6-5-1999

DDASaccident258

Humanitarian Demining Accident and Incident Database

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DDAS Accident Report

Accident details

- **Report date:** 18/05/2006
- **Accident time:** not recorded
- **Where it occurred:** Plowshare minefield, Cordon Sanitaire
- **Primary cause:** Unavoidable (?)
- **Class:** Excavation accident
- **ID original source:** none
- **Organisation:** Name removed
- **Mine/device:** R2M2 AP blast
- **Date record created:** 18/02/2004
- **No of victims:** 1
- **No of documents:** 1

- **Accident number:** 258
- **Accident Date:** 05/06/1999
- **Country:** Zimbabwe
- **Secondary cause:** Inadequate equipment (?)
- **Date of main report:** [No date recorded]
- **Name of source:** KMS
- **Ground condition:** woodland (bush)
- **Date last modified:** 18/02/2004

Map details

- **Longitude:**
- **Latitude:**
- **Alt. coord. system:**
- **Coordinates fixed by:**
- **Map east:**
- **Map north:**
- **Map scale:** not recorded
- **Map series:**
- **Map edition:**
- **Map sheet:**

Accident Notes

- no independent investigation available (?)
- squatting/kneeling to excavate (?)

Accident report

At the time of this accident the demining company operated in two-man teams using a one-man drill. One deminer looked for tripwires, cut undergrowth, used the detector and excavated finds while the other watched from a safe distance and "controlled" him. The group issued frontal protection and their drills assumed that the deminer would kneel or squat while excavating.

An internal Accident report was made available by the demining group in December 1999. The following summarises its content.
While the victim was "excavating" a detector signal "the mine functioned". It was later described as a "likely R2M2". The victim sustained "a slight cut and some bruising to his right hand and both forearms.

The victim was treated "on the spot" by the medic and then taken to the field medical unit. The demining site was closed and the mines found that day were destroyed.

A site investigation showed that the victim's detector was "on and functioning". His water carrier was about five metres away in the cleared lane. His prodder was on site and undamaged. His trowel was not found. His visor was 80cms away with the head-frame broken.

**Conclusion**

The investigators concluded that the victim was working correctly and was excavating a detector reading rather than prodding because of "high gravel content" in the ground. They found that "sufficient water was on site and used". They believed that the mine may have been in a tilted position. They added that the victim "was protected from serious injury by wearing protective clothing correctly".

**Victim Report**

<table>
<thead>
<tr>
<th>Victim number: 332</th>
<th>Name: Name removed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
<td>Gender: Male</td>
</tr>
<tr>
<td>Status: deminer</td>
<td>Fit for work: yes</td>
</tr>
<tr>
<td>Compensation: not made available</td>
<td>Time to hospital: not applicable</td>
</tr>
<tr>
<td>Protection issued: Frontal apron</td>
<td>Protection used: Frontal apron, Long visor</td>
</tr>
<tr>
<td></td>
<td>Long visor</td>
</tr>
</tbody>
</table>

**Summary of injuries:**

INJURIES

minor Arms

minor Hands

COMMENT

No medical report was made available. The victim was not taken to hospital, so his injuries are believed to have been minor.

**Analysis**

The primary cause of this accident is listed as "Unavoidable" because the victim appears to have been working properly in accordance with his SOPs when the accident occurred. The damage to his hand was almost certainly a consequence of using a short tool. The secondary cause is listed as "Inadequate equipment".