

DDAS Accident Report

Accident details

Report date: 19/05/2006	Accident number: 320
Accident time: 14:25	Accident Date: 22/11/1998
Where it occurred: Songo, Cahorra Bassa	Country: Mozambique
Primary cause: Inadequate training (?)	Secondary cause: Management/control inadequacy (?)
Class: Handling accident	Date of main report: 07/01/1999
ID original source: FM	Name of source: NPA (field)
Organisation: Name removed	
Mine/device: Type 72 AP blast	Ground condition: not applicable
Date record created: 20/02/2004	Date last modified: 20/02/2004
No of victims: 1	No of documents: 3

Map details

Longitude: 32° 47' 38" E	Latitude: 15° 38' 56" S
Alt. coord. system: Long: 032.47' 38"E	Coordinates fixed by:
Map east:	Map north:
Map scale:	Map series:
Map edition:	Map sheet:
Map name:	

Accident Notes

inconsistent statements (?)
no independent investigation available (?)
incomplete detonation (?)
inadequate training (?)
disciplinary action against victim (?)

Accident report

A report on the accident was made available by the demining group in November 2000. The report included all related documents in one binding. The following summarises its content:

The accident was formally investigated on 04/01/99, presenting its findings on 07/01/99, more than six weeks after the accident. After discussions, it was decided to hold a second round of investigations by holding interviews with those present.

First inquiry

The first inquiry found that the accident occurred at the supervisor's campsite after demining work had stopped for the day. [The time is variously recorded as 14:30 and 15:25.] A Trainee Supervisor was trying to explain the operation of the Type-72a mine to some of his colleagues in a "self initiated" lecture. The Senior Supervisor was absent.

Photographs show that the accident occurred in a canvas-roofed area between two tents.

The Trainee Supervisor "tried to force open the mine whilst explaining the function mechanism" and "initiated the detonator", suffering a minor injury to one finger.

The headquarters were informed and summoned the victim and the Senior Supervisor to the office in Tete. They left at 16:15, arriving at 17:45. Both individuals were suspended from duty pending the outcome of an investigation.

This inquiry concluded that the accident occurred because the victim violated SOPs.

Second inquiry

The second inquiry found that:

1. When the Senior Supervisor was promoted to that position in February 1997, he found some mines in the explosive store of the group.
2. "From February 1997 until December 1998 [he] has transported the mines through five different campsites within Tete, Manica and Sofala provinces."
3. "Apart from these mines, [the group] was also keeping 63 detonators for AP M-969. These detonators are now... awaiting demolition."
4. "Monitor co-ordinator did not have any idea of the existence of such items in [the group's] explosive store."
5. "No information was given to Operations room in Tete when the victim went to do some work in the explosive store after active demining period (06:00-14:00)."

Recommendations

The second inquiry recommended that:

1. Sufficient time should be allowed for a handover of responsibility when Senior Supervisors take over a group. The time should allow for a full inventory of equipment including explosive items to be made.
2. No group should transport mines and explosives from one site to another with the express approval of the HQ.
3. The group now destroy all devices at the end of the day, so no render-safe procedures are being used. However, the use of MDDs require some rendered-safe mines for training. These should be inspected and certified "rendered-safe".
4. At least one in every quarter, the monitoring team should make an inventory of all devices held in the explosives store.
5. Each explosive store should have a register book listing names of all those with authority to enter. Time of entry and departure must be logged. The key should remain with the Senior Supervisor.
6. To ensure Medevac availability, no one should enter the explosive store outside normal working hours without first gaining full radio contact with the Operations room in Tete.
7. Under no circumstances should visitors handle or be briefed using devices containing explosive. Only FFEs should be used for this purpose.
8. No training involving explosive devices should be conducted unless authorized by HQ.

The victim was "soon back on duty" – demoted to his previous position as "Platoon Leader".

Victim Report

Victim number: 403	Name: Name removed
Age: 38	Gender: Male
Status: supervisory	Fit for work: yes
Compensation: none	Time to hospital: not applicable
Protection issued: Not recorded	Protection used: none

Summary of injuries:

INJURIES

minor Hand

COMMENT

See medical report.

Medical report

An "Accident info sheet" recorded the victim's injury as "slight injury on the right index finger".

A summary of all demining accidents with the demining group was made available in 2002. This described his injuries as "very light" with a full recovery "soon after".

"No compensation was paid – as this was classified to a clear violation of the demining SOPs and in addition, he did suffer very minor injuries."

Analysis

The primary cause of this accident is listed as "*Inadequate training*" because the victim was attempting to train others without realizing that he was handling a mine that could detonate. The booster was presumably missing, which probably gave him confidence that the device could not detonate. However, the stab-sensitive detonator at the start of the firing train would have been visible in the booster-well if he had checked to see (or if he had known what to look for), from which I infer that he was inadequately trained for the activity he was undertaking.

The secondary cause is listed as a "*Management/control inadequacy*" because the demining group's internal investigation revealed that they did not have sufficient controls in place to know what mines were held on site, their condition, or who had access to them. The management made comprehensive recommendations to improve this situation which should be applauded – as should the fact that they investigated such a minor accident so thoroughly.

Related papers

The file included a history of the Cahorra Bassa minefield along with maps.

The file also included the victim's contract of employment showing that his salary was US\$200 per month with US\$40 subsistence.

A summary of the group's accidents in the country was made available in 2002. This stated that the victim received "disciplinary sanctions" after the accident.

Statements

Statements from four individuals involved in the accident are summarized below.

Senior Supervisor

On 23/11/99 the Senior Supervisor signed a statement saying that on 20/11/98 he sent the victim to clean the explosives store. On 22/11/99 the group carried out some demolitions in preparation to leave the site the next day. He told the victim to bring out some explosive charges, not knowing that he had already found some mines in the store.

At 14:30 he heard an explosion and ran to find out what had happened. When he asked why the victim had taken the mine out of the box, he answered that he was simply curious. He called the paramedic to attend the victim.

Victim

On 23/11/98 the victim signed a statement saying that he had received instructions to clean the explosive store previously. On 22/22/98 he was told to remove all the explosive boxes and prepare them to move to a new campsite on the next day. He opened a box containing Type-72 mines which had no booster. He wanted to show the medic what the Type-72 looked like because she did not know. He took the mine and placed it on the table to show her. As he was returning the mine he tried to open it and the detonator exploded. He suffered light injuries to the index finger on his left hand.

Paramedic

On 24/11/98 the paramedic made a statement saying that the victim had asked if she knew what a Type-72 looked like and she had replied that she did not. After lunch he had brought one and put it on the table. After showing those present, he tried to open it and it detonated. "We ran away and left him still holding the mine in his hands." The victim sustained slight injuries on the "phalange" of the index finger of his left hand. She later gave first aid and dressed the wound.