out of the lane onto the road where the team medics are waiting to provide first aid. The accident is reported to the demining NGO base.

12:55 – Radio call to senior partner reporting the accident detail.

12:57 – Radio call to KFOR, MNB (W) and reports that there is a mine accident at this location. [They request the grid reference and there is some confusion over callsigns.] Confirmation that they need a helicopter and that there is 1 casualty with a foot amputation.

Kilo Foxtrot confirms that they will send a helicopter, and they then ask for the name of the injured person. Demining group gives the name of the injured deminer and that his injuries are to the face and his eyes. Kilo Foxtrot then requests the name of the Medic TL and medic on site that will accompany the casualty on the helicopter. This information is given.

Kilo Foxtrot then asks if they would like the casualty to go to the Italian Field Hospital in Peja or to a hospital in Pristina. They replies that they want the casualty to go to the Italian Field Hospital in Peja and reconfirms the HLS. Kilo Foxtrot replies that the helicopter will arrive in 30 minutes (present time 13:04). They ask Kilo Foxtrot if there is any further information required. Kilo Foxtrot replies that there isn't at present, but will call again soon.

13:05 – confirmation that the hospital that the casualty will go to is the Italian Field Hospital in Peja.

13:07– Kilo Foxtrot asks what are the injuries to the casualty. They reply that the injuries are to the face and eyes. Kilo Foxtrot tries to ascertain if there are injuries to the head. They reply that the injuries are to the eyes. Kilo Foxtrot reconfirms the hospital as the Italian Field Hospital in Peja.

13: 09 – Kilo Foxtrot requests that they be informed when the helicopter arrives at the HLS and when it departs.

13:11 – Kilo Foxtrot reconfirms that the medical team will accompany the casualty on the helicopter to the hospital.

13:47 – They call Kilo Foxtrot and inform that the helicopter has arrived at the HLS.

13:49 – They call Kilo Foxtrot and inform that the helicopter has departed the HLS with the casualty and medical team.

13:55 – The helicopter arrives at the Italian Field Hospital in Peja.

Insurance Details

The victim is covered by the demining NGO personal insurance it has for all staff. All insurance policies for the demining NGO are through Willis Insurance Group of London. A copy of the insurance detail is kept in the MACC QA Office.

Conclusions

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

As part of the demining NGO strategy for clearance of the numerous minefields in the Koshare Task Dossier W02 – 37, the survey team is employed to locate the minefields and to then identify the actual mine rows. This allows the manual clearance teams to commence clearance immediately on the mine rows.

The Operations Officer assessed the Eastern side of the road that bisects minefield 358 as being difficult and therefore tasked the International Supervisor to locate these two mine rows and identify the pattern of mines.

The International Supervisor was the only person to have worked on the eastern side of the minefield and up until the accident the only person to have walked in this area.

The method that was employed by the International Supervisor to conduct this survey was not in accordance with the demining NGO's SOPs or to a recognised standard. He did not use a base stick during clearance. The width of the lane was less than 100cm and did not have the 10cm safety overlap on either side of the lane. Therefore the standard of clearance was questionable and not consistent along the complete length of the lane.

The victim should not have been permitted to enter this lane. He was not aware of the method used for clearance and therefore assumed the standard to be that as for normal clearance on a the demining NGO minefield site.

The victim was conducting marking without wearing personal safety equipment. Whilst bending down to pick up a marking stick, the victim placed his right foot on the very edge of the clearance lane which should have been within the 10cm safety overlap and detonated a PMA-3 blast mine.

Had the victim been wearing his personal protective equipment at the time of the accident then the injuries to his face and chest would have been greatly reduced. As he did not step directly on top of the mine, the injury to his right foot was comparatively insignificant. The victim was very lucky not to have suffered more severe injuries than he did.

The first aid provided to the victim after the accident was swift and to a high standard.

KFOR had the helicopter on site at the HLS 50 minutes after being notified.

