

# DDAS Accident Report

## Accident details

<b>Report date:</b> 15/03/2004	<b>Accident number:</b> 273
<b>Accident time:</b> 10:05	<b>Accident Date:</b> 25/08/2000
<b>Where it occurred:</b> Near Restelicia, Gora, MNB South	<b>Country:</b> Kosovo
<b>Primary cause:</b> Management/control inadequacy (?)	<b>Secondary cause:</b> Inadequate training (?)
<b>Class:</b> Handling accident	<b>Date of main report:</b> 17/09/2000
<b>ID original source:</b> KC/MD/JF	<b>Name of source:</b> KMACC
<b>Organisation:</b> Name removed	
<b>Mine/device:</b> Fuze	<b>Ground condition:</b> bushes/scrub grass/grazing area hard
<b>Date record created:</b> 18/02/2004	<b>Date last modified:</b> 18/02/2004
<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> DM 689 460: MGRS	<b>Coordinates fixed by:</b> GPS
<b>Map east:</b> 68954	<b>Map north:</b> 49047
<b>Map scale:</b> Restelica	<b>Map series:</b> M709
<b>Map edition:</b> 5-NIMA	<b>Map sheet:</b> 3178 IV
<b>Map name:</b> 1:50,000	

## Accident Notes

inadequate training (?)  
metal-detector not used (?)

## Accident report

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

The accident occurred at a site with "several dangerous areas" recorded. The mines found were mainly PMA-3 and PMR-2A. TMA-5 AT mines had been present but "people from Albania" had removed most of them. Clearance work was progressing well "due to open ground and sparse vegetation" although some of the PMA-3 mines had been "affected" by

local people having burnt off the vegetation about three weeks previously. The ground was described as "semi-hard" and compacted with "small bush". A photograph showed very little ground cover and large areas of burnt ground. The weather was described as sunny with a temperature of 25C and a light breeze.



The photograph above shows the area being worked on.

The demining group was made up of "local Kosovo Albanians" headed by a Team Leader and Assistant who were both expatriates. The deminers worked a one man drill in two man teams (inferred) working "for 30 minutes on and 30 minutes off". The team were last visited by a MACC QA on the day before the accident.

The victim was an expatriate supervisor with 24 years military experience. He had been a member of the demining group for a year and had been in Kosovo previously.

Work began at the site at 08:00. At 09:50 a deminer reported having found a PMA-3 while prodding [no mention of detectors was made]. The victim ordered the deminers out of the field and went to "neutralise" the mine. He removed the UPMAH initiator from the mine and noticed that it was "slightly damaged". He carried the mine body in his right hand and the initiator in his left hand as he walked out of the mined area. At 10.05 the detonator in the initiator exploded in his hand.

The victim called for help and his assistant and the medic went to him. The demining group's manager and the authorities were notified of the accident by radio.

The photograph shows the victim's hand during treatment.



The medic examined the victim's hand and decided to evacuate him by road. The victim was "conscious and stable the whole time". At 11:45 they reached the KFOR hospital where a "small problem" with identity cards delayed their entry.

The investigators determined that the victim had been wearing appropriate PPE but did not record what it was.

## Conclusion

The investigators concluded that the victim "took a risk" by carrying an initiator that he had noticed was damaged. The demining group's SOPs state that destruction in-situ should take place unless it proves "to be impractical". If it did prove to be impractical, the mine was to be "remotely pulled " before handling. They said that there was no reason not to destroy the mine in-situ. They determined that the mine casing was not damaged by fire and that the mine had been found under the ground.

## Recommendations

The investigators recommended that the demining group should produce annex documents to their SOPs covering "each type of mine they intend to neutralise in Kosovo". When neutralisation was done, a special box should be provided for the "fuse" to be stored in after separation. They added, "only in exceptional cases should the PMA-3 mine be neutralised. They have an UPMAH-3 pressure friction (chemical) fuse which is very unstable."

A final recommendation was for the MACC to address the "small inconvenience" experienced at the KFOR base where an absence of appropriate ID cards caused a problem.

The MACC Programme Manager added a document requiring the demining group to make the changes to their SOPs recommended in the accident report.

## Victim Report

<b>Victim number:</b> 348	<b>Name:</b> Name removed
<b>Age:</b> 43	<b>Gender:</b> Male
<b>Status:</b> supervisory	<b>Fit for work:</b> yes
<b>Compensation:</b> not made available	<b>Time to hospital:</b> 1 hour 45 minutes
<b>Protection issued:</b> Not recorded	<b>Protection used:</b> not recorded (worn)

## Summary of injuries:

INJURIES

minor Hand

COMMENT

No medical report was made available.

## Analysis

The primary cause of this accident is listed as a "*Management/control inadequacy*" because the demining group was operating in breach of their published SOPs. The victim was the most senior manager in the field, and the responsibility for his selection and training rested with higher management. The secondary cause is listed as "*Inadequate training*".