11-28-1996

DDASaccident061

Humanitarian Demining Accident and Incident Database

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DDAS Accident Report

Accident details

Report date: 19/04/2006  Accident number: 61
Accident time: 11:30  Accident Date: 28/11/1996
Where it occurred: Libongo, Caxito,  Country: Angola
Bengo Province
Primary cause: Field control in adequacy (?)  Secondary cause: Management/control in adequacy (?)
Class: Missed-mine accident  Date of main report: 12/12/1996
ID original source: NO/PH/JJ/TF  Name of source: Other/UCAM
Organisation: [Name removed]  Ground condition: bushes/scrub
Mine/device: MAI-75 AP blast  grass/grazing area
hard  rocks/stones
route/path
Date record created: 23/01/2004  Date last modified: 23/01/2004
No of victims: 2  No of documents: 2

Map details

Longitude:  Latitude:
Alt. coord. system: Coordinates fixed by:
Map east:  Map north:
Map scale: Barro Do Dande  Map series:
Map edition: Map SC33/B1  Map sheet: 71
Map name: 1:100 000

Accident Notes

inadequate equipment (?)
safety distances ignored (?)
pressure to work quickly (?)
protective equipment not worn (?)
inadequate area marking (?)
**Accident report**

The demining group worked in three-man teams with one deminer detecting, one cutting undergrowth and excavating, and one resting at any one time.

No copy of the Board of Inquiry report was found on file at the country MAC. A copy was obtained by other means and the following summarises its content.

The investigators were unable to approach the accident site when they visited on 2\textsuperscript{nd} December 1996. They returned on 5\textsuperscript{th} December when the area had been re-cleared. Their report stated that the demining group were working on two sites, with 18 men at one site and seven men working at the other. Both came under an expatriate supervisor who was at the larger site 18k away). The track being cleared ran along the side of "an old railway embankment". It was described as "distinct" but "overgrown with sparse vegetation". [A photograph showed stubs of coarse grass in the path and long grass and light bush around it.] The ground was quite hard and "stony" with "a lot of metal fragments".

The investigators concluded that the mine had not been buried very deeply. The team was clearing at an average rate of "at least 6 square metres per hour" per three man team, from which the investigation inferred that either the teams was working too quickly or it was missing out "drills". They believed that the failure to use "base sticks" "may have been a contributing factor to this accident". The "level and experience" of the Angolan team Commanders was questioned and the demining group's failure to use any means of marking cleared areas as they worked "could quite easily lead to unchecked areas". Concern about working distances, lane widths and the practice of leaving metal in the ground were expressed. The investigators decided that medical procedures were good.

**Conclusion**

The investigators recommended that the demining platoon should stop working until they had undergone an "extended period of retraining". They also recommended that the group change to a one-man drill. They said that the demining group should review the practice of placing "Angolan staff in control of a job" before they were sufficiently trained and experienced.
Victim Report

Victim number: 83
Name: [Name removed]
Age: 
Gender: Male
Status: deminer
Fit for work: not known
Compensation: not made available
Time to hospital: not recorded
Protection issued: None
Protection used: none

Summary of injuries:
AMPUTATION/LOSS
Leg Below knee
COMMENT
No medical report was made available.

Victim Report

Victim number: 84
Name: [Name removed]
Age: 
Gender: Male
Status: deminer
Fit for work: presumed
Compensation: not made available
Time to hospital: not recorded
Protection issued: None
Protection used: none

Summary of injuries:
INJURIES
minor Body
minor Foot
minor Hand
minor Leg
COMMENT
No medical report was made available.

Analysis
The primary cause of this accident is listed as a "Field control inadequacy" because the demining field operation was carried out in a way that led to mines being missed.
There were also management failings because the systems they had devised allowed the exchange of shared protective equipment to take place inside the working area, mined area marking to be inadequate and for supervisors to lack appropriate experience or training. The secondary cause is listed as a "Management/control inadequacy".
The development NGO demining group involved in this accident is no longer working in humanitarian demining in Angola – their withdrawal was reported to be as a direct consequence of its two accidents in late 1996.

**Related papers**

A document (in Portuguese) and signed by a senior UN Technical Advisor was at file at the UN MAC. It stated that there were three casualties in this accident but gave no additional detail.