

DDAS Accident Report

Accident details

Report date: 11/03/2004	Accident number: 32
Accident time: 10:55	Accident Date: 10/05/1996
Where it occurred: Namaacha, Maputo Province	Country: Mozambique
Primary cause: Field control inadequacy (?)	Secondary cause: Inadequate training (?)
Class: Detection accident	Date of main report: 20/05/1996
ID original source: ADP-7/MC/AN/BF	Name of source: CND/IND/ADP
Organisation: [Name removed]	
Mine/device: OZM-4 AP Bfrag	Ground condition: metal fragments grass/grazing area

Date record created: 22/01/2004

Date last modified: 22/01/2004

No of victims: 3

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 training (?)
inconsistent statements (?)
no independent investigation available (?)
inadequate investigation (?)
safety distances ignored (?)

Accident report

An internal investigation dated 20th May 1996 was made available. Its content is summarised here.

The demining platoon had been at the site since 11th March 1996. The minefield was a defensive ring on largely flat ground with long grass and small bushes. Mines found previously included POMZs and an OZM-4. The ground was contaminated by fragments from mines that had gone off. The deminers were using shears and detectors. They were supplied with "protective clothing" comprising a cotton apron, boots and industrial safety glasses.

Victim No.1 was working downhill without his detector and was two metres in front of the end of his end-of-lane marker when the accident occurred at 10:55. He pulled a tripwire and initiated an OZM-4 that was a metre away. He suffered traumatic amputation of his left foot.

Two other deminers were slightly injured with single fragments to the elbow and chin. The Platoon Commander ordered a helicopter from Maputo. The platoon paramedic gave first aid.

One of the UN investigators arrived with the helicopter at 12:00. It left with Victim Nos.1 & 2 at 12:05. Victim No.3 was evacuated by road. Victim No.1 had an operation at Maputo Central Hospital and the other two victims were released after treatment.

The investigators felt that if SOPs had been followed the accident could have been avoided. SOPs stated that slopes must be cleared uphill [there was "ambiguity" about how the base of a slope should be reached]. They believed that Victim No.1 was interpreting the SOP as he thought best and walked through an uncleared area to reach the base of the slope. The usual supervisor (subcontracted from a commercial demining company) was away, which may have been relevant. The Section Commander said that he was happy with the methods used that day.

Conclusion

The investigators found that Victim No.1 and his partner had cleared 25 metres in three hours (the normal rate was 4-5 metres per hour). Fragments were found in the part of the lane they had cleared. The lane began at a width of 1m, expanding to 1.75m. They concluded that Victim No.1 was not using his detector at the time. They felt there was no doubt that the principle cause was Victim No.1's negligence and also blamed a lack of supervision. Had the usual supervisor been present the breaches of SOP would have been noticed. The section commander failed to take responsibility for safety by failing to stop the victim working too fast.

Recommendations

The investigators made lengthy recommendations including reinforcing the need to remove all metal and expanding the group's operational procedures.

Victim Report

Victim number: 46

Name: [Name removed]

Age:

Gender: Male

Status: deminer

Fit for work: not known

Compensation: US\$1,188

Time to hospital: not recorded

Protection issued: Safety spectacles

Protection used: Safety spectacles

Summary of injuries:

AMPUTATION/LOSS

Leg Below knee

COMMENT

See medical report.

Medical report

An accident report (written in Portuguese) dated 15th May 1996 stated that Victim No.1 had an amputation of the left foot and was then treated in the Special Clinic of Maputo Central Hospital.

A medical report stated that the victim was judged to be 50% incapable of doing any work, with a permanent physical disability of 70%. It was recommended that his suitability for other employment should be assessed after six months.

Victim Report

Victim number: 47

Name: [Name removed]

Age:

Gender: Male

Status: deminer

Fit for work: yes

Compensation: not made available

Time to hospital: not recorded

Protection issued: Safety spectacles

Protection used: Safety spectacles

Summary of injuries:

INJURIES

minor Arm

COMMENT

No medical report was made available.

Victim Report

Victim number: 48

Name: [Name removed]

Age:

Gender: Male

Status: deminer

Fit for work: yes

Compensation: not made available

Time to hospital: not recorded

Protection issued: Safety spectacles

Protection used: not recorded

Summary of injuries:

INJURIES

minor Face

COMMENT

No medical report was made available.

Analysis

The primary cause of this accident is listed as a "*Field control inadequacy*" because the main victim was in breach of SOPs and his errors went uncorrected. The secondary cause is listed as "*Inadequate training*" because it seems that the Victim did not know the risks he was taking.

It is not clear what the victim was doing when he initiated the mine. Quite how he tripped a tripwire on a bounding mine and lost a foot without suffered wide fragment injury is unclear. It would make more sense if he stepped on the trigger mechanism of the fuse, or the mine were a non-bounding type.

It is possible that the SOPs and/or training were inadequate, which would represent failings higher in the management chain.

Related papers

The recommendation of the UN Compensation Committee was that compensation of $36\% \times 30 \times \text{US\$110} (\text{salary}) = \text{US\$1,188}$ be paid to victim No.1.