DDAS Accident Report

Accident details

Report date:	19/04/2006	**Accident number:**	71
Accident time:	not recorded	**Accident Date:**	15/11/1995
Where it occurred:	Luchimba Bridge, Malanje	**Country:**	Angola
Primary cause:	Unavoidable (?)	**Secondary cause:**	Inadequate training (?)
Class:	Excavation accident	**Date of main report:**	[No date recorded]
ID original source:	none	**Name of source:**	Other
Organisation:	[Name removed]		
Mine/device:	Type 72 AP blast	**Ground condition:**	bridge and surrounds
Date record created:	23/01/2004	**Date last modified:**	23/01/2004
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

squatting/kneeling to excavate (?)

non injurious accident (?)

incomplete detonation (?)

no independent investigation available (?)

inadequate metal-detector (?)

inadequate investigation (?)

inadequate training (?)

Accident report

The date of this accident is uncertain.

A senior official with the demining group reported in informal discussions during December 1998 that an accident had occurred at Luchimba (spelt phonetically) Bridge in Malanje in 1995. In this accident an expatriate Technical Advisor was using a Schiebel detector in an uncleared area and detonated a Type 72 blast mine. It did not have a booster charge so he only initiated the percussion cap and escaped unhurt. He left Angola soon afterwards.

Another Technical Advisor with the group at the time reported in January 1999 that the victim was actually prodding when he initiated the mine and confirmed that only the percussion cap detonated. He was prodding because he could not use the Schiebel AN/19 to find the Type 72 mines.

Nine other Type 72 mines were found at the site after the accident, all of which were "fully operational". The demining group generally prodding and/or excavated in a squatting position at the time.

In June 1999 the group's country manager at the time confirmed that the accident had occurred.

The demining NGO involved may not have been issuing visors and vests at that time.

Victim Report

Victim number: 101	**Name: [Name removed]**
Age:	**Gender:** Male
Status: supervisory	**Fit for work:** yes
Compensation: not made available	**Time to hospital:** not appropriate
Protection issued: Not recorded	**Protection used:** not recorded

Summary of injuries:

COMMENT

No medical report was made available. No injury was recorded.

Analysis

The primary cause of this accident is listed as *“Unavoidable”* because it is possible that the victim was working appropriately (following widely approved SOPs) when the accident occurred. If the victim was working inappropriately without correction, that would be a *"Field control inadequacy”*.

The victim was an expatriate Technical Advisor who may have had little prodding experience, and so prodded with too much force. His failing may not have been corrected because the victim was the person with the senior management authority to make corrections. The secondary cause is listed as *“Inadequate training”*.

Nine other mines were found at the site without accident. While this does not prove that the victim was working improperly, it does imply that soil movement or the mine having been laid on its side were unlikely causes.