

1-19-1995

# DDASaccident041

Humanitarian Demining Accident and Incident Database  
*AID*

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## Recommended Citation

Database, Humanitarian Demining Accident and Incident, "DDASaccident041" (1995). *Global CWD Repository*. 241.  
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# DDAS Accident Report

## Accident details

<b>Report date:</b> 11/03/2004	<b>Accident number:</b> 41
<b>Accident time:</b> 12:45	<b>Accident Date:</b> 19/01/1995
<b>Where it occurred:</b> Mulangeni-Antonia District, Tete Province	<b>Country:</b> Mozambique
<b>Primary cause:</b> Field control inadequacy (?)	<b>Secondary cause:</b> Inadequate training (?)
<b>Class:</b> Excavation accident	<b>Date of main report:</b> 01/11/1995
<b>ID original source:</b> HB	<b>Name of source:</b> HB/NPA field
<b>Organisation:</b> [Name removed]	
<b>Mine/device:</b> PMN AP blast	<b>Ground condition:</b> not recorded
<b>Date record created:</b> 22/01/2004	<b>Date last modified:</b> 22/01/2004
<b>No of victims:</b> 1	<b>No of documents:</b> 2

## 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

handtool may have increased injury (?)  
squatting/kneeling to excavate (?)  
no independent investigation available (?)  
inadequate investigation (?)  
inadequate equipment (?)

## Accident report

This accident was mentioned in the demining group's "demining activity report" for 1995. No details of the accident were available from their country office in Tete in November 1998 or on subsequent visits.

The Deputy Country Director was interviewed by the researcher on 18<sup>th</sup> November 1998 and later send a one page summary of the accident and two others (dated 01/11/95). He said that the victim had initiated a PMN mine at approximately 12:45 whilst prodding with his three-pronged fork. At the time an internal investigation [not made available] concluded that he had not used his detector in that area prior to the accident, which was against instructions from his supervisors. "If he had been using the detector the accident would probably have been avoided."

The victim "broke his right arm and got burning wounds in his face and on his chest". The Country Director believed that safety spectacles prevented injury to the victim's eyes.

## Victim Report

<b>Victim number:</b> 59	<b>Name:</b> [Name removed]
<b>Age:</b>	<b>Gender:</b> Male
<b>Status:</b> deminer	<b>Fit for work:</b> yes
<b>Compensation:</b> none	<b>Time to hospital:</b> 30 minutes
<b>Protection issued:</b> Safety spectacles	<b>Protection used:</b> Safety spectacles

### Summary of injuries:

#### INJURIES

minor Chest

minor Face

severe Arm

#### COMMENT

No medical report was made available.

## Analysis

The primary cause of this accident is listed as a "*Field control inadequacy*" because the victim did not use his detector prior to prodding. This implies that the field supervisors did not have appropriate control over the victim.

The demining group's three-pronged fork is a long-handled tool, shown in the picture below with an 18" (45cm) bayonet alongside it.



The use of a tool that kept his hand away from the detonation may have prevented serious hand injury, but may have caused the arm injury. The tool had three tines, meaning that it takes three times the force needed for a single tined tool to push it into the ground. Tactile feedback on ground obstructions would be less than from a single blade, so the use of the tool in an unapproved manner may have helped cause the accident. If so that may have been the consequence of *“Inadequate training”*.

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

### **Related papers**

No record of this accident was held by the country MAC in November 1998. An agreement by the head office of the organisation to provide details in February 1999 was not honoured.

An ex-pat Technical Advisor with the demining group at the time of the accident was interviewed in February 1998 (then working for another demining group). He said that the accident was caused by the use of the three pronged prodder with which the deminer could not "feel" the mine properly. This opinion has subsequently been opposed by other Technical Advisors to the group.

The three pronged prodder was used in a kneeling or squatting position.

A summary the accident was made available by the demining group’s Country Manager in March 2002. This stated that the victim “broke his arm and got burning wounds on his face and chest. Soon after [he] was not able to see but regained his sight on the same day”. The victim recovered and was offered his job back. He declined and was given three months’ severance pay (US\$210). He got no compensation.