DDAS Accident Report

Accident details

Report date:	11/03/2004	**Accident number:**	44
Accident time:	13:50	**Accident Date:**	23/05/1994
Where it occurred:	Caprizanje, Moatize District, Tete Province	**Country:**	Mozambique
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Inadequate training (?)
Class:	Vegetation removal accident	**Date of main report:**	29/05/1994
ID original source:	HB/HH	**Name of source:**	HB/NPA field
Organisation:	[Name removed]		
Mine/device:	OZM-4 AP Bfrag	**Ground condition:**	metal fragments bushes/scrub grass/grazing area
Date record created:	22/01/2004	**Date last modified:**	22/01/2004
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 training (?)

vegetation clearance problem (?)

inadequate investigation (?)

no independent investigation available (?)

victim ill (?)

inadequate equipment (?)

Accident report

An internal investigation was made available by the group's ex-pat Demining Team Leader. Dated 29th May 1994, it recorded the fact that the victim had graduated from his training only a week before the accident. He was tested and inducted at the demining group for a few days and seemed to be well trained and worked slowly and carefully. His group had been drilled especially on trip-wires.

The victim was working in an area covered with tall grass and bushes. The soil was heavily contaminated by metal, so detectors were only used to detect trip-wires. He was not using a detector at the time of the accident. The procedure for trip-wires was to report a find to a supervisor and not to touch it. The victim had been tested on this and the procedure had been followed for previous finds in the area.

He saw a tripwire, and before he could do anything the mine went off. The mine was approximately 1.5m to the victim's left side, and he was kneeling behind the end-of-lane marker at the time. Other deminers were 20m away at the time of the accident, in accordance with SOPs.

During the investigation, the tripwire and the base-plate from the mine were found. No booby traps were found in the area.

The investigator's report recorded a detailed sequence of events following the accident, starting with the record that on 23rd May 1994 at 13:50 the victim detonated an OZM-4. The victim was injured in the leg and the arm and was given first aid. The victim was conscious and after stabilisation was moved to Tete hospital at 14:05, arriving at 15:15.

The victim was described as stable but a severed "main vein" in his leg was said to be causing "low blood circulation". A doctor informed the demining group that there were complications with the leg injury but by 19:00 the severed "vein" had been treated and the victim was said to be stable. At 08:00 the next day it was reported that the "blood circulation" in his leg was now better. By 19:00 that evening the victim was showing signs of recovery and was able to talk and eat. He told other staff that he had detected a trip-wire but didn't touch it.

At 08:00 on the morning of 29th May 1994 the demining group were informed by the hospital that the victim had fallen into a coma in the early hours of the morning. His condition was described as critical. At 14:00 that day the victim died.

Conclusion

The investigation concluded that the victim had found the trip-wire before the mine detonated and was aware that he should stop work and inform a supervisor. His failure to do so implies that the correct procedure was not followed. It was thought possible that he knelt down to take a closer look, or that he may have even tried to cut the grass.

Recommendations

The investigation found no reason to change the procedures on finding trip-wires, but recommended that they be re-emphasised to deminers and demining students.

Victim Report

Victim number: 63	**Name:** [Name removed]
Age:	**Gender:** Male
Status: deminer	**Fit for work:** DECEASED
Compensation: none	**Time to hospital:** 1 hour 25 minutes
Protection issued: Safety spectacles	**Protection used:** not recorded

Summary of injuries:

INJURIES

severe Arm

severe Head

severe Legs

FATAL

COMMENT

Victim died in hospital six days after the accident. See medical report.

Medical report

In a summary of all demining injuries from the group's management in March 2003, it was recorded that the victim suffered "brain injury" and "injury of the left popliteal artery with ischaemia of the left lower leg and foot by splinters of the mine". He died a day later with "clinical signs of intracerebral haemorrhage".

No compensation was paid because the family could not be found.

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because the investigators found that the victim was working improperly and he was not corrected by his supervisors.

The fact that the Victim has only recently finished his training implies that the training may have been inadequate.

Any failure of the medical care can be seen as a senior management failing because the responsibility for the provision of adequate medical care rests higher in the command chain.

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

Related papers

No other documents were made available.

An ex-pat Technical Advisor at the time (the man who took the victim to hospital) reported in February 1999 that the doctor at the hospital had refused to take the victim's head wounds seriously. The Advisor "asked many times and then demanded a head x-ray" before being forcibly removed from the hospital. He said that the victim died days later of a brain haemorrhage.

The senior ex-pat Technical Advisor at the time disputed this in June 1999, and said that the victim was sick before the accident.

In a summary of the group's accidents made available in March 2002, it was reported that the victim was a former RENAMO soldier and his relatives could not be located. As a result, no compensation was paid. That summary records that the victim died one day after the accident, conflicting with the six days reported elsewhere.