9-26-1998

DDASaccident047

Humanitarian Demining Accident and Incident Database

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DDAS Accident Report

Accident details

Report date: 11/03/2004  Accident number: 47
Accident time: 11:45  Accident Date: 26/09/1998
Where it occurred: Cuquema / Cunhinga  Country: Angola
Primary cause: Management/control inadequacy (?)
Secondary cause: Inadequate training (?)
Class: Detection accident (survey)
Date of main report: 28/09/1998
ID original source: S/MJD/HC - H106  Name of source: HT (field)
Organisation: [Name removed]  Ground condition: woodland (bush)
Mine/device: MAI-75 AP blast
Date record created: 22/01/2004  Date last modified: 21/02/2004
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

inadequate metal-detector (?)
inadequate communications (?)
inadequate equipment (?)
inadequate medical provision (?)
no independent investigation available (?)
inadequate area marking (?)
safety distances ignored (?)
Accident report

No formal accident report was on file at the Angolan MAC. An internal demining group Accident Report was made available by the group's office in Angola. The report was not dated but was faxed on 27th September 1998. The following summarises its content.

The accident occurred on a day when a team consisting of the victim (Operations Officer), an ex-pat Technical Advisor and a Survey Officer were in the process of re-surveying a number of sites. The team arrived at the Cuquema Village at about 11:00, picked up the village “Soba” and went to the suspected mined area. The victim and the Soba went to the suspect area using a well-used track while the ex-pat and the Survey Officer stayed at the vehicle to take a GPS reading.

When the victim returned, he told the Survey Officer to check a disused path to the East of the main track. The Survey Officer did so and returned having found no mines and the area was declared clear. The team then moved 20m further down the track to examine a disused path to the West of the main track, where a civilian accident had occurred about two years previously. The Technical Advisor heard a call on the radio and returned to the vehicle to answer it, staying at the vehicle for about 10 minutes trying to establish communications with the group's office in Kuito.

The Survey Officer cleared a lane through to a regularly used path approximately 30m West of the main track. The victim walked along the main track and joined him on the path. The Survey Officer then told him that he had seen bones and possibly an old trip-wire and stake. The victim took a detector to investigate, while the Survey Officer followed about 6m behind. The victim stopped approximately 15m between the track and the path and approached the suspected trip-wire. His detector did not signal. Both men then made their way towards the main track with the victim leading with the detector. He stood on a pressure mine, "possibly" a MAI-75. [The time of the accident was not recorded: 11:45 is inferred.]

The Technical Advisor heard the explosion and drove towards it. He saw the Survey Officer come out of the bush with the victim over on his shoulders. The victim had lost his left foot. The Technical Advisor administered first aid while the Survey Officer tried to make radio contact with the group's Kuito office. He did not succeed so used a Motorola Handheld radio to speak to another NGO's demining operation in Cunhinga. The team then drove towards Cunhinga and were met by a vehicle from the other group carrying their paramedic. Together with the paramedic the team drove to Kuito MSF Hospital where the doctor amputated a further 3-4 inches from the victim's leg.

Victim Report

<table>
<thead>
<tr>
<th>Victim number: 66</th>
<th>Name: [Name removed]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
<td>Gender: Male</td>
</tr>
<tr>
<td>Status: surveyor</td>
<td>Fit for work: not known</td>
</tr>
<tr>
<td>Compensation: not made available</td>
<td>Time to hospital: not recorded</td>
</tr>
<tr>
<td>Protection issued: Long visor</td>
<td>Protection used: not recorded</td>
</tr>
<tr>
<td>Short frontal vest</td>
<td></td>
</tr>
</tbody>
</table>

Summary of injuries:

AMPUTATION/LOSS
Leg Below knee

COMMENT
No medical report was made available.
Analysis

The primary cause of this accident is listed as a "Management/control inadequacy" because senior staff from the demining organisation were present and in breach of normal Level 2 survey operating procedures - operating a survey without paramedic, radio contact, etc. The fact that they did so implies that they were inadequately trained.

The failure of the demining group's most senior management to correct errors of field supervision - rather than suggesting ways to pretend they were conducting a recce - leaves them open to criticism [see Related papers].

Related papers

A letter from the demining group to their UK head office dated 26th September 1998 stated that the victim was undergoing a below-the-knee amputation at the time. He had stayed conscious and was able to talk up until surgery.

The survey team had gone to the site in a Land Rover with a Major Trauma kit but with no paramedic or driver. The other demining NGO was working approximately 5-6km away. The author expressed concern about the decision to sweep into a suspected area down an old footpath and the lack of a paramedic and driver. He then concluded that the SOPs did cover the generalities of the operation but that "what is perhaps lacking is a more detailed code of conduct". He then stated "Two accidents within 10 days, however, may cause us a problem."

A return fax sent from the group's director, dated 27th September 1998, said "If it was a recce rather than a detailed survey, then we have all been on similar recces a thousand times, and taken along a detector to check soil contamination etc. If they had switched to real live mine clearance, then it looks like a cock-up… I would put emphasis on [word missing] recce, which more often than not do not include paramedics, drivers etc."

A letter signed by the group's Angolan Programme Manager at the time, dated 28th September 1998, to the Angolan MAC states that the accident occurred during a reconnaissance mission when the victim stepped on what was believed to be a MAI-75 AP mine. The reconnaissance team were "establishing the presence of a suspect area" and it is stated that the exercise "was not part of a formal demining process or level 2 survey process but was an information reconnaissance".