Recommendations

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

The area on the eastern side of the road where the International Supervisor conducted his survey task is to be considered uncleared and is to be completely recleared in accordance with the demining NGO SOPs.

The clearance drill carried out by the International Supervisor is considered to be a serious breach of the demining NGO SOPs as well as recognised International mine-clearance standards. It is certainly not what is expected of an International Supervisor. Therefore it is recommended that the demining NGO management take the appropriate disciplinary action against the International Supervisor for not adhering to the demining NGO SOPs, and for placing a deminer in a dangerous situation by allowing him to enter a questionably cleared area without personal safety equipment.

All future survey tasks conducted by the demining NGO are to be in accordance with their in country accredited SOPs and recognised standards.

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

Annexes: [not made available.]

- A. MACC convening order for accident investigation Board of Inquiry.
- B. Map of the general area.
- C. Schematic diagram of the general accident area.
- D. Medical report from the MACC QA Officer.

Attachment: the demining NGO Preliminary Investigation Report

Comments by the MACC Chief Operations Officer

Whilst the demining NGO have had a number of accidents recently, it has been the findings of the Board of Inquiry that they were "genuine accidents", largely attributable to the extremely heavily mine contaminated area they are working in and to the continually changing and difficult topography. This accident was clearly preventable and should not have occurred in an organisation with an established character of professionalism using effective SOPs.

Fortunately the casualty suffered only superficial injuries and will experience no long-term incapacitation. This may be considered extremely lucky and in no way should detract from the seriousness of the circumstances causing this accident.

The demining NGO have extremely well thought out and effective SOPs and their utilisation will serve to mitigate any further accidents.

The Conclusions and Recommendations of the Board of Inquiry are fully endorsed and are to be implemented immediately.

Signed: UNMIK Mine Action Co-ordination Centre, Chief of Operations

Comments by the MACC Programme Manager

The conclusions and recommendations of this BOI, along with comments by the Chief of Operations are completely concurred with.

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

Victim Report

Victim number: 407	Name: Name removed
Age:	Gender: Male
Status: deminer	Fit for work: not known
Compensation: not made available	Time to hospital: 1 hour 5 minutes
Protection issued: Helmet	Protection used: none
Long visor	
Short frontal vest	

Summary of injuries:

INJURIES

severe Arm

severe Chest

severe Eyes

severe Face

severe Foot

COMMENT

See medical report.

Medical report

The following medical reports are edited for anonymity only.

Medical report concerning Rasa Koshare accident 30/05/01 12.55 PM.

This report is based on interviews/statements of the following staff member of the demining NGO involved:

- Medical Coordinator .
- Medical Team Leader of the Rrasa Koshare VI Medical Team.
- Medic of the Rrasa Koshare VI Medical Team.
- Medical Team Leader of Rrasa Koshare III Medical Team.
- Ambulance driver of Rrasa Koshare VI Medical Team.
- Chief Surgeon Italian Field Hospital Peja.

The victim was born in 1980.

Injuries:

Internal fracture of right foot.

Several burn wounds of front surface right leg, front surface of chest, front surface of neck and face. (including eyes, nose & lips).

Surgical procedures carried out at Italian KFOR Hospital Peja.

- Cleaning and treating the burn wounds.

- Assessment of the eye injuries and the level of damage.

Attachments:

- Accident report by Medical Coordinator.
- The sequence of events, by Medical Coordinator.
- Medical report of Italian KFOR Field Hospital Peja. (It will not be released before the victim has been discharged from hospital.)

Introduction

The demining group have been conducting clearance operations in the Koshare mountains since March of this year. On Wednesday 30 May 2001 at approximately 1255hrs a member of the Level Two Survey Team stood on a PMA-3 blast mine in minefield 358 as part of Task Dossier W02-37....

