

DDAS Accident Report

Accident details

Report date: 15/03/2004	Accident number: 272
Accident time: 08:20	Accident Date: 10/08/2000
Where it occurred: Nr Stajk and Miljaj, Gorazup region	Country: Kosovo
Primary cause: Inadequate equipment (?)	Secondary cause: Management/control inadequacy (?)
Class: Missed-mine accident	Date of main report: 21/08/2000
ID original source: KC/MD/JF	Name of source: KMACC
Organisation: Name removed	
Mine/device: PMA-3 AP blast	Ground condition: bushes/scrub electromagnetic hard rocks/stones sparse trees
Date record created: 18/02/2004	Date last modified: 18/02/2004
No of victims: 1	No of documents: 3

Map details

Longitude: 20° 56' 65"	Latitude: 42° 19' 22"
Alt. coord. system: DM 640 710	Coordinates fixed by: GPS
Map east: 46420	Map north: 46712
Map scale: PRIZREN	Map series: GSGS 5726
Map edition: 1-GSGS	Map sheet: 680
Map name: 1:100,000	

Accident Notes

inadequate metal-detector (?)
inadequate equipment (?)
inadequate medical provision (?)
partner's failure to "control" (?)
squatting/kneeling to excavate (?)
visor not worn or worn raised (?)

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. (See also the Demining group's Internal reports under Related papers.)

The victim had been a deminer in neighbouring Bosnia Herzegovina for five years. The area being cleared had no minefield record but a pattern of mines had been found – consisting of "fragmentation mines protected by PMA-3 blast mines" [PMR-2A fragmentation mines]. The area was described as "semi-wooded" and ground conditions were hard and rocky with a high mineral content, so a "prodding drill was used". Photographs showed fairly thick bushy vegetation to two metres high. The weather was sunny with temperatures of "25 to 30 Celsius with a light breeze". The last QA visit to the site had been made eight days before. Because detectors were not used at the site, the QA inspection was "visual".

The accident occurred at the start of the working day when the victim began working in the same lane as he had been working in on the previous day. Work started at 08:00 and he was "squatting on his knees" and prodding at 08:20 when he detonated a PMA-3 mine.

The victim suffered "serious blast trauma to his right leg resulting in an amputation above the knee...". He also received "minor" injuries to his left leg and to both arms.

The picture below shows the inside of the victim's visor, heavily sooted.



The victim was stabilised and taken to a helicopter landing pad within 22 minutes [34 minutes according to the itemised account in the same report] of the accident. At the pad, a German helicopter arrived ten minutes after the ambulance. The doctor on the helicopter treated the victim for "almost one hour" to stabilise him before the helicopter departed for Prizren. The total time taken to reach a surgical facility was 110 minutes.



The picture above shows a clearance lane at the site and shows the typical vegetation. The vegetation at the clearance site, coupled with "the curvature of the clearance lane" meant that there were no witnesses to the accident.



A photograph of the accident site showed the victim's base-stick ahead of the site of the detonation. The ground shown was made up largely of small stones. The victim's shears were pictured alongside the small crater, his helmet was several metres back up the lane.

The victim's partner was the first on the scene and "informed the Team Leader". The two of them moved the victim "into a safe area". Two minutes later the medic arrived and began stabilising the victim. The Team Leader notified the demining group's "country manager to organise the evacuation".

At 08:30 the victim was taken by ambulance to the helicopter landing strip, arriving 24 minutes later. At 08:55 the helicopter landed and the German doctor on board treated the victim for 45 minutes before it departed at 09:55. [The record of times is confused and inconsistent in the original.]

The investigators found that the medical equipment at the site was incomplete. They examined the victim's PPE and found traces of blast damage on his frag-jacket "and inside the helmet and visor". Photographs show the visor with the outside gleaming and smooth while the inside was blackened. There were also traces of damage on the inside of the front of the helmet. The victim's base stick had some traces of blast-sooting on it.

Conclusion

The investigators concluded that the victim was kneeling on both knees and prodding at the time of the accident. "He put pressure on the PMA-3 mine while he was concentrating on the left side of his base lane. He was trying to follow the pattern because he found a mine on the left side of the lane the previous day". They added "We will never know exactly what happened.... If he had... cleared along his base stick using an adequate detector he would have located the mine and avoided" the accident.

