

# DDAS Accident Report

## Accident details

<b>Report date:</b> 17/03/2004	<b>Accident number:</b> 404
<b>Accident time:</b> 09:10	<b>Accident Date:</b> 21/10/1999
<b>Where it occurred:</b> Hotonj, Vogosca, Sarjevo Canton	<b>Country:</b> Bosnia Herzegovina
<b>Primary cause:</b> Inadequate survey (?)	<b>Secondary cause:</b> Inadequate training (?)
<b>Class:</b> Missed-mine accident	<b>Date of main report:</b> 02/11/1999
<b>ID original source:</b> MAC/QA/1000/RS	<b>Name of source:</b> TJ/NH
<b>Organisation:</b> Name removed	
<b>Mine/device:</b> KB1 submunition	<b>Ground condition:</b> building rubble residential/urban
<b>Date record created:</b> 16/03/2004	<b>Date last modified:</b> 17/03/2004
<b>No of victims:</b> 2	<b>No of documents:</b> 1

## Map details

<b>Longitude:</b>	<b>Latitude:</b>
<b>Alt. coord. system:</b>	<b>Coordinates fixed by:</b>
<b>Map east:</b>	<b>Map north:</b>
<b>Map scale:</b> not recorded	<b>Map series:</b>
<b>Map edition:</b>	<b>Map sheet:</b>
<b>Map name:</b>	

## Accident Notes

inadequate training (?)  
mine/device found in "cleared" area (?)  
inadequate investigation (?)  
protective equipment not worn (?)

## Accident report

No formal accident report has been made available (March 2004). The accident was deemed an "incident" despite occurring to a group engaged in demining and while they were at work, which makes it an "accident" according to IMAS definitions. The accident occurred before the current IMAS were published, which presumably explains the reversed use of the terms. The following document from the Bosnia Herzegovina MAC was made available in 2003. It has been edited for anonymity.

## **Demining incident 21/10/99 - Lesson Learned**

2nd November 1999, MAC QA/1000/RB

### **INTRODUCTION**

1. BH MAC to conduct and investigation on the circumstances of the incident that happened at the site ID 10228, Hotonj, Vogosca, Sarajevoo Canton, Federation of Bosnia and Herzegovina convened a Board of Inquiry. Incident was initially reported by SFOR.
2. Two persons suffered minor injuries in this incident.

### **SUMMARY**

3. Demining incident occurred on October 21<sup>st</sup> 1999 at 09:10 hours in the very vicinity of the control point, approximately 120 metres away from the active minefield. Weather was windy and cloudy. Rest area is a 20 square metre area in front of a devastated house, while the part of the rest area is one of the rooms in the very house, cleared as well. The area by the rest area is mined and marked with 1.5m high pickets and a mine tape attached to each. There were four persons wearing no PPE at the rest area at the moment. The site itself is constantly supervised by SFOR.

A roof of the devastated house is burnt so there were pieces of metal parapets left on sides. Incident was due to a piece of parapet that fell to the ground and activated KB1 cluster bomb. The fallen piece of parapet and the wall of the house took almost all the bomblets [fragments] from KB1. One of them injured an SFOR supervisor in the upper part of his thigh while a deminer was injured under a rib. These were all minor injuries and the bomblets [fragments] were taken out in the hospital. The medic was close to the incident site as well so the injured were given first aid and taken to hospital in a very short period of time.

### **CONCLUSION**

4. The site is located in an urban area where the areas where people live are mined. Backyards are cleared according to priorities so there are lots of mined areas in between, which is of great danger for the inhabitants.
5. Five (5) cluster bombs [submunitions] were found at the same spot. They were not destroyed in situ since it is the urban area so that the police forbade destruction. They had to be disarmed and removed to the demolition area.
6. Operational site being very narrow, safety distances allowed only one two-man team working at a time, while the rest of deminers were either at the control point or the rest area.

### **RECOMMENDATIONS**

7. Since these teams are not house clearance teams, which is a big problem in an urban area, the training of deminers for house clearance should be done. Every cleared backyard would include the house clearance and such unfortunate incidents could be avoided.
8. Tasks should be issued as a whole, so that administrative areas could be located inside the safe area and therefore minimise the dangers for civilians,

Signed: AD Coordination BH MAC

## **Victim Report**

**Victim number:** 521

**Name:** Name removed  
(SFOR-1)

<b>Age:</b>	<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> not recorded
<b>Protection issued:</b> Not recorded	<b>Protection used:</b> none

**Summary of injuries:**

INJURIES

severe Leg

COMMENT

No medical report was made available.

### Victim Report

<b>Victim number:</b> 522	<b>Name:</b> Name removed (SFOR-2)
<b>Age:</b>	<b>Gender:</b> Male
<b>Status:</b> deminer	<b>Fit for work:</b> yes
<b>Compensation:</b> not made available	<b>Time to hospital:</b> not recorded
<b>Protection issued:</b> Not recorded	<b>Protection used:</b> none

**Summary of injuries:**

INJURIES

severe Chest

COMMENT

No medical report was made available.

### Analysis

The primary cause of this incident is listed as *"Inadequate survey"* because the demining group established their rest area inside a property they presumably believed was safe. The report does state that the "room" in the house had been "cleared as well" so presumably the KB1 fell to the floor with the rubble that fell into the house from the roof.

The report identified a lack of appropriate training in its recommendations, so the secondary cause is listed as *"Inadequate training"*. Both the primary and secondary causes could be considered to be *"Management/control inadequacies"* because the responsibility for ensuring that appropriate surveys are made and adequate training is given lies high in the command chain.

Despite the report stating that the Victim's injuries were minor, the fragments had to be surgically removed and all injuries requiring surgery are classed as "severe" in this database.

It is not clear why the details of this accident have not been made available. The fact that the victims were serving SFOR soldiers may have made the accident details "sensitive" but the lessons to be derived from the accident were relevant to all.