

10-10-1995

DDASaccident035

Humanitarian Demining Accident and Incident Database
AID

Follow this and additional works at: <https://commons.lib.jmu.edu/cisr-globalcwd>



Part of the [Defense and Security Studies Commons](#), [Peace and Conflict Studies Commons](#), [Public Policy Commons](#), and the [Social Policy Commons](#)

Recommended Citation

Database, Humanitarian Demining Accident and Incident, "DDASaccident035" (1995). *Global CWD Repository*. 235.
<https://commons.lib.jmu.edu/cisr-globalcwd/235>

This Other is brought to you for free and open access by the Center for International Stabilization and Recovery at JMU Scholarly Commons. It has been accepted for inclusion in Global CWD Repository by an authorized administrator of JMU Scholarly Commons. For more information, please contact dc_admin@jmu.edu.

DDAS Accident Report

Accident details

Report date: 11/03/2004	Accident number: 35
Accident time: 05:30	Accident Date: 10/10/1995
Where it occurred: Songo, Cahorra Bassa District, Tete Province	Country: Mozambique
Primary cause: Field control inadequacy (?)	Secondary cause: Inadequate training (?)
Class: Handling accident	Date of main report: 14/10/1995
ID original source: AO	Name of source: NPA field
Organisation: [Name removed]	
Mine/device: AP blast (unrecorded)	Ground condition: not applicable
Date record created: 22/01/2004	Date last modified: 22/01/2004
No of victims: 1	No of documents: 2

Map details

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

Accident Notes

inconsistent statements (?)
inadequate equipment (?)
inadequate medical provision (?)
no independent investigation available (?)
inadequate investigation (?)

Accident report

An internal accident report was prepared by the demining group. It was made available and the following summarises its content.

The demining group had been working in the area since 4th September 1995. After the accident the victim was "immediately evacuated to Tete Hospital after a short stop at Songo Hospital". He was operated on the same day but died later. "The local police and [the demining group] are still investigating..." [Further detail sheds light on the use of the word "immediate" in the above statement.]

On October 10th at 05:30 the victim initiated the mine in his tent within the camping area, seriously injuring his right arm, left leg and "breast". Nobody else was injured. First aid was given by the medical co-ordinator and two paramedics.

At 06:40 the victim "was taken" to Songo hospital where no surgeon was available. He was given "advanced first aid" and prepared for evacuation to Tete Hospital. At 07:20 the ambulance left for Tete. At 09:30 the ambulance arrived at Tete Hospital. At 02.00 on the following day the victim died of "internal injuries"

The report went on to state that the funeral costs would be paid by the demining group. Also that, due to the special circumstances of this accident, they would await the police report before paying compensation.

Victim Report

Victim number: 51	Name: [Name removed]
Age:	Gender: Male
Status: deminer	Fit for work: DECEASED
Compensation: none	Time to hospital: 4 hours
Protection issued: Safety spectacles	Protection used: none

Summary of injuries:

INJURIES

severe Body

severe Chest

severe Leg

FATAL

COMMENT

No medical report was made available. The victim suffered severe injuries to his right arm, left leg and chest. He died 20.5 hours after the accident.

Analysis

The accident's primary cause is listed as "*Field control inadequacy*" because the victim was able to breach basic operating procedures without correction. His apparent ignorance of the dangers involved in his activity implies a lack of appropriate training, which would be a "*Management/control inadequacy*". The secondary cause is listed as "*Inadequate training*".

The “inadequate equipment (?)” noted refers to the issue of industrial safety spectacles as PPE.

The absence of an effective Medevac plan led to the victim’s hospitalisation being delayed (see Related papers). This is the “inadequate medical provision” referenced in the notes.

Related papers

The accident is mentioned in the group's "demining activity report" for 1995. The summary of the accident is incomplete (was still under investigation), saying only that the victim activated an AP mine inside his tent and died of "complications".

On 18th November 1998, the group's Mozambique Deputy Director said that the deminer had taken the mine back to his tent and set it off whilst rummaging in his bag. The victim admitted that he had placed the mine in his tent himself before he died – so stopping further police inquiry.

On 20th November 1998, an ex-pat Technical Advisor to the group reported that the victim initiated the mine by rolling over onto it while it was in his trouser pocket.

In June 1999, a senior Technical Advisor to the group at the time said that the victim had been dismissed and was working out his notice at the time of the accident.

A summary of the accident was made available by the Country Manager of the demining group in March 2002. This summarised the injuries and stated that the Victim’s funeral was paid for and they were given three month’s salary (US\$210) but compensation was not paid. The police report was never shown to the demining group.

The victim was first taken to a hospital where there was no surgeon, then taken to another hospital, which explained the delay in hospitalisation.