Recommendations

The investigators recommended that the KFOR medical staff be thanked for their help and that "immediate action" be taken to include oxygen, scoop stretcher and blood pressure manometer in the demining group's medical kit.

The investigators agreed with the demining group that a deminer should not get closer than 10cm to his base stick when clearing on rocky ground, and that rocks should be carefully removed by hand. They further recommended that the demining group should purchase detectors capable of locating mines in laterite soil (and confirmed that the Mine-Lab could do this [no specific model was specified]). [The demining group were not using any metal detector during clearance.]

Victim Report

Victim number: 347

Name: Name removed

Age: 36

Gender: Male

Status: deminer

Fit for work: yes

Compensation: not made available

Time to hospital: 1 hour 50 minutes

Protection issued: Frag jacket

Protection used: Frag jacket, Helmet

Helmet

Short visor

Summary of injuries:

INJURIES

minor Arms

minor Hands

minor Legs

AMPUTATION/LOSS

Leg Above knee

COMMENT

See medical report.

Medical report

A report based on statements and interviews with the medic on site stated that the medic responded to a call for assistance at 08:20 and met two deminers carrying the victim about 50 metres from the accident site. He was transferred to a stretcher and examined. The medic found a 40cm long "open wound...from under the knee up to femur, a badly injured knee with an open fracture above the knee, and he was in a lot of pain. The wound was black of dust from the explosion but there was no large bleeding. He also had some minor wounds on his arms and hands".

The medic cleaned, bandaged and immobilised the leg, set up an IV cannula (Ringer solution and analgesic Trodon, then took him to the ambulance. In the ambulance, the victim's minor wounds on his arms and legs were cleaned and bandaged en-route to the helicopter pad. The ambulance had no oxygen or blood pressure manometer. At the helicopter pad the victim was given "one more injection of Trodon because of the pain and a tourniquet was put on his leg because of increased bleeding".

The lack of a "scoop stretcher" meant that the victim "had to be lifted from the stretcher and put on the ground before the KFOR doctor could treat him". The KFOR doctor gave the victim an "intravenous cannula, analgesic, oxygen, ECG and he was intubated and put to sleep". He was "treated on the ground for approximately one hour before they put him in the helicopter". "The medic was not allowed to go with the helicopter".

In December 2001 the MACC reported that the Victim had been fitted with a permanent prosthesis and was living and working in Tuzla, Bosnia.

Analysis

This accident is classed as a "Missed-mine accident" because the injuries imply very strongly that the victim knelt on the mine (or on a stone over the mine) while he was working beyond it. The light injuries to hand and arms and the severe knee injury appear to corroborate this.

The primary cause of this accident is listed as "*Inadequate equipment*" because the authorities in the country agree that detectors capable of finding the mines in the prevailing conditions were available, but not used by the demining group. The failure to provide adequate equipment is a "*Management/control inadequacy*".

Several other aspects of the accident indicate failing of management. These include the fact that the demining method and tools appears to have been inappropriate (using a needle-prod for excavation is actually impossible) and the absence of a full medical kit.

The investigators did not make it clear whether they decided that the victim "put pressure" on the mine with his knee. The number of stones in the ground make it possible that he knelt on one side of a stone under which the mine was concealed.

The severe sooting of the inside of the victim's visor was not accompanied by any facial injury. This may indicate that the victim's visor was fully raised, but if that were true the victim's head would have had to have been very close to the detonation and directly over it – which does not match the investigator's re-enactment position. It is possible that the helmet and visor were on the ground alongside the seat of the explosion. If the visor was not worn or was worn raised, the victim was poorly supervised.

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

Comment from the MACC manager (attached to the accident report) observed that this was the fifth accident in Kosovo where a Bosnian deminer had not been using a detector. In his opinion, the Bosnian deminers lacked confidence in the detectors and this lack of confidence was unjustified because of the recent advances in detector technology and the proximity to the surface of mines in Kosovo. He stated that "ground compensating detectors are essential in this environment".

The MACC manager agreed with the demining group management that "complacency" was "a contributing factor" to the cause of this accident, and praised the group's internal investigation as "thorough...transparent...comprehensive".

Three brief internal reports by the demining group were found on file and are reproduced below, edited for anonymity.

Initial report (internal demining group)

This is an initial report by [Technical Advisor] into the accident occurring in Stajk, Gorazup region.

