

# DDAS Accident Report

## Accident details

<b>Report date:</b> 19/05/2006	<b>Accident number:</b> 303
<b>Accident time:</b> not recorded	<b>Accident Date:</b> 30/10/2000
<b>Where it occurred:</b> Cordon Sanitaire minefield	<b>Country:</b> Zimbabwe
<b>Primary cause:</b> Unavoidable (?)	<b>Secondary cause:</b> Inadequate equipment (?)
<b>Class:</b> Other	<b>Date of main report:</b> 07/11/2000
<b>ID original source:</b> DH	<b>Name of source:</b> Mounser/AVS 2001:Z10
<b>Organisation:</b> Name removed	
<b>Mine/device:</b> R2M2 AP blast	<b>Ground condition:</b> woodland (bush)
<b>Date record created:</b> 19/02/2004	<b>Date last modified:</b> 19/02/2004
<b>No of victims:</b> 1	<b>No of documents:</b> 2

## Map details

<b>Longitude:</b>	<b>Latitude:</b>
<b>Alt. coord. system:</b>	<b>Coordinates fixed by:</b>
<b>Map east:</b>	<b>Map north:</b>
<b>Map scale:</b> not recorded	<b>Map series:</b>
<b>Map edition:</b>	<b>Map sheet:</b>
<b>Map name:</b>	

## Accident Notes

no independent investigation available (?)

inadequate investigation (?)

mechanical follow-up (?)

## Accident report

The following official "accident summary" was made available in January 2001. No other report was made. The summary was compiled by the demining group's acting site manager. For obscure reasons, the country manager of the programme censored the content of the following before making it available. The report was dated 7<sup>th</sup> October, 23 days *before* the accident, so it is presumed that it should have been dated 7<sup>th</sup> November.

The following text has only been further edited when necessary to conceal the identity of individuals and organisations involved.

On the 30<sup>th</sup> October 2000, an Anti Personnel Mine, Type R2M2, detonated app 3,5m in front of [the victim] without obvious reason.

The Mine had been exposed by the minecollector [a large ground processing machine] and this type of mine is known as very sensitive.

The deminer sustained minor injuries to his shoulder and was complaining about hearing loss.

Since similar accidents happened already a few times in the past, Management suspects the change in temperature during the day in conjunction with the strain of being lifted and moved by the MC to be the most probable cause of the accident. During the investigation carried out by the Safety Officer, it was found, that all drills were carried out according to the SOP and the deminer was wearing his PPE correctly.

The [QA] Monitor witnessed the accident and confirmed that the deminer was not closer than 3,5m to the mine, when it went off.

The deminer is not at fault.

Accidents of this kind are unavoidable as long as [the company] is clearing R2M2 in mechanically prepared areas.

Senior Staff has to make sure, that no one is entering the minefield without wearing full PPE. All violations of this rule have to be taken very serious and appropriate disciplinary action has to be taken immediately.

Please find attached the accident report of the Safety Officer as well as the WCIF 14A form

Signed: Acting Operations Manager

### Victim Report

<b>Victim number:</b> 383	<b>Name:</b> Name removed
<b>Age:</b>	<b>Gender:</b> Male
<b>Status:</b> deminer	<b>Fit for work:</b> yes
<b>Compensation:</b> not made available	<b>Time to hospital:</b> not applicable
<b>Protection issued:</b> Frontal apron Long visor	<b>Protection used:</b> Frontal apron, Long visor

#### Summary of injuries:

##### INJURIES

minor Hearing

minor Shoulder

##### COMMENT

No medical report was made available.

## Analysis

The primary cause of this accident is classed as “*Unavoidable*” because the victim appears to have been working properly and fallen victim to a spontaneous detonation.

However, it was known by this time that the mechanical preparation on the site left mines exposed and in a dangerous condition (see Related Papers) so the secondary cause is listed as “*Inadequate equipment*”. Management revised demolition procedures because of a perceived increased risk, but apparently did not reconsider the manner in which the machines were deployed. This may be seen as a “*Management/control inadequacy*”.

The accident investigation is considered inadequate because it was censored prior to being made available.

## Related papers

In an exchange with one of the Field Supervisors at the site, the researcher asked the following:

Q) It seems that several accidents involved spontaneous detonations of R2M2s after machines had worked in the area. Is this so?

A) True the R2M2 had a strange habit of detonating without anything directly appearing to cause the mine to function. This did usually occur after a machine had been in the vicinity. Remember that we (the mechanical unit) were operating in advance of the manual follow up using bush-cutting equipment, bulldozers and the MineBuster excavator. I witnessed mines detonating without external influence personally – one went off 35m from my vehicle as I was travelling up the safety road.

This happened only in the R2M2 areas and I suspect that the plastic assembly of the fuse housing was damaged (the plastic distorted) and although the metallic balls of the safety release had released, the distortion of the plastic prevented the firing spring from creeping forward and initiating the mine. When the heat of the day expanded the plastic, the spring was released and the pin forced into the stab-detonator.

The thought of moving R2M2 mines in this condition - putting them into a pit to be destroyed (max 10 in a pit) – was unacceptable. So R2M2s found in areas after the machines had worked were burned in-situ. Other mines were still destroyed in pits.