DDAS Accident Report

Accident details

Report date:	19/04/2006	**Accident number:**	64
Accident time:	not recorded	**Accident Date:**	18/10/1996
Where it occurred:	Sangondo, Luena	**Country:**	Angola
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Inadequate training (?)
Class:	Other	**Date of main report:**	[No date recorded]
ID original source:	none	**Name of source:**	Other
Organisation:	[Name removed]		
Mine/device:	MAI-75 AP blast	**Ground condition:**	route/path
Date record created:	23/01/2004	**Date last modified:**	21/02/2004
No of victims:	1	**No of documents:**	1

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 investigation (?)

no independent investigation available (?)

inadequate area marking (?)

inadequate training (?)

Accident report

No accident report was found on file at the Angola MAC. The head office of the demining group also had no written record of the accident but they arranged for a staff member who had been in country at the time (although not on site) to explain what had happened. The following summarises that interview.

The demining group's spokesman reported that the accident occurred on a day when two clearance teams were sent to work at an area that had been previously surveyed and marked. When the teams arrived they found that the warning signs and marking system had

been removed (presumed stolen). The teams had to determine the borders of the area to be cleared again. There was a path running along one side of the area and the two Team Leaders disagreed over whether the path had been inside or outside of the original marked area. They finally decided that it had been outside the marked area and used it. While walking on that path the victim trod on a mine and lost his foot.

The mine was believed to have been a MAI-75. It was identified by inference from other mines found in that area.

The victim was taken to the Brazilian UN hospital where his surgical amputation took place.

Another member of the demining group stated that the SOP stated that at times of confusion supervisors should contact a Technical Advisor. In his view, their failure to do this made their actions a breach of SOP.

After his treatment the victim was retrained as a carpenter and was employed at the group's main office in Luena.

Victim Report

Victim number: 91	**Name:** **[Name removed]**
Age:	**Gender:** Male
Status: deminer	**Fit for work:** yes
Compensation: not made available	**Time to hospital:** not recorded
Protection issued: Not recorded	**Protection used:** not recorded

Summary of injuries:

AMPUTATION/LOSS

Leg Below knee

COMMENT

No medical report was made available.

Analysis

The primary cause of this accident is listed as a "Field control inadequacy" because the supervisors on the site acted improperly when they found that the previous markings had been removed. Instead of erring on the side of caution, they gambled on the area being safe and the victim suffered as a result. While this may have been simply “human error”, it implies a possible lack of appropriate training. The secondary cause is listed as “Inadequate training”.