This accident occurred in the clearance lane on the site being worked by team 06. The lane being worked was very difficult terrain due to the ground conditions being very rocky and the high density of mines. Prior to this numerous PMA-3 mines had been found both on the surface and sub-surface.

On investigation the following points were found;

- Fragments of PMA-3 in and adjacent to the crater
- Basestick forward of the crater
- Prodder blown into bush on the right side of the clearance lane

- String length indicating cleared area
- Blast on front of the crater indicating where the mine was initiated

Conclusion

The accident happened within 15mins of the deminer starting work within his lane. The deminer was the last person to work in the lane the previous day.

The length of string from the last lane marker to the base stick's left hand side is approximately 30cm. If the base stick was placed in it's original position (immediately prior to the blast) then the crater would be in the still uncleared area.

The injury to the deminer is above the knee on the thigh indicating that the mine was not directly activated by the deminer's knee.

The deminer's prodder is in a bush on the right side of the lane in an uncleared area indicating that he was using the prodder at the time of the explosion. The deminer's visor has most of the dirt/debris on the inside. This is because the mine was activated below the deminer.

All of this information indicate that the deminer was working in the kneeling position on the far left of his base stick. His right knee moved forward slightly, also moving the base stick forward slightly. Then downward pressure on the rear of the mine, either by a stone or another activated the mine. If the mine had been directly activated by the deminer's knee then he would have suffered direct damage to the knee, but this was not the case.

Internal [demining group] accident report 1 – preliminary

Project Manager's pre-survey comments

Having read and received all the statements from the personnel involved I have come up with the following points:-

1. Team 06 were operating in the Gorozup area on Task Dossier S20-38 very close to the village of Stajk and Miljaj. They have been working in this area for a number of weeks under the supervision of the [Demining group]'s technical advisor for that area. The team were working in an area of a high concentration of anti-personnel mines both blast and fragmentation. I have visited this site on numerous occasions and in my opinion the clearance was made even more difficult due to the difficult terrain in which the deminers had to operate.
2. The terrain consists of high density of bushes and the ground very hard with compact rocks and stones. Again this made it very difficult for the deminers to clear taking into account that the use of detectors was not possible due to the high mineral content and uneven rocky ground. Prodding was also made difficult due to the fact that while prodding the deminers had to physically remove rocks and stones from the clearance lane to achieve the required depth as stated in the SOPs.
3. The injured deminer and his no. 2 operator had been working in this particular part of the mined area since opening up the clearance lane. This is normal practice for our deminers to stay in the same area therefore becoming totally familiar with the area they are working in. [The Victim] had been working at the base line at the close of operations on the 9th August 2000 and had physically closed down the lane himself prior to leaving the site. At approximately 8.00am on the morning of the 10th August 2000 [the Victim] and his no. 2, after being briefed by the Team Leader and conducting an equipment check proceeded into the mined area and along their clearance lane. Again it is normal practice for the last operator at the base line the day before to recommence operations the following day, thus preventing a break down in communications between the two operators.
4. At approximately 8.20am on 10th August 2000 [the Victim] was injured while conducting clearance operations within his lane. At 8.22 am having been informed by the Team Interpreter the CASEVAC Emergency Procedure went into operation. In my opinion the extraction and treatment of the injured deminer from the minefield was faultless. All

operations in the area was suspended and the injured deminer, along with the medic and the interpreter proceeded from the mined area to the designated KFOR HLS. By this stage the KFOR CASEVAC helicopter was en route from Suva Reka to the HLS. At approximately 8.55am the helicopter landed at the HLS and from then onwards the KFOR Major Surgeon took over the treatment of the injured deminer. The helicopter medical crew worked on the deminer for approximately 45 minutes - this is normal practice for the KFOR CASEVAC medical crew to assess and stabilise the casualty before flying. The casualty was treated for his injuries including inserting fluids by means of intravenous infusion and then intubated prior to take off. The helicopter departed at approximately 9.55am for the KFOR Field hospital in Prizren.

