DDASaccident067

Humanitarian Demining Accident and Incident Database
AID

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DDAS Accident Report

Accident details

Report date: 19/04/2006  Accident number: 67
Accident time: 14:30  Accident Date: 13/04/1996
Where it occurred: Lombe, 20km West of Malange  Country: Angola
Primary cause: Field control inadequacy (?)  Secondary cause: Management/control inadequacy (?)
Class: Other
ID original source: HB  Name of source: NPA field/MCHM
Organisation: [Name removed]  Ground condition: bridge and surrounds sandy
Mine/device: Type 72 AP blast
Date record created: 23/01/2004  Date last modified: 21/02/2004
No of victims: 1  No of documents: 2

Map details

Longitude:  Latitude:
Alt. coord. system: 9 27' 32"S  Coordinates fixed by: GPS
Map east: 16 08' 32"E  Map north:
Map scale:  Map series:
Map edition:  Map sheet:
Map name:

Accident Notes

inadequate medical provision (?)
inadequate investigation (?)
no independent investigation available (?)

Accident report

No record of this accident was on file at the Angola MAC.

In an "Accident report" supplied by the commercial demining company on 13th January 1999 the accident was described as having occurred on a narrow section of bridge that was left spanning the River "Lui" (the main part of the bridge was destroyed). The demining company had been contracted to clear the road and did not have responsibility for clearing the bridge. The narrow section was used to gain access to the far side of the bridge and continue
working along the road. The demining team crossed it in order to work. When they returned the victim (who was a medic) was the last (of four) to cross. As he did so he stepped on an "AP mine" that was "covered in sand" with his right heel.

The company doctor and a second medic were on the scene quickly and stabilised the victim. He was taken to Malange by road, then by UN aircraft to Luanda and on from there in another aircraft to "the Morning Side Clinic" in South Africa where he was admitted at 21:30.

See also “Related papers”.

<table>
<thead>
<tr>
<th>Victim Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victim number: 96</td>
</tr>
<tr>
<td>Name: [Name removed]</td>
</tr>
<tr>
<td>Age:</td>
</tr>
<tr>
<td>Gender: Male</td>
</tr>
<tr>
<td>Status: medic</td>
</tr>
<tr>
<td>Fit for work: yes</td>
</tr>
<tr>
<td>Compensation: not made available</td>
</tr>
<tr>
<td>Protection issued: Not recorded</td>
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<tr>
<td>Time to hospital: 6 hours</td>
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<tr>
<td>Protection used: not recorded</td>
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</tbody>
</table>

**Summary of injuries:**

AMPUTATION/LOSS

Leg Below knee

COMMENT

No medical report was made available.

**Analysis**

Theis accident is classed as a “Survey accident” because the surveyors failed to recognise that the remaining part of the bridge was likely to have been mined.

The primary cause of this accident is listed as a "Field control inadequacy" because the field supervisors failed to ensure that the path was checked before allowing its use.

The lack of timely CASEVAC facilities was a failing at group management level.

**Related papers**

In a telephone interview with a senior spokesman for the company on 6th January 1999 he explained that the victim’s foot had been subsequently amputated, adding that he was still working for the company.

In another interview with the company in May 2001, the victim’s shoe was photographed and the mine was reported to have been a Type 72 AP blast mine.
The victim’s “trainer” showing remarkably little damage to the sole.