

10-5-2006

## DDASaccident529

Humanitarian Demining Accident and Incident Database  
*AID*

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# DDAS Accident Report

## Accident details

<b>Report date:</b> 27/01/2008	<b>Accident number:</b> 529
<b>Accident time:</b> Not made available	<b>Accident Date:</b> 05/10/2006
<b>Where it occurred:</b> Not made available	<b>Country:</b> Angola
<b>Primary cause:</b> Field control inadequacy (?)	<b>Secondary cause:</b> Management/control inadequacy (?)
<b>Class:</b> Excavation accident	<b>Date of main report:</b> Not made available
<b>ID original source:</b> None	<b>Name of source:</b> [Name removed]
<b>Organisation:</b> [Name removed]	
<b>Mine/device:</b> PPM-2 AP blast	<b>Ground condition:</b> not recorded
<b>Date record created:</b>	<b>Date last modified:</b> 27/01/2008
<b>No of victims:</b> 1	<b>No of documents:</b> 1

## Map details

<b>Longitude:</b>	<b>Latitude:</b>
<b>Alt. coord. system:</b> Not made available	<b>Coordinates fixed by:</b>
<b>Map east:</b>	<b>Map north:</b>
<b>Map scale:</b>	<b>Map series:</b>
<b>Map edition:</b>	<b>Map sheet:</b>
<b>Map name:</b>	

## Accident Notes

inadequate investigation (?)  
squatting/kneeling to excavate (?)  
visor not worn or worn raised (?)

## Accident report

Details of this accident have been withheld by the demining NGO that employed the Victim. A spreadsheet including the Victim's name and very brief details of the accident was made available in 2007. Some detail can be inferred from the information made available. For example, the fact that six people were injured during excavation of a small AP blast mine implies that safety distances were being ignored and field discipline was low. The main Victim also suffered head injuries that indicate that his head protection and visor were not being worn.

This entry will be expanded if access to the report of the investigation is made available in future.

The spreadsheet data is reproduced below, edited for anonymity.

“Date and country.

[Four names removed]

[Two names removed] - minor injuries

Head injury resulting in loss of one eye

Prodding activated a deeply buried PPM 2 ap mine.”

[If the above were accurate, it would be presumed that all six Victims were deminers, although at least one would probably have been a supervisor because the demining group typically has a supervision ratio of 1:4 or lower. However, the names listed are identical to those listed for another accident and an error is presumed. It is presumed that only one deminer was injured in this accident.]

### Victim Report

<b>Victim number:</b> 701	<b>Name:</b> [Name removed]
<b>Age:</b>	<b>Gender:</b> Male
<b>Status:</b> deminer	<b>Fit for work:</b> not known
<b>Compensation:</b> Not made available	<b>Time to hospital:</b> Not made available
<b>Protection issued:</b> Not recorded	<b>Protection used:</b> Not made available

#### Summary of injuries:

severe Face

severe Head

AMPUTATION/LOSS: Eye

COMMENT: No Medical report was made available.

#### Analysis

The primary cause of this accident is listed as a “Field control inadequacy” because the Victim was working without wearing his visor correctly and his error was not corrected.

The secondary cause is listed as a “Management control inadequacy” because the management of the demining group declined to make the accident details available. Although this is sometimes done to protect the Victims, in this case the Victims’ names were among the limited detail made available. It is possible that the managers have chosen to avoid transparency because they are afraid that the circumstances of the accident would reflect badly on their organisation.