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Accidents, Database of Demining, "DDASaccident049" (1998). *Global CWD Repository*. 249.
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DDAS Accident Report

Accident details

Report date:	11/03/2004	**Accident number:**	50
Accident time:	08:55	**Accident Date:**	10/07/1998
Where it occurred:	Cassua, Dombo, Kwanza North	**Country:**	Angola
Primary cause:	Victim inattention (?)	**Secondary cause:**	Field control inadequacy (?)
Class:	Vegetation removal accident	**Date of main report:**	11/08/1998
ID original source:	AM	**Name of source:**	NPA (field)
Organisation:	[Name removed]		
Mine/device:	POMZ AP frag	**Ground condition:**	grass/grazing area
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

victim ill (?)

inadequate equipment (?)

vegetation clearance problem (?)

no independent investigation available (?)

visor not worn or worn raised (?)

Accident report

No accident report was on file at the Angolan MAC. The demining group's Angola office made available an internal report written by the Acting Senior Supervisor and dated 11th July 1998. The following summarises its content.

The investigation team consisted of the Acting Senior Supervisor, The Step 1 Site Supervisor, the Paramedic Team Leader, the Platoon Commander and the Section Commander. [From the names it seems that there was no expatriate involvement in the investigation].

The accident occurred at 08:55 on the 10th July 1998 at the Cassua minefield in Kwanza North. The victim was "seriously injured" in the forehead, suffered some small wounds to the face and had a very small fragment in the eye. He also "considerably lost" his hearing. "Five minutes after the accident, he was immediately evacuated from the spot" to a safe point where the paramedics stopped his bleeding before moving him to the rest area where they "sutured" the head wound, which measured 7cm long and 3cm deep with a "slightly serious haemorrhage… During all that time the deminer was conscious, able to answer questions and aware." The victim was taken to Alvadale Clinic, Luanda by road because of the "complexity of the case and the poor additional medical assistance in the local hospitals".

[The Victim later stated that he had been taken to hospital in Luanda in order to remove a fragment from his eye. This had been successful and his eyesight was not affected.]

The investigators found a crater 1.65m (5 feet) to the left and beyond the end of the lane where the victim was working. Fragments in the crater and a trip-wire with a pin attached led them to conclude that the mine was a POMZ. Its location meant it was part of a known belt. The mine seemed to have fallen from its stake and its body been "partially buried with the fuse upwards and unearthed". The trip-wire had been lying on the ground and a section of it was found in the first 30cm (12”) ahead of the victim's lane. Vegetation had been cleared ahead of the end-of-lane marker, so it was possible that the victim had pulled the trip-wire while cutting undergrowth. The victim's visor was scratched on both sides. The direction and location of the scratches, together with the injuries of the victim, suggested he was not wearing his visor correctly.

The victim said that he had cleared a 30cm section ahead of him and then moved the end-of-lane marker. He suddenly felt dizzy and accidentally put his hand into an uncleared area. The next thing he knew he was being attended by paramedics in the rest area. The victim also mentioned he had seen the tripwire "and had been picking up the pieces left" from former clearance. [An accompanying sketch map showed that another mine had been removed close to the accident site. It is possible that the victim notified his superiors of a tripwire and was told that it was a part of a booby trap that had already been removed. He then picked up the length of tripwire believing it to be safe. Note that the "superiors" were among the investigators.]

Conclusion

The investigation could not decide whether the deminer had been negligent. It found that either he pulled the tripwire while removing vegetation (if so he was negligent), or he disturbed the tripwire when putting his hand on the ground to steady himself after feeling dizzy (if so he was sick). They decided that his injuries were caused by his wearing his visor incorrectly.

Recommendations

The investigators recommended that the victim be interviewed again to determine the truth. [See Related papers.]

Victim Report

Victim number:	69	**Name:**	**[Name removed]**
Age:		**Gender:**	Male
Status:	deminer	**Fit for work:**	yes
Compensation:	not made available	**Time to hospital:**	3 hours
Protection issued:	Frontal apron Long visor	**Protection used:**	Frontal apron

Summary of injuries:

INJURIES

minor Eye

minor Face

minor Head

minor Hearing

COMMENT

No medical report was made available.

Analysis

The primary cause of this accident is listed as *"Victim inattention"* because the victim appears to have acted irresponsibly because he was sick at the time.

The victim was working carelessly and had his visor raised, which his field supervisors should have corrected. This was a *"Field control inadequacy"*.

It is far from certain that the 5mm visor would have stopped the fragment from a POMZ at close quarters, so the victim's head injury may not have been the result of his visor being raised.

The victim was clearing undergrowth with a "sickle" in an area where tripwires were expected. The locally made sickle is not, in the researcher's opinion, an appropriate tool for this task.

The investigator's lack of understanding of malaria and its recurrence should have been corrected - it is not known whether the group's management addressed this.

Related papers

A report on an interview with the victim, dated 22nd July 1998 and signed by the Supervisor was on file. This document recorded the date of the accident as 9th July 1998. The victim said that he had felt dizzy as a result of malaria he had two weeks before. He thought it would pass so worked his first shift. 25 minutes into his second shift he felt dizzy again. He lifted his visor and moved the end-of-lane marker forward. He then laid his right hand in front of the marker or behind "he does not remember very well because of the dizziness". There was an explosion. When he woke up the visor was not on his head.

The interview record included the conclusion that for "some days before the deminer has been finding several small fragments of the trip-wire on the ground," so he knew there was a mine. His claims of dizziness were discounted because his malaria had been treated and if he was sick he should have reported it.

The demining group management in Angola reported that the victim had fully recovered and had received a "post traumatic stress syndrome debrief" before working as a deminer again.

The researcher interviewed the victim on 7th December 1998 in a mined area. The photograph below shows the position he was in when the mine was initiated.

The victim reported that he was clearing vegetation with a sickle when he felt dizzy. He stopped and happened to touch his end-of-lane marker, and in doing so initiated what was thought to be a POMZ. The victim did not know where the mine was and did not see a tripwire. He was wearing a visor but had it fully raised at the time. A fragment grazed the middle of his forehead across the hairline, leaving a 2-inch scar. He was knocked unconscious. He also received a splinter to the right eye that has now fully healed. He was partly deafened for a short time.

When questioned he remembered no breathing problems or blood in his mucus. The visor was slightly damaged at the top and bottom edges. After first aid (in which his head wound was stitched) he was taken by road to Luanda Hospital, arriving after 3 hours. He spent a week in hospital [where a fragment was removed from his eye] and was then off work for about 20 days before resuming his normal duties as a deminer.