5. At this stage it is very difficult to even attempt to establish the cause of the accident until a statement had been taken from the injured deminer himself. The deminer's no. 2 although was 25m away from the scene of the accident could not keep a constant visual on his no.1 due to the terrain and the curvature of the clearance lane. Therefore he is unable to give us an accurate account of what actually happened. It is in my opinion and that of the technical adviser that the accident could have been caused with the deminer activating a mine by moving his knee forward of his known cleared area whilst clearing the far left extent of his base stick, thus causing his body to pivot moving his right knee forward possibly taking the base stick forward as well. The deminer was also concentrating on the far left of his clearance lane due to the fact that he had located a mine the night before albeit on the surface and also there was a tripwire visible on his immediate left.
6. The anti-personnel mine being a PMA-3 detonated between the deminers right knee and left heel. The blast due to the hard ground was mostly directed upwards taking with it sharp debris such as stones and rocks. According to the team medic during the post accident interview and the KFOR Flight Surgeon who stated at the HLS on site and the HLS at the KFOR Barracks that there were major injuries to the casualty's inner and upper right thigh from the upper part of the knee cap upwards. There were no injuries to the deminer's left foot. At this stage this indicates that there was no direct pressure from the deminer onto the mine by either his knee or left foot. The impact of the blast was taken by the deminer's right inner thigh from just below his groin to the upper side of his right knee cap. The result of the blast caused a fourth degree open fracture of the right femur with the loss of a large amount of flesh from his inner thigh and severe damage to his knee cap. Unfortunately the injuries were so severe that the surgeon could not save the leg therefore the leg was amputated below the right groin.

Post survey comments:

On the 11th August 2000 myself, [Name excised] and the UNMACC Accident Investigation Board of Inquiry visited the site of the accident to establish its cause. After spending some time at the scene it was very difficult to establish what exactly occurred. After retrieval of the base stick and prodder it was apparent that the blast was forward of the base stick and that if the deminer was in the kneeling position and holding his prodder while clearing the extreme left of the clearance area the blast apparently was in the middle of the base stick and between the deminer's legs very close to his right leg. It was also established through interviewing the team leader that the deminer prods while kneeling down on both knees - this is due to an injury to his left foot he sustained during the war and that this position on both knees is most comfortable for him.

It was also apparent from inspecting the crater that the mine was surrounded with sharp rocks and small stones which had a fragmentation effect to the mine resulting in abnormally severe injuries.

On my return to Prizren I then visited the field hospital in an attempt to speak to the casualty and to meet the surgeon who conducted the operation. The casualty, although awake, was not in any fit state to give out any information regarding the accident and due to the fact that he was in intensive care and that he had only recently recovered from general anaesthetic it did not seem right to pursue any statement. I asked the surgeon a number of questions regarding his opinion of the injuries - attempting to establish whether the blast was to the side of the knee or directly underneath. His analysis of the injury was that the damage was so severe to the upper right thigh and knee cap that he was not prepared to state the direction of the blast.

Probable Cause:

Again it is difficult to establish a definite cause of the accident without interviewing the casualty and even he might not know exactly what happened. Therefore we can only surmise at a probable cause at this stage. It is my opinion that the deminer while reaching across to clear the extreme left side of his clearance lane inadvertently dragged his right knee onto the base stick applying pressure to the stick consequently, possibly applying pressure to a stone that activated the mine.

Recommendations:

Again it is difficult to recommend a solution without knowing the cause. However to prevent the deminer from inadvertently applying pressure to the base stick with either his foot or knees/knees, I intend to amend SOPs. This will state while working in uneven rocky terrain the deminers knee or front part of the deminers foot must be no closer than 10cm to the base stick and the area of clearance forward of the base stick should exceed no further than 20cm thus preventing the deminer from reaching too far. To put this SOP into operation will be up to the discretion of the on-site Technical Advisor.

I will also attempt to devise a more flexible base stick again to alleviate the problem of applying pressure to a large area.

Signed: Country Manager

Internal [Demining group] accident report 2

Dated 14-08-00

[The Demining group] MINE ACCIDENT INTERNAL INVESTIGATION REPORT

Project Manager's conclusion and recommendations

Having now visited the injured deminer on a number of occasions and had the opportunity to interview him not only personally but also in the presence of his Team Leader I have managed to establish the following conclusions and subsequently make the following recommendations.

I managed to interview [The Victim] on the afternoon of the 12th August and although he was still very uncomfortable and in some pain he did attempt to tell me what he thought happened on the morning of the 10th August 2000.

He explained that he was working in the clearance lane the afternoon before and located a PMA 3 AP mine albeit on the surface just before the cease of operations that day. He also noticed a tripwire form a PMR2A heading away from where he had located the mine on the surface.

