

DDAS Accident Report

Accident details

Report date: 21/07/2005	Accident number: 420
Accident time: 08:30	Accident Date: 28/11/2001
Where it occurred: Cabina Vermelha road, 22 km SW of Ndatatando city, Kuanza North Province	Country: Angola
Primary cause: Field control inadequacy (?)	Secondary cause: Unavoidable (?)
Class: Missed-mine accident	Date of main report: 20/04/2005
ID original source:	Name of source: NPA
Organisation: Name removed	
Mine/device: MAI-75 AP blast	Ground condition: route/path wet
Date record created: 21/07/2005	Date last modified: 21/07/2005
No of victims: 1	No of documents: 1

Map details

Longitude:	Latitude:
Alt. coord. system: Not recorded	Coordinates fixed by:
Map east:	Map north:
Map scale:	Map series:
Map edition:	Map sheet:
Map name:	

Accident Notes

no independent investigation available (?)

inadequate metal-detector (?)

non injurious accident (?)

Accident report

The Demining group made available an accident report in 2005. The following is a lightly edited version of that report, with identifying names removed.

Cabina Vermelha road is located approximately 22 km southwest of Ndalatando city, Kuanza North province. It takes approximately 60 minutes driving from Ndalatando city to the beginning of the road.

There is a military position and a small village, approximately 3 km from the start of the road.

Until 1992, vehicles used to be driven in this road normally, to give access to agricultural land cultivated.

Due to the tense political and military situation in Angola, in 1992 the road was mined by FAA with AP mines MAI-75 and POMZ aiming to make difficult any military movement towards the military position or Ndalatando city.

In 1995, one FAA soldier stepped on an AP mine (probably a MAI-75) in the beginning of the road, and he lost a leg. In 1996, there was a mine accident with a truck, also in the beginning of the road, and it became destroyed. From that time no vehicle was used in that road.

The estimated total area to be cleared was 36.000 m² (6.000 long x 6 m wide). [The demining group] started the task on 13.07.01. Until 27.11.01 it had already removed two AP mines MAI-75 (51 and 300 metres from start of the task), one 82 mm mortar and one F1 hand grenade. Those mines were buried in approximately 5-6 cm deep, they seemed to be very old and it was difficult to unscrew the cover after their removal. They were easily detected, with a mine detector.

The vegetation in the task is low and it facilitates the demining activities.

The ground is clay, slightly stony and very hard, mainly in the dry season. During the rainy season the ground becomes less hard, very slippery and it makes the movement of vehicles difficult.

The road metal content is very high until approximately 20 metres but it is very low in the rest of the road.

The safety distance between the five pairs of deminers was 25 metres and they had been using mine detector EBEX PB 420. If metal was detected, deminers excavated until they found the metal but in the beginning of the task it was applied just excavation drill (10 cm deep) due to the high metal content on the ground. The Team Leaders had been doing some random quality assurance in the areas cleared by the deminers and there was not any case in which a deminer left metal on the ground.

Details of the accident

The accident occurred on 28.11.01, wednesday at approximately 08.30.

It happened when the personnel were driving from [the Demining Group] office to the task location with two vehicles, one land cruiser behind and one DAF truck in front. The land cruiser was taking four employees, the Team Leader, one Paramedic, one Deminer and the Driver. The truck was carrying the rest of the personnel deployed in the task.

It had been raining a lot one day before, then the ground became less hard and slippery. The truck drove on the usual track that both vehicles used to pass without any problem but due to the slippery ground conditions, the land cruiser escaped from the usual track and it activated a MAI-75 AP mine with its right rear wheel which caused an immediate explosion. This happened inside the cleared area, approximately 287 metres from the beginning of the road (at that time, 4700 metres had already been cleared).

The mine explosion made a hole which was 28 cm deep and 70 cm in diameter

There was no personnel injury, only the right rear wheel of the land cruiser was destroyed.

At the time of the accident the truck and land cruiser were separated in a distance of about 20 metres.

Actions taken after the accident:

28.11.01 – Wednesday

1. Immediately after the accident both vehicles stopped.

2. 08.30 – Paramedic called [the Demining Group] Offices in Luanda and Ndalatando to inform about the accident and wait for superior instructions
3. While waiting for instructions, the Team Leader assessed the accident place and he concluded that it was really a mine accident.
4. [The Demining Group] suspended immediately all demining activities in the province
5. The Project Manager contacted the authorities (Army, Police and INAROOE) in the province to inform them about the accident.
6. The Team Leader assessed the accident place and verify with a mine detector the way back to the safe area
7. 08.50: Deminers started verifying the road towards the safe area and the damaged tyre was being changed by the drivers with support of some deminers
8. 09.00 – Project Manager together with FAA and Police Representatives, left Ndalatando town and at approximately 10.40 they arrived to the accident local
9. 12:40 – All personnel left to [the Demining Group] office in Ndalatando, for further discussions

29.11.01 – Thursday

1. The suspension of demining activities continued.
2. Operations and Information Officers left Luanda to Ndalatando to undertake an internal mine accident investigation
3. On this day [the Demining Group] Head Office in Luanda informed the donors, OCHA and INAROOE about the incident.

04.12.01 – Tuesday

1. Operations and Information Officers travelled back to Luanda by road to present and discuss the accident with Mine Action Management.

Final comments

This is the first time that an incident like that happened, with [the Demining Group] in Kuanza North. The actions on the technical aspects were carried out in a satisfactory manner.

There were some rumours about remining but there were not strong evidences of remining. It seemed to be an old mine buried in the middle of the road that a deminer left in the cleared area probably due to a mistake or technical problems with metal detector.

Probably, this accident did not happen before because the ground was very hard and the mine was buried in approximately 15 cm deep in the middle of the road. People have been using this area normally. Due to the rain, the ground became less hard and slippery. The vehicle escaped approximately 30 cm from the usual track and it drove over the mine for the first time causing the accident.



The accident site. The AP mine was buried in the middle of the path.



The damaged wheel and tyre.

Victim Report

Victim number: 551	Name: Name removed
Age:	Gender: Male
Status: supervisory	Fit for work: yes
Compensation: not made available	Time to hospital: not recorded
Protection issued:	Protection used: None

Summary of injuries:

COMMENT

No medical report was made available. No injuries were recorded.

Analysis

This was a non-injurious missed-mine accident and the demining group are to be commended for having investigated and recorded it with transparency.

The Primary cause is listed as a *“Field-control inadequacy”* because the investigator decided that the mine had been missed, possibly due to inappropriate use of the metal-detector. It is the field supervisors’ role to ensure that all equipment is used properly. No record was made of the investigator checking that a MAI-75 at that depth in that ground was actually detectable. If it were not, the accident would have been classed as *“Unavoidable”* because the deminers were working in an approved way with approved equipment.