DDAS Accident Report

Accident details

Report date:	22/01/2004	**Accident number:**	24
Accident time:	07:30	**Accident Date:**	10/11/1997
Where it occurred:	Zimuala, Machanga District, Sofala Province	**Country:**	Mozambique
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Inadequate equipment (?)
Class:	Vegetation removal accident	**Date of main report:**	18/11/1997
ID original source:	CP	**Name of source:**	NPA (field)
Organisation:	[Name removed]		
Mine/device:	MUV fuze	**Ground condition:**	not applicable
Date record created:	12/01/2004	**Date last modified:**	12/01/2004
No of victims:	1	**No of documents:**	2

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

inadequate equipment (?)

inadequate medical provision (?)

vegetation clearance problem (?)

no independent investigation available (?)

inadequate investigation (?)

Accident report

An internal accident report by the demining group took the form of a memo written by the Deputy Programme Manager at the time. Dated 18th November 1997, it accompanied a range of internal documents giving the information summarised here.

The demining operation was in a fenced minefield intended as defence for a bridge over the Rio Save. Sixty mines had been found previously, including POMZ, OZM and PP MI-SR (a Czech copy of the OZM) all with tripwires. A small dust road crossed the minefield and evidence of cultivation had been found within the boundaries. A POMZ had been found "lying on the side" at the accident site five days earlier, without a stick or "fuse-tripwire". The mine was removed and replaced with a marker. The group then stopped work for a four-day leave and started again on 10th November 1997.

On the day of the accident the victim started work at 07:00 clearing "a line to the spot were they earlier had found the POMZ and started 10 metres from the spot". His lane was one metre wide and required the cutting of foliage with a machete before clearing. When he was about a metre from the spot a detonator (MUV-2) exploded (at 07:30). "He got small stones in the face and head which gave him small wounds".

The Section Commander and another deminer found the victim sitting five metres from the detonation. The victim was treated by the paramedic, taken to Chimoio Hospital and "he is today totally recovered".

An on-site investigation revealed that the detonator was lying one metre from the place where the POMZ had been found and was connected to a four metre long tripwire hidden by grass.

Conclusion

The investigators concluded that the victim was not following SOPs. He knew about the POMZ, saw the marker and "he was supposed to check for tripwire before he started to cut the bush". Group members were briefed about the accident and reminded to follow SOPs.

Victim Report

Victim number:	38	**Name:**	**[Name removed]**
Age:		**Gender:**	Male
Status:	deminer	**Fit for work:**	yes
Compensation:	none	**Time to hospital:**	6 hours 30 minutes
Protection issued:	Safety spectacles	**Protection used:**	Safety spectacles

Summary of injuries:

INJURIES

minor Face

minor Head

minor Neck

COMMENT

See medical report.

Medical report

A medical report dated 14th November 1997 stated that the casualty was first treated in the rest area and he was able to walk unaided. He arrived at Chimoio at 13:15 where he was given an X-ray. It was found that he had only suffered "minor skin injuries". At 14:45 the casualty left for Tete "by ambulance" and arrived at 19:05. The Medical Supervisor also stated that "Today the deminer is back in the field working".

In a summary of all the group's demining accidents made available in 2002, it was recorded that the victim was not paid any compensation because his injuries were so minor. That same summary also recorded his time to reach hospital as 30 minutes.

Analysis

The primary cause of the accident is listed as a *"Field control inadequacy"* because the victim was apparently in breach of SOPs and his actions were not corrected by field supervisors.

The secondary cause is listed as *"Inadequate equipment"* because the provision of a machete to cut undergrowth in a tripwire area may be taken to represent a significant failing of those responsible for the selection and supply of methods and tools in use. It seems that visual methods and the use of a detector were the only means of tripwire identification is use (see Related papers). The time taken to reach hospital (more than six hours) indicates a failure of management to provide appropriate CASEVAC facilities.

The "inadequate equipment (?)" noted also refers to the issue of industrial safety spectacles as PPE.

Related papers

No Country MAC report was made available.

Handwritten in Portuguese and dated 11th November 1997, a senior supervisor's report indicated that the accident occurred at 07:30 when the victim hit a tripwire while cutting vegetation with a machete. He was evacuated to Chimoio Provincial Hospital where he was checked by X-ray (the results were still pending at the time this report was written). The Supervisor concluded that the victim had not used visual methods or a detector to check the site before cutting the vegetation, so the accident occurred because standard procedures were not followed.

The demining group's Annual Report for 1997 records that a deminer "initiated a mine fuse..(that)..was not attached to a mine. The deminer suffered only light injuries and was back at work within a few days".

In an interview in Tete, Mozambique on 18th November 1998, a senior member of the demining group stated that the victim was wearing safety spectacles at the time of the accident.

A summary of the accident was made available by the demining group's Country Manager in March 2002. This stated that the medivac time was 30 minutes and that no compensation was paid because the injuries were "very minor".