As normal, the next morning he commenced demining where he had left off the afternoon before, and in his opinion and according to his experience he knew there would be another mine very close, probably within the next 50cm.

He commenced clearance 10cm back form where he had left off the day before as stated in SOP's and then studied the area to establish where the next mine might be. He then commenced clearance of the top left hand side of his clearance area in an attempt to locate the next mine. This location being the logical position for the next mine bearing in mind that there was tripwire to the left. From then on he does not remember much of what occurred next, he explained that he was at full stretch to the left and in his own words that he may have either moved his knee onto the base stick or worse moved his knee over the base stick into an uncleared area.

He explained to me that he was 100% sure that there was another mine within the base stick area however he did not expect it to be where the explosion occurred. As the deminer has no

recollection of what happened I couldn't establish the actual cause of the accident. I must stress that I can only surmise of the probable cause.

Conclusion

We will never know exactly what occurred that morning due to the fact that there were no witnesses. [The Victim] was wearing his full protective clothing and working under the supervision of his Team Leader as according to [the Demining group]'s SOPs. The outcome of this accident was the detonation of a PMA 3 resulting in injury so severe that he had to have his right leg amputated just below the groin. It is possible that this accident could have been avoided if he had managed to control his instincts and adhered to SOPs. If the deminer had continued with his clearance procedure according to SOPs and cleared along his base stick he would have eventually located the next mine thus possibly avoiding such an awful accident.

Also in fairness, the type of ground in which he was working was far from ideal. There is a strong possibility that he indirectly dislodged a stone with his leg thus setting off a chain of events resulting in the detonation of the mine. The cause might never be known, however I do class this as a preventable accident regardless of how small the breach of [the Demining group] SOPs.

Recommendation

I do not intend to undertake a retraining program, this will take up valuable clearance time, in my opinion it is not a matter of inexperience but that of complacency and a macho Balkans attitude. This is a problem that all organisations and companies working in the Balkans have encountered at some stage. I will ensure that all Technical Advisors and Team Leaders monitor their men even more closely and that any other breach of SOP will be followed by instant dismissal.

As far as clearance procedures are concerned there will be no major changes to SOPs, the only change will be while working in uneven terrain such as rocky surfaces the deminer will get no closer to his base stick than 10cm. All loose rocks will be carefully removed by hand prior to clearance and placed behind the deminer. If some rocks are lodged then excavation of these rocks will be conducted.

Final Thought

[The Victim] is a very experienced mine clearance operator with at least six years commercial and humanitarian experience not only in Kosovo but in Bosnia and Croatia. He has been working with [Demining group] and in the same team on and off for over five years. He has also worked for [a second group], and last year worked in Kosovo for [Another Group]. He has been working in Kosovo on this [Demining group] contract since March this year and is a highly respected member of the team.

Having worked with [Demining group] for the last 12 months they have proven to be a highly professional and hard working team of deminers who have taken their work seriously and responsibly. This not only shows in their general behaviour and attitude in the workplace, but in the statistics of mines found and areas cleared. However, my personal opinion I stress this is my own opinion having worked and trained Bosnian deminers for a number of years, they occasionally allow their experience in this field to get the better of them, and they tend to forget the constant dangers involved which can affect their judgements. This tragic accident occurred while [The Victim] was conducting humanitarian demining within Kosovo, a task he believed in. He fully understood the dangers, like all deminers from the Balkans; unfortunately a minor human error resulted in such a tragic conclusion.

Signed: [The Demining group] Project Manager.

Statements

The following are signed statements from witnesses, edited for anonymity.

Team Leader

We have been operating in [the] location from 21st July to 10th August '00- the day when the accident occurred. I have had information about that location that a civilian stood on mine 300m far from RP1. I hadn't further information for the location. I used to brief every morning with deminers before operating in the minefield. The location we operating in is stony with high vegetation and difficult conditions to work in. In that location we have found surface laid mines and buried PMA-3 and PMR-2A. They have been removed or demolished. Every day we have found a couple of PMA-3 and PMR-2A mines.

On the 9th August we have found four (4) PMA-3 mines. When the accident occurred [the Victim] and [his partner] were working at the same lane. The day before a PMA-3 was found by [the Victim] in the same lane. The mine was surface laid, and removed safely and then transported to the store. Then I told [the Victim] to close the lane and have a rest. On the lane number four we have found three (3) PMA-3.

