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DDAS Accident Report

Accident details

Report date: 19/05/2006Accident time: 06:20Where it occurred: Milha 8 MF, Dondo
District, Sofala
ProvincePrimary cause: Field control
inadequacy (?)Class: Excavation accidentID original source: FM
Organisation: Name removed
Mine/device: Type 72 AP blastDate record created: 20/02/2004
No of victims: 1

Accident number: 317 Accident Date: 23/11/1999 Country: Mozambique

Secondary cause: Inadequate training (?)

Date of main report: 24/11/1999 Name of source: NPA

Ground condition: metal scrap Date last modified: 20/02/2004 No of documents: 2

Map details

Longitude: 34° 43' 18" ELatitude: 19° 30' 33" SAlt. coord. system:Coordinates fixed by:Map east:Map north:Map scale:Map series:Map edition:Map sheet:Map name:Map sheet:

Accident Notes

inconsistent statements (?) no independent investigation available (?) protective equipment not worn (?) long handtool may have reduced injury (?) victim ill (?) visor not worn or worn raised (?) use of pick (?) use of shovel (?) inadequate training (?)

Accident report

The demining group made available a copy of their internal accident report in November 2000, provided as text and in the preferred IND format. The following summarises its content.

An internal investigation team arrived at the accident site at 14:40 on the day of the accident to carry out an investigation. The accident took place in a mined area 30k North West of Beira along the Beira-Mwanza road. The mined area surrounded a former Frelimo military camp. The area was contaminated with scrap metal.

The investigators found that the victim had been recently sick with "wounds on both his feet". He returned to work and was supposed to be given "light duties" such as "painting and distributing marking sticks". The Deputy Platoon Commander gave him the additional task of collecting all the metal from the various "metal collection points".

One of the metal collection points was marked with four red sticks. Deminers had excavated to 35cm in the area but been unable to locate the source of the detector's signal. They had found Type-72 mines in a line before the marked area, and in a belt afterwards. The Senior Supervisor took the decision to mark the area and work beyond it.

The victim was told by the Deputy Platoon Commander to take a hoe and a garden spade to the place marked with four red sticks and dig it out to find the metal that was making the detector signal. He suspected that there might be hidden weapons or other large metallic objects in the place. The victim started to dig at the place. He was not wearing protective equipment. After digging for ten minutes, at 06:20 the hoe he was using detonated a Type-72a mine [both 72a and 72b are mentioned in the varied papers]. He suffered "a graze on the left hand and a cut in the left arm" or a graze on the right arm and a cut on the left palm [variation in reports].

The victim was given "first aid and evacuated to Beira Central Hospital for further medical examination. It was later confirmed that the deminer did not suffer serious injuries and was immediately discharged. Two days after, the deminer was back on duty." The victim was evacuated by ambulance and arrived at Beira hospital at 07:15, that is 55 minutes after the accident.

Conclusion

The investigators concluded:

"The existence of a land mine in the spot where the accident happened was very clear. The deminer who was involved in the accident was considered sick, that is the reason why the paramedic recommended that he was supposed to be given light work, which is totally different from working in a mine belt. The area was marked showing that it was still considered unsafe (uncleared), however unapproved tools (hoe and spade) were used in this unsafe place. Therefore, the apparent cause of the accident was a clear deviation from [the group's] SOPs. To be precise, we noted that there was insufficient supervision on what was happening in the unit, especially in the minefield."

"....if an accident takes place in any demining unit, nothing should be removed from the accident spot before the investigation team from the headquarters arrives."

No recommendations were made.

[The report made available included poor photocopies of photographs which cannot be reproduced. These photographs showed the separated head of the hoe that the victim was using at the time, and other deminers wearing a Long visor and frontal vest. There was also a photograph of the accident site – showing no evidence of significant excavation at the deminer's original 35cm hole or as a result of his subsequent 10 minutes digging with a hoe. The demarcated area where the victim was digging was also shown. It was about a metre square.]

Victim Report

Victim number: 399

Age: 31

Status: deminer

Compensation: none

Protection issued: Long visor

Frontal apron

Name: Name removed Gender: Male Fit for work: yes Time to hospital: 55 minutes Protection used: none

Summary of injuries:

INJURIES

minor Arm

minor Hand

COMMENT

See medical report.

Medical report

A field medical report gave the victim's age and listed his injuries as:

At 06:35 the victim's vital signs were assessed as stable. He had light injuries on both arms, right forearm and on left palm.

The victim's blood pressure was recorded at 120/90; resp 27 c/m; Pulse 80/min; Temp 36.5

At 10:15 he was discharged from hospital in Beira. Light injury to "both arms" was noted.

A photograph showed the victim with his left hand entirely bandaged, and his right elbow also bandaged.

In a summary of all the demining accidents at the group (made available in 2002) it was stated that the victim returned to work and that he received no compensation "due to the nature of his injuries" [presumably too minor]. It was also recorded that the time to hospital was 30 minutes.

Analysis

The accident is classed as an "Excavation" rather than a "Missed-mine" accident because the area where it occurred was marked by red sticks and so not declared clear. The Supervisor may have decided that the area was safe for the victim to dig up and so considered it clear, but the area was still marked as hazardous.

The primary cause of the accident is listed as a *"Field control inadequacy"* because the field supervisors ordered the victim to act in direct breach of several of the demining group's SOPs. The secondary cause is listed as *"Inadequate training"* because it seems that the Field supervisors did not understand the risk that was being run.

Statements

There were statements from five people at the accident site in the file. These are summarised and edited for anonymity below.

Statement 1

The time was 06:20 when the accident occurred.... in an area already demarcated by poles and the work involved removing all metallic objects in the area,

The mine was a T72a and at 06:22 we started evacuating all deminers from the camp, started clearing the area and finished at 06:37. At that time we moved the victim to a safe place and at 06:38 the ambulance left for Beira Provincial hospital arriving at 07:15.

The ambulance was accompanied by the Senior Paramedic and the Senior Supervisor.

The victim sustained light injuries on the arms.

Signed

Statement 2

The accident happened at 06:20 and the mine was a Type 72a. All the deminers were evacuated from the minefield as soon as the accident occurred. The area around the victim was cleared and first aid administered at 06:37

Signed: Deputy Supervisor

Statement 3

We had asked [the victim] to start digging in the place where there was much sound coming from it. The place was demarcated and it was there that the accident happened.

Signed Vice Platoon Commander

Statement 4

In relation to the accident involving [the victim] I have this to say:

On 23/11/99 the worker was given instructions to dig the place which had been previously demarcated but without it being realised that a Type 72a mine was there. It was during the digging that he hit the mine.

Signed: Section Leader

Statement 5

I declare that I have been the victim of a mine accident which caused me injuries on the fingers. My leader had given me some work to do. There was a demarcated place where the Leader told me to start digging using a spade. I had suggested using a hoe (enxada) but he said there would be no problem in using the spade.

[The last paragraph is illegible. The translator believed he was writing about the time he was digging and the mine exploded without causing him serious injury.]

Signed: [The victim]