10-8-2001

DDASaccident364

HD-AID
Humanitarian DeminingAccident and Incident Database

DDAS Accident Report

Accident details

Report date:	19/05/2006	**Accident number:**	364
Accident time:	09:15	**Accident Date:**	08/10/2001
Where it occurred:	Nova Mambone, Govuro District, Inhambane Province	**Country:**	Mozambique
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Management/control inadequacy (?)
Class:	Missed-mine accident	**Date of main report:**	12/10/2001
ID original source:	JLT	**Name of source:**	IND
Organisation:	Name removed		
Mine/device:	PMN AP blast	**Ground condition:**	bushes/scrub electromagnetic rocks/stones
Date record created:	21/02/2004	**Date last modified:**	23/03/2004
No of victims:	1	**No of documents:**	2

Map details

Longitude:	34° 33' 69" E	**Latitude:**	21° 06' 62" S
Alt. coord. system:	Long: 21 06' 616" S	**Coordinates fixed by:**	
Map east:	Lat: 34 33' 690" E	**Map north:**	[sic]
Map scale:		**Map series:**	
Map edition:		**Map sheet:**	
Map name:			

Accident Notes

inadequate medical provision (?)

mine/device found in "cleared" area (?)

inadequate investigation (?)

Accident report

The Accident report is derived from an IND database entry that has been translated. The IND database shadows the limited IMSMA accident provision and so is not detailed.

The Deputy Team Leader was in charge of a marked area with 8.5m width and 25m long (Block 2), where he had started to work on Saturday, October 6, 2001. That Saturday, he

completed the first lane to the south along the minefield length. At 06:0 on Monday October 8th 2001, he started working on the second lane, crossing the minefield in a diagonal line, starting from the East and heading towards the North. [This was not crossing the Block diagonally, but may have been crossing the mined area that way.] He used a Vallon VMH 1 detector. He completed this lane (missing a mine) and started with the third lane, from West to East. He made approximately 5 metres in this lane. The soil was rocky, highly metallic and with dense vegetation, but still he carried on working only with the detector. After he finished that lane he returned to the second lane, which he had cleared that same morning. He was walked to the East in order to cut the vegetation of the third lane from another angle when his left foot stepped on a mine and detonated it. This was a PMN mine. His right foot was amputated right above his ankle. The Team Leader was at his commanding and radio control point, 30 metres north, when the victim detonated the mine.

The Victim was placed on “a long spine board in the back of a pick-up truck” and taken into Zimbabwe for a rendezvous with an air ambulance. That meeting took place 4.5 hours later.

Block 1 had been cleared the week before and finished on October 4th. The deminer doing this could not carry on demining on Friday because he had contracted malaria and was undergoing medical treatment at the compound until Sunday. Before he concluded Block 1, he had found three mines in it and had used mainly the metal detection method. These three mines were removed and safely destroyed (1 PMN and 2 POMZ). The block was still marked with tape. He had started the burning of Block 2 so that it could be clearly identified.

The IND report includes a map indicating that the deminer first worked on the edge adjacent to the finished “Block 1”. Access was via a “safe-lane” only one meter wide. Having cut a first lane he returned to the “safe-lane” and began clearing a lane adjacent to his first cut. As he did so he encountered an obstruction and stepped into the lane he had already cleared (apparently in order to cut undergrowth from the side). He stepped on a PMN that was in a straight line with the two PMNs found previously, and equally spaced from them.

See also “Related papers”.

Victim Report

Victim number: 468	**Name:** **Name removed**
Age: 31	**Gender:** Male
Status: deminer	**Fit for work:** not known
Compensation: not made available	**Time to hospital:** More than 4 hours 30 minutes
Protection issued: Not recorded	**Protection used:** not recorded

Summary of injuries:

AMPUTATION/LOSS

Leg Below knee

COMMENT

See medical report.

Medical report

A medical report was signed by a Doctor in Harare, Zimbabwe.

The victim “sustained traumatic amputation of right foot above ankle… He was airlifted by MARS at 14:30. The medic who attended him ha applied the following medical treatment:

Arrested bleeding with tight crepe bandage

Started intravenous infusion of Ringers Lactate Solution

Started pain control management with Pethidine 50 mgs intramuscularly 4 hourly

Documented all their interventions

On arrived [at the air-lift site] patient was found on a long spine board in the back of a pick-up truck.

On examination no other injuries were found other than the traumatic amputation of the right foot. A new line of intravenous infusion was put up and another litre of Ringers lactate started. Patient was started on the following management:

Oxygen was given at 10 litres per minute via partial rebreather mask

Morphine up to a total of 15 mgs intravenous

ATT 0.5mls intramusculatory stat.

Mandokerf 1g intravenous stat.

Metoclopremide 10 mgs intravenous.

Reinforced crepe bandage to prevent further bleeding.

Transported patient on a spine board with headblocks to South Med Hospital.”

Analysis

The primary cause of this accident is listed as a *“Field control inadequacy”* because the victim trod on a mine that would have been found if adequate clearance methods were being used. The mine had a large metal signature and was in a predictable position in relation to previous finds.

The accident report does not make it clear why the Deputy Team Leader appeared to have been working alone in the minefield, or what PPE or tools he was using. Also, it is not possible to be sure what happened to the victim after the accident. It seems that the demining group not only failed to have an ambulance on site, but their medical provision was also unable to cope. Another demining group had to lend them a medic (see Related papers).

The time taken for the Medevac – the victim only reached the air ambulance four and half hours after the time of the accident – was too long.

The failure to carry out an adequate investigation is a management failing which implies that other aspects of the work may not have been carried out in a professional manner. This, coupled with the inadequate medical provision, leads to the secondary cause being listed as a *“Management/control inadequacy”*.

Related papers

In an interview with another commercial demining group active in the region the researcher learned that the second company provided medical assistance to the victim who was then transferred by road into Zimbabwe in the back of an unconverted pick-up truck because the demining group had no ambulance. This version of events was confirmed by others and fits the recorded data.