On 10th August we have had the briefing at the office with [Technical Advisor] up to 06.20. Then we departed office, checked the radio and then arrived to the location. At 0800 I had briefing with deminers before starting the operation in the minefield. The deminers then pulled out the equipment from the vehicle and started demining. Then I went to check the deminers and I arrived to 3rd pair, and then I heard an explosion. It was 0820. Then I heard the voice of [deminer no.2]. He was rushing and informed me that an accident occurred. I informed immediately the medic and stopped the operations, and ran into the lane where the accident occurred. I started to give first aid to [the Victim]. Then we pulled him out of minefield to safe lane. All the deminers came here.

The medic gave him first aid from 0820 to 0830 and then we carried him to emergency vehicle. Then I called the deminers and talked with them to be calm. Then [name excised] arrived at 1015. We went to the place of the accident where [he] took some photos and then closed the lane.

Deminor No.2

On 9th August I and [the Victim] have worked in pairs and found a PMA-3 mine. It was removed by the team leader. At 13.30 our Team Leader came to our lane and checked lane as he does every day at the end of work. We closed the lane and got out of minefield. [The Victim] was the last deminer to clear in this lane.

On 10th August we had a briefing with our Team Leader. [The Victim] who closed the lane himself opened the lane and started demining. As the lane wasn't straight (bent) we couldn't see each other. at 08.20 I heard an explosion and rushed towards [the Victim], and saw that he was injured, and immediately informed my team leader. Me and team leader pulled him out of the minefield to safety lane.

Regarding the terrain I have to stress that it is stony, a lot of trees and contains surface laid and buried mines PMA-3 and PMR-2A.

Team no.6 interpreter

As usual we arrived on site and informed 31 by radio that we had arrived, as well as a radio communications check. After that, a site briefing was held by the Team Leader, followed by equipment preparations. After that mine clearance operations began. I was in the rest area talking with the medic when we heard an explosion. The Team Leader call the medic to inform him about the accident. I then started to inform 31 base that an accident occurred and also gave them a grid number of HLS. At that time I had no further information about the casualty so I waited in the vehicle which was in the beginning of the safe lane.

They then took the casualty from the minefield and put him in the vehicle. Then I kept in contact with 31 Base and informed them of the name, blood group, type of injury, ETA at the HLS. When we arrived on HLS I also informed 31 Base that we arrived as well as condition of casualty. When the helicopter landed, KFOR doctor gave first aid to casualty.

I was there till helicopter departure to VJ Barracks - KFOR Hospital. After that we went back to the site to close down site and returned back to [the] office in Prizren.

Medic

On 10th August 2000 we arrived on site at 7.40 I established that everyone is prepared and ready for work (demining). At 7.50 I checked the vehicle's condition and medical equipment. At 8.00 I did a radio check with team leader. Some time at 8.20 I heard an explosion (I was in the medical area). Right after the explosion the Team Leader called me on the radio to inform me that we had an accident. I wore jacket and helmet and took medical bags and ran to the place of the accident. Whilst running to the place the team leader informed me in which lane is the injury. When I arrived to the safety lane of 2 metres the deminers were already carrying the casualty towards me. Immediately I established large knee injury of right leg and light injuries of both hands.

Firstly I administered first aid on wounded knee. All the time the injured was conscious. I took the first abdominal dressing and put it on the wounded area and then added another stronger dressing. Then I inserted the drip in the left hand and then gave him IV drip and one ampoule of Trodon 50 (analgesic) 1ml intravenous. I established that the other injuries could be dressed while transporting the casualty and told the deminers to take him to the ambulance vehicle.

All the time I was talking with the casualty. We put him in the vehicle which was in place and switched on the rotation light. While transporting the casualty to the HLS I checked also two light injuries. All the time I was in contact with him. While transporting him we were escorted with the 2nd vehicle. When we arrived on HLS we pulled the injured out of the vehicle. During the transport I was informing the interpreter about the injury and condition of the casualty. On the HLS were two medics and they helped me until the helicopter arrived.

Due to the pain we gave him one more Trodon 50 (analgesic). When the helicopter arrived I gave all information to KFOR Doctors regarding the casualty, what was done and what we gave him from analgesics and infusion. After KFOR assumed responsibility I stayed with the casualty for information. The casualty was conscious throughout and was in pain. After our job was completed they transported him with helicopter and we returned back to base.