The victim was carried by stretcher to the road where the medics were waiting. They then provided the victim with first aid treatment according to the Pre-Hospital Trauma Life Support concept. Once he was stabilised the medical team then transported the victim by ambulance to the HLS located approximately 1.5km to the south. Further medical aid was provided to the victim whilst awaiting the helicopter. Once the helicopter arrived he was then CASEVACED to the Italian Field Hospital in Peja. The "On Scene Time" was approximately 60 minutes, which goes very well with the rule of the "Golden Hour".

The below mentioned assessment/therapy was carried out at the scene of accident:

Primary survey:

Glasgow Coma Scale 4-6-5 =15

Airways: Intact and open.

Breathing Respiratory pattern and rate within the normal rate.

Circulation: Blood pressure/pulse rate within the normal rate/limits. The bleeding was assessed as not being extensive and controlled by the application of compressive dressings. The burn wounds were assessed and then treated by covering with paraffin gauzes.

Disability: A cervical collar "Stiffneck" was applied after manual stabilization of head/neck.

Second Survey:

Therapy at the scene of accident:

IV line*2 (Both arms) 18 gauge.

500 ml Ringer solution*2 Infusion.

Oxygen therapy via face mask with reservoir 15 l/min.

10 mg of morphine IV was administered.

One additional doses of 10mg Morphine was administered due to more pain.

Conclusions

CASEVAC was performed according to S.O.P

"On Scene Time" within one hour.

The treatment/assessment that the victim received by the medical team at the scene of accident was carried out in a swift and very professional manner.

Recommendations:

If possible use IV canula with minimum size of 16 gauge to all trauma patients.

When working in remote areas and the estimated "On Scene Time" is going to exceed more than one hour, the patient should be evacuated by helicopter.

Signed: Quality Assurance Medical Officer, UNMIK MACC Kosovo

Demining NGO Accident Report

The following accident report was created by the demining NGO's Medical Coordinator on the basis of interviews with the following persons involved in the medical part of CASEVAC as of 30/05/01 (in timely order):

1. Medical Team Leader of the Rrasa Koshare VI Medical Team
2. Medic of the Rrasa Koshare VI Medical Team
3. Medical Team Leader of Rrasa Koshare III Medical Team
4. Ambulance driver of Rrasa Koshare VI Medical Team
5. Demining Supervisor
6. Section Leader
7. The Italian KFOR Hospital Surgeon responsible for the hospital treatment

Accident details

Accident location: Rrasa Koshare VI

Accident date: 30/05/2001

Accident time: approximately 12.55

Medical Team Response Time: approximately 01 minutes

Persons involved:

1. Victim: DOB 1980; Deminer
2. Section Leader
3. Demining Supervisor
4. Medical Team Leader
5. Medic
6. Medical Team Leader
7. Ambulance driver

Timing:

Stabilization Phase Time: approximately 15 minutes

Transporting time: from calling of Helicopter to arrival in KFOR Hospital approximately 47 minutes

Arrival Time to Italian KFOR Hospital in Peja: 13.55

Overall CASEVAC time: approximately 60 minutes

Patient's Destination: Italian Military KFOR Hospital Peja

Receiving Doctor's Name: [omitted]

Surgical Procedures:

Cleaning and treating the burn wounds.

Assessment of eyes injures and level of damaging.

Assessment and treatment processes description

Primary survey:

The patient was conscious and responsive in full and logical verbal contact,

Airways intact and open,

Respiratory pattern and rate, pulse rate and blood pressure within normal limits,

Stiffneck collar was applied after manual stabilization of the head,

The bleeding was assessed as not extensive and was controlled by application of the compressive dressing.

The burn wounds were assessed and treated by covering with paraffin gauzes.

Secondary survey:

Wounds description

Internal fracture of right foot.

Several burn wounds of the frontal surface of right leg; frontal surface of chest; frontal surface of neck and face (including: eyes; nose and lips).

Therapy

1000 ml Nacl 0.9%

100% oxygen via face mask with reservoir-oxygen flow: 15l/min.,

Stiffneck collar applied

Drugs:

10mg Morphine i.v

Followed en-route by additional 10mg Morphine i.v. approximately 10 minutes after first dose.

