DDAS Accident Report

Accident details

Report date:	19/04/2006	**Accident number:**	69
Accident time:	16:30	**Accident Date:**	05/03/1996
Where it occurred:	Bridge over River Lui, 50km East of Malange	**Country:**	Angola
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Management/control inadequacy (?)
Class:	Excavation accident	**Date of main report:**	06/03/1996
ID original source:	FO/TVD	**Name of source:**	MCHM
Organisation:	[Name removed]		
Mine/device:	PMN AP blast	**Ground condition:**	bridge and surrounds
Date record created:	23/01/2004	**Date last modified:**	23/01/2004
No of victims:	2	**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 medical provision (?)

safety distances ignored (?)

no independent investigation available (?)

protective equipment not worn (?)

inadequate investigation (?)

Accident report

No record of this accident was found on file at the Angola MAC. Details were supplied by the demining company on 13th January 1999.

In a copy of a FAX dated 6th March 1996 to another company (presumed to have been the victims' direct employers) the accident is recorded as "two members of our North Team were

seriously injured in a landmine detonation while they were demining the bridge site over the river Lui". It goes on "both men are in a serious but fortunately stable condition. One man has regrettably lost the use of his eyes whilst the prognosis for the other man is slightly better".

In a telephone conversation with a spokesman for the company on 6th January 1999 he said that one deminer lost 80% of his vision and also had a traumatic amputation of his fingers (parts of which were subsequently stitched back in place. He also said that the device was a "PMN-1" AP mine.

[I infer from this that both men suffered facial and eye injury while in close proximity to the mine. The hand injury implies that the mine was being "investigated", so the accident is classed as an "Excavation" accident. It is assumed that the victims wore no protection because of the eye injuries.]

Medevac took place via helicopter to Luanda and the demining company expressed thanks to the UN for its assistance in arranging this.

In a FAX of 6th March 1996 that was made available later, it was explained that the victims were taken by helicopter from the River Lui to Luanda (arriving at 22:50) where they were met by a full medical team from the Romanian field hospital who stabilised them before they were flown on to South Africa. The demining group management expressed profound thanks for their professionalism.

Victim Report

Victim number: 98 **Name:** [Name removed]

Age: **Gender:** Male

Status: deminer **Fit for work:** not known

Compensation: not made available **Time to hospital:** 11 hours

Protection issued: Not recorded **Protection used:** not recorded

Summary of injuries:

AMPUTATION/LOSS

Fingers

COMMENT

No medical report was made available.

Victim Report

Victim number: 99 **Name:** [Name removed]

Age: **Gender:** Male

Status: deminer **Fit for work:** not known

Compensation: not made available **Time to hospital:** 11 hours

Protection issued: Not recorded **Protection used:** not recorded

Summary of injuries:

INJURIES

minor Eyes

COMMENT

No medical report was made available.

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because the men were operating in close proximity and are believed to have detonated a mine while prodding.

Either they were breaching SOPs or there were failings of approved procedure that allowed them to work in this way.

It is probable that (as ex-pats) the victims were field supervisors and so the fact of them being close together and without eye protection could represent a failing of the management system that appointed them. The secondary cause is listed as a *“Management/control inadequacy”.*

No mention is made of the victims' position at the time of the accident. They may have been squatting or lying down.

It was further failing of group management that the CASEVAC took so long to arrange.