

James Madison University

JMU Scholarly Commons

Global CWD Repository

Center for International Stabilization and
Recovery

1-17-2001

DDASaccident583

HD-AID

Humanitarian Demining Accident and Incident Database

Follow this and additional works at: <https://commons.lib.jmu.edu/cisr-globalcwd>



Part of the [Defense and Security Studies Commons](#), [Peace and Conflict Studies Commons](#), [Public Policy Commons](#), and the [Social Policy Commons](#)

Recommended Citation

HD-AID, "DDASaccident583" (2001). *Global CWD Repository*. 782.
<https://commons.lib.jmu.edu/cisr-globalcwd/782>

This Other is brought to you for free and open access by the Center for International Stabilization and Recovery at JMU Scholarly Commons. It has been accepted for inclusion in Global CWD Repository by an authorized administrator of JMU Scholarly Commons. For more information, please contact dc_admin@jmu.edu.

DDAS Accident Report

Accident details

Report date: 24/06/2008	Accident number: 583
Accident time: Not recorded	Accident Date: 17/01/2001
Where it occurred: Helicopter base, San Francisco Libre, Nr Managua	Country: Nicaragua
Primary cause: Field control inadequacy (?)	Secondary cause: Management/control inadequacy (?)
Class: Other	Date of main report: None
ID original source: RG	Name of source: Printed report
Organisation: [Name removed]	
Mine/device: PMN AP blast	Ground condition: steep slope
Date record created:	Date last modified: 24/06/2008
No of victims: 1	No of documents: 1

Map details

Longitude:	Latitude:
Alt. coord. system:	Coordinates fixed by:
Map east:	Map north:
Map scale:	Map series:
Map edition:	Map sheet:
Map name:	

Accident Notes

inadequate investigation (?)
no independent investigation available (?)
inadequate area marking (?)
safety distances ignored (?)

Accident report

The details of this accident are taken from the publication "Minas Antipersonal y Desmindo en Nicaragua, Avances y Limitaciones" (Antipersonnel mines and demining in Nicaragua, Advances and Limitations) published by Centro de Estudios Internacionales (CEI), Managua. Those details are augmented by an interview with the medic involved. An internal army Board of Inquiry report was not made available. This record will be revised if more information becomes available.

The Medic is a qualified doctor with two years experience in emergency medicine in a regional hospital in Rivas, Southern Nicaragua and five years in a major hospital in Managua. He applied for the demining work because it had better conditions and pay than the national health system. He joined the demining programme on 1 March 1999. US Army advisors and trainers were involved.

All demining in Nicaragua is officially done by the army, with OEA observers present.

"According to military records, by January 1999 there had been 12 deaths of military personnel and another 78 had suffered injuries during demining activities. " [Page 15.]

According to the medic many accidents occurred while moving concrete fence posts and fence wires that marked the boundaries of the mined areas and had fallen or been pushed on to the mines, Many other accidents occurred while prodding.

The hospitals which specialise in attending mine victims are Aldo Chavarria [Rehabilitation Hospital] and Davila Bolanos Hospital (both in Managua) and the Red Cross.

The demining teams have an ambulance and medic (fully qualified doctor) and have helicopter transport available for transport to hospital. The helicopter is not on standby but is a military helicopter that is made available for hospital transport. As is a small country it is unlikely that flight time would be more than 30 minutes each way.

The doctor/Medic interviewed had attended two accidents [See also DDASaccident582].

On 17th January 2001 demining was being conducted around a former helicopter base in San Francisco Libre, near Managua. A deminer stepped on a PMN mine just outside the marked area while moving between the front and back of the lane. He was "going to prod" so had presumably returned to the back of the lane to remove his metal-detector.

The Medic reported that there was not much blood. The wound has been cleanly cauterised by the heat of the explosion. The Victim's heel was blown away, and his foot was later surgically amputated at the ankle. Three weeks later [when the Medic was interviewed] the Victim had already been released from hospital.

The Victim was wearing padded over-trousers which may have limited his injuries. [No further information about PPE was made available.]

The deminers blamed the high wind because the marking tapes were not closely staked. Wide spacing was correct according to their SOP but the tape could stretch and get blown around, leading to uncertainty about precisely where the edge of the safe area was. As a result of the accident, the deminers began to use marking stakes at roughly one metre intervals.

Victim Report

Victim number: 759	Name: [Name removed]
Age:	Gender: Male
Status: deminer	Fit for work: not known
Compensation: Not made available	Time to hospital: Not recorded
Protection issued: Trousers/leggings Not recorded	Protection used: Trousers/leggings; Not recorded

Summary of injuries:

AMPUTATION/LOSS: Leg Below knee

COMMENT: No Medical report was made available.

Analysis

This accident is classed as "Other" because the mine was not missed.

The primary cause of this accident is listed as a "Field control inadequacy" because the worksite conditions made the marking system inadequate but nothing was done to correct this. The secondary cause is listed as a "Management Control Inadequacy" because the marking system in use (plastic tape with widely spaced wooden stakes) had been approved by senior management and included in SOPs without paying due attention to the climate where demining was being conducted.

The very large number of accidents suffered by this demining group raises questions about the quality of their Advisors and training.

This accident record will be revised if more information becomes available.