

7-8-1997

DDASaccident057

Humanitarian Demining Accident and Incident Database
AID

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DDAS Accident Report

Accident details

Report date: 19/04/2006	Accident number: 57
Accident time: 11:00	Accident Date: 08/07/1997
Where it occurred: Cap. Agua, Uige	Country: Angola
Primary cause: Management/control inadequacy (?)	Secondary cause: Field control inadequacy (?)
Class: Missed-mine accident	Date of main report: 16/07/1997
ID original source: MD/MJ/JP/TJ/SC	Name of source: INAROOE
Organisation: [Name removed]	
Mine/device: PPM-2 AP blast	Ground condition: bushes/scrub clay grass/grazing area hard
Date record created: 23/01/2004	Date last modified: 23/01/2004
No of victims: 3	No of documents: 2

Map details

Longitude:	Latitude:
Alt. coord. system:	Coordinates fixed by:
Map east:	Map north:
Map scale: Uige	Map series: Map 59
Map edition:	Map sheet:
Map name: 1:100 000	

Accident Notes

victim ill (?)
inadequate communications (?)
handtool may have increased injury (?)
inadequate medical provision (?)
no independent investigation available (?)
safety distances ignored (?)
inadequate investigation (?)

Accident report

An internal report from the demining group dated 16th July 1997 was made available. The following summarises its content.

The investigators visited the site on 9/10th July. They found that the accident occurred in a minefield laid by government troops in 1991/2. The mines were irregularly spaced in 3km long lanes. PPM-2 and POMZ-2 mines were found (largely) in different parts of the field. There was "scrub" about a metre high where the accident occurred and the ground was "hard clay with some organic mix" which allowed the use of detectors. Two parallel lines of PPM-2 mines had been found with an "exploratory base line". Further lanes were being cut to confirm the direction of the mine-lines. The accident occurred in a lane that was beside another in which the location of found mines had been marked with sticks after their removal. On the other side of the accident lane, mines were "visible", so allowing a visual assessment of where the mines could be expected.

Victim No.1 wore a frag-jacket and visor. The accident occurred when he was "due to start his handover" at 11:00. The Commanders pointed out to him that he appeared to have missed a mine and as he was "crouching down... his right foot slipped backwards and activated the concealed mine". The Commanders were not wearing visors but were wearing frag-jackets.

At 11.42 the ambulance arrived at Uige hospital. At 15:10 the Medevac flight left for Luanda.

The investigators tested Victim No.1's metal detector and found it to be working properly. They commented that there was no procedure to separate and test equipment involved in an accident, [which implied they were uncertain whether they had tested the right detector]. Victim No.1's frag-jacket was damaged, but how extensively was not recorded.

The Brigade Commander said that he and the Section Commander approached Victim No.1 as he was demining and noticed a break in the mine-pattern. They "instructed the deminer to return to a safe area and to recheck his lane". The accident occurred as he was returning to the safe area.

The victim said that he was feeling unwell. He knew there were missed mines in his lane and could see the pattern" and one mine. There was a concealed mine a metre in front of the visible mine and he stepped on that.

Conclusion

The investigators concluded that the deminer "was focusing on the exposed mine.. and...did not employ the detector correctly". He kept on working when others were too close. The injuries to the Commanders were the result of them "being within a 25 metre distance of a working deminer" and, in Victim No.3's case his injuries occurred because he was not wearing the protective equipment available. The paramedics acted quickly and effectively but the hospital was "ill equipped". Supervisors had to buy medical equipment to allow a blood transfusion to take place. The communications equipment was "unsuitable". They found there was a "lack of direction on discipline matters" from above, which had "impeded" the supervisors, and commented that absenteeism was rife, with periods of up to one month's absence common. Similarities with an accident that occurred in Angola in February 1997 were noted.

Recommendations

The investigators recommended that the SOP requiring "safety equipment" to be worn at all times should specify visors. Also that a procedure for "handling equipment" involved in an accident must be devised, that disciplinary procedure for absenteeism should be formulated and that the demining group should have a period of leave, followed by retraining. They further recommended that all accident victims should be evacuated to Luanda and that communications problems should be rectified.

Victim Report

Victim number: 77	Name: [Name removed]
Age:	Gender: Male
Status: deminer	Fit for work: not known
Compensation: not made available	Time to hospital: 4 hours 10 minutes
Protection issued: Frag jacket Long visor	Protection used: Frag jacket

Summary of injuries:

AMPUTATION/LOSS

Leg Below knee

Arm Below elbow

COMMENT

No medical report was made available.

Victim Report

Victim number: 78	Name: [Name removed]
Age:	Gender: Male
Status: supervisory	Fit for work: yes
Compensation: not made available	Time to hospital: not recorded
Protection issued: Frag jacket Long visor	Protection used: Frag jacket

Summary of injuries:

INJURIES

minor Leg

COMMENT

No medical report was made available.

Victim Report

Victim number: 79	Name: [Name removed]
Age:	Gender: Male
Status: supervisory	Fit for work: presumed
Compensation: not made available	Time to hospital: not recorded
Protection issued: Frag jacket	Protection used: Frag jacket

Long visor

Summary of injuries:

INJURIES

minor Eye

minor Face

COMMENT

No medical report was made available.

Analysis

The primary cause of this accident is listed as "*Management/control inadequacy*" because the procedures in place were inadequate to cover the situation.

The field supervisors noticed Victim No.1's errors but did not instruct him how best to recover from the situation, were not wearing visors and were standing too close to the victim, so also suffered injury. They were not criticised for this, although changes to procedures were recommended. The secondary cause is listed as a "*Field control inadequacy*".

The investigators made recommendations for improved medical and communication procedures which imply that they did not work well, but the failings are not detailed in their report.

Related papers

A document titled "Immediate action drill" was on file at the country MAC. The document detailed what a deminer should do if he suddenly found himself in a mined area.

The Portuguese version of the accident report includes obvious errors of times, dates and interpretation: the word "internal" is translated as "international" for example. [The failure to transpose numerical data accurately implies a carelessness that may make the veracity of translated reports suspect.]