Accident Chart

Filled by the MTL and handed over to the Surgeon (the signed copy is in the possession of the Medical Coordinator).

Signed: Medical Coordinator

Date: 31/05/2001

The sequence of events

1. The ambulance with the medics and pre-hospital trauma care equipment was called approximately 12.55 by Demining Supervisor that was next to the injured deminer and arrived to the base lane approximately 01 minutes thereafter.
2. The Medical Team Leader assessed the victim, stopped the bleeding, treated the burn wounds and since the vital signs were stable performed a secondary survey, wound care and therapy. The Medical Team Leader decided to call KFOR Helicopter.
3. The base location was informed about the details of the accident on the radio by the Demining Supervisor and subsequently contacted Italian KFOR requesting the notification of the sending Helicopter and receiving hospital.
4. At the same time as Medical Coordinator I went to KFOR Military Hospital in Peja and was there when the Helicopter landed in hospital approx.13.55.

5. The Helicopter arrived to the hospital approx.13.55 and the casualty was immediately admitted and assessed by Dr. [name omitted]. Upon completion of the detailed assessment the treatment was carried out in Italian KFOR Hospital.

Communication description

Demining Supervisor with Medical Team Leader – effective

Demining Supervisor with base location – effective

Base location with group – effective

Group with KFOR – effective

Signed: Medical Coordinator

In December 2001, the MACC reported that the victim was partially blind in his left eye. He had been sent to Denmark for surgical treatment on his eyes and was then undergoing rehabilitation in Kosovo. At that time he was still employed by the demining group.

Analysis

The primary cause of this accident is listed as a *“Field Control Inadequacy”* because the victim acted on instruction from the senior supervisor in the field and those instructions were in direct breach of basic safety SOPs. The secondary cause is listed as *“Inadequate training”* because the Field supervisor responsible for putting the victim at risk was a senior ex-pat specialist appointed by management. Management must take responsibility for his selection and training, which seems to have been inadequate.

As with most reports from the Kosovo MACC, 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

Sample BOI convening papers.

NO 006/2001 DATED 30 MAY 2001

CONVENING ORDER FOR ACCIDENT INVESTIGATION BOARD OF INQUIRY.

6. The Programme Manager of the Mine Action Co-ordination Centre hereby appoints the following members to form a Board of Inquiry to investigate the Mine Accident that occurred on Wednesday 30 May 2001:
 - a. President - MACC QA Officer,
 - b. Member - MACC QA Medical Officer,
 - c. Member - MACC QA Assistant
7. The Board of Inquiry is to carry out a full investigation and provide a written report to the MACC Programme Manager by 0800hrs Thursday 7 June 2001. The report is to be written in the English language.
8. The Report of the Board of Inquiry is to consider the details attached at Appendix 1 to this Annex.
9. The Board of Inquiry is to issue an information bulletin to members of the mine/UXO clearance community in Kosova, to inform them of the accident and any relevant information and actions that should be taken by them immediately.

Programme Manager, UN MACC, 30 May 2001

NO 006/2001 DATED 30 MAY 2001

CONTENTS OF REPORT FOR ACCIDENT INVESTIGATION BOARD OF INQUIRY

The Report of the Board of Inquiry is to consider the details below:

1. Introduction.
2. Sequence Documentation and Procedures of Tasking.
3. Geography and Weather.
4. Priority of Task.
5. Site Layout and Marking.
6. Management, Supervision and Discipline on site.
7. Quality Assurance and Quality Control.
8. Communications and Reporting.
9. Medical, including injuries sustained.
10. Personalities, Team Identity No's and Interviews.
11. Equipment and Tools.
12. Details of the Mine/UXO involved.
13. Evidence of re-mining.
14. Dress and Personal Protective Equipment.
15. Use of Dogs.
16. Use of Machines.
17. Particulars of Deminers Insurance.
18. Detailed account of the activities on the day of the accident.
19. Summary.
20. Conclusion.
21. Recommendations.