# DDAS Accident Report

## Accident details

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|---|---|---|---|
| **Report date:** | 11/03/2004 | **Accident number:** | 42 |
| **Accident time:** | 12:27 | **Accident Date:** | 19/01/1995 |
| **Where it occurred:** | Manhica minefield, Manhica District, Maputo Province | **Country:** | Mozambique |
| **Primary cause:** | Field control inadequacy (?) | **Secondary cause:** | Inadequate training (?) |
| **Class:** | Tripwire accident | **Date of main report:** | 01/11/1995 |
| **ID original source:** | HB | **Name of source:** | HB/NPA field |
| **Organisation:** | [Name removed] | | |
| **Mine/device:** | OZM-72 AP Bfrag | **Ground condition:** | not recorded |
| **Date record created:** | 22/01/2004 | **Date last modified:** | 22/01/2004 |
| **No of victims:** | 1 | **No of documents:** | 2 |

## 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 training (?)

no independent investigation available (?)

inadequate investigation (?)

inadequate equipment (?)

## Accident report

This accident is mentioned in the demining group's demining activity report for 1995. A single page summary of three accidents, dated 01/11/95, was made available by the demining group.

The victim set off an OZM-72 bounding fragmentation mine at about 12:27, and was killed. An internal investigation concluded that he had been rolling up a trip-wire as he was working his way towards the mine. This contravened safety procedures, according to which deminers should not touch trip-wires at all but should call a supervisor.

See also “Related papers”.

## Victim Report

| | |
|---|---|
| **Victim number:** 60 | **Name: [Name removed]** |
| **Age:** | **Gender:** Male |
| **Status:** deminer | **Fit for work:** DECEASED |
| **Compensation:** US$4,500 | **Time to hospital:** not recorded |
| **Protection issued:** Safety spectacles | **Protection used:** not recorded |

**Summary of injuries:**

INJURIES

severe Chest

severe Face

severe Neck

FATAL

COMMENT

The victim suffered severe fragmentation injuries to the head, neck and chest. No medical report was made available.

## Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because the victim was working in an unsafe manner and was not corrected by his field supervisors. He may not have realised that he was working inappropriately, which would be an example of *“Inadequate training”*.

The failure to provide any realistic safety equipment was probably irrelevant in this instance (the mine was capable of defeating all armour currently used) but still indicates a significant management failing. The demining group began to supply 5mm full-face visors in this theatre in June 1999.

The “inadequate equipment (?)” noted refers to the issue of industrial safety spectacles as PPE.

The demining group failed to provide any report of the accident despite repeated requests.

## Related papers

An agreement by the head office of the demining organisation to provide details in February 1999 was not honoured.

In a summary of the accident made available by the demining group’s Country Manager in March 2002, the victim’s injuries were described as “splinters on the head, neck and chest”.

He died “on the spot”. The demining group paid for his funeral and paid US$4,500 in compensation to his family.