2-15-2000

DDASaccident296

HD-AID
Humanitarian DeminingAccident and Incident Database

DDAS Accident Report

Accident details

Report date:	06/04/2006	**Accident number:**	296
Accident time:	08:25	**Accident Date:**	15/02/2000
Where it occurred:	Ploughshare minefield, Mozambique border	**Country:**	Zimbabwe
Primary cause:	Management/control inadequacy (?)	**Secondary cause:**	Inadequate training (?)
Class:	Vegetation removal accident	**Date of main report:**	21/02/2000
ID original source:	JM	**Name of source:**	Mounser/AVS 2001:Z01
Organisation:	[Name removed]		
Mine/device:	R2M2 AP blast	**Ground condition:**	woodland (bush)
Date record created:	19/02/2004	**Date last modified:**	19/02/2004
No of victims:	1	**No of documents:**	1

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

no independent investigation available (?)

inadequate training (?)

inadequate metal-detector (?)

inadequate investigation (?)

Accident report

A limited accident report was made available by the programme manager in January 2001. The report provided was not an original document. Documents of any kind were only provided by this demining group in 2001 after pressure had been applied through the funder. To try to counter any omissions in the reports provided, statements were also taken from a field

supervisor and the doctor who treated the victims in March 2001. The following summarises the content of the documents provided and includes detail added by the other sources.

At the time of this accident the demining company operated in one-man teams using a one-man drill [from the start of 2000 this drill was adopted]. In this a single deminer looks for tripwires, cuts undergrowth, uses the detector and excavates finds. The group issued frontal protection and their drills assumed that the deminer would kneel or squat while excavating.

The victim was part of a “Survey Team” which was investigating the boundaries of a reinforcement (a belt of additional mines laid at random between the maintenance road and the first “A” row of mapped mines). The reinforcement had been “reported by local inhabitants”. Following the patterns expected in the ploughshare minefield, the strip of ground being surveyed was not expected to be mined. It was later found that the reinforced area extended further than the site of the accident.

Wearing his visor and armour apron, the victim swept the ground with his detector and noticed no signal. He then got up to cut vegetation and, at 0825 hours, detonated an R2M2 mine by stepping on it. “He sustained traumatic high velocity blast amputation of the right foot with sparing of the ipsilateral ankle joint. He also sustained first degree burns to the right arm”. The site supervisor corrected this to “part of” his right foot being amputated.

The victim was evacuated from the accident site by a medic immediately and was attended by the Site Doctor within five minutes. He was transported in the “backup ambulance” (a Landrover) to Karanda Mission Hospital. “At the hospital, successful surgery was conducted with the right foot being amputated at ankle height”. Two days later “the Doctor noticed an unexpected drop in oxygen saturation and the patient died later that night. From an X-ray picture taken that evening, the surgeon concluded that the cause of death was Aspiration Pneumonia”.

“A subsequent accident investigation showed that the centre of the blast was on the edge of the clearing lane. The depth of the crater suggested that the mine was buried at least 16 centimetres deep and not easily detectable by the detectors in common use [Vallon]. That the mine was located on the edge of the lane and that it was buried so deep might have contributed to it being missed.”

The victim was visited in hospital on the day following the accident and was sitting up in bed making jokes.

Victim Report

Victim number:	376	**Name:**	**[Name removed]**
Age:		**Gender:**	Male
Status:	deminer	**Fit for work:**	DECEASED
Compensation:	not made available	**Time to hospital:**	2 hours 5 minutes
Protection issued:	Frontal apron Long visor	**Protection used:**	Frontal apron, Long visor

Summary of injuries:

INJURIES

severe Arm

AMPUTATION/LOSS

Leg Below knee

FATAL

COMMENT

See medical report.

Medical report

A brief medical report made out by the site doctor was obtained. This stated that the victim suffered “traumatic amputation of his right foot”.

Field treatment involved:

> “Pressure bandaging R foot
>
> Fluid replacement with Ringers Lactate solution IV
>
> Bentyl [sp?] penicillin antibiotic 1 [illegible] 5ml
>
> ATT 0.5 ml 1ml, Pethizine [Sp?] 100mg 1 ml”

The victim was evacuated to Karanda hospital leaving at 09:00 and arriving at 10:30. He was in the operating theatre from 11:00 – 14:00. The surgical procedure was a “definitive surgical amputation of right foot”.

On “Day Two post-operative” the victim was “stable, ambulatory”.

An addendum notes: “Patient in acute respiratory distress on Thurs 17/02/2000, demising on same day around 22:00 hrs”.

From an X-ray picture taken that evening, the surgeon concluded that the cause of death was “Aspiration Pneumonia”.

Analysis

The primary cause of this accident is listed as a *“Management Control inadequacy”* because the preliminary survey of local people indicated that the area was mined. The Survey team then went mine-hunting without using clearance drills or marking systems. This was an inappropriate method of “reducing” the suspect area by “Survey” and implies inadequate training and preparation. The secondary cause is listed as *“Inadequate training”*.

The accident investigation is considered inadequate because it was edited prior to being made available. And because only a limited summary was made available.