DDAS Accident Report

Accident details

Report date:	18/05/2006	**Accident number:**	186
Accident time:	06:20	**Accident Date:**	22/03/1999
Where it occurred:	Kapfudze Village, Mukumbura	**Country:**	Zimbabwe
Primary cause:	Management/control inadequacy (?)	**Secondary cause:**	Field control inadequacy (?)
Class:	Handling accident	**Date of main report:**	[No date recorded]
ID original source:	none	**Name of source:**	KMS
Organisation:	Name removed		
Mine/device:	R2M2 AP blast	**Ground condition:**	not applicable
Date record created:	14/02/2004	**Date last modified:**	14/02/2004
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

no independent investigation available (?)

inconsistent statements (?)

inadequate training (?)

Accident report

An internal accident report was written by the demining group's safety officer and the QA team and made available. The following summarises its content.

The investigators stated that the accident occurred at 06:20 as the men were preparing to start work. Supposedly free-from-explosive R2M2 mines were placed on the dashboard of a truck used to transport equipment and personnel. The mines still retained their stab-sensitive detonators and were used as test pieces for calibrating detectors. [The small detonator is the largest metallic signature in the mine.]

The report stated that at the time of the accident there were three team leaders and the driver in the cab and an unspecified number of deminers in the back. On arriving at the site the driver inquired about the mines and subsequently pressed the top of one as it was being held by a Team Leader, making the detonator explode. The victim sustained an injury to the flesh of the mid-finger of his right hand. [However, the victim was the driver and as the blast emanated from the bottom of the mine it seems likely that he held it in his own hand.]

The Supervisor stated that the driver placed his hand on the top of the mine and it shattered as the detonator functioned. He stated that he doctor was called at 07:02, and maintained that the mines were normally carried in his vehicle in a locked container.

One Team Leader stated that there were two mines in the vehicle and that they were being held by a colleague.

Another Team Leader stated that he was sitting next to the driver and holding two mines when the driver asked him how the mines functioned. On explaining that you had to apply force to the top, the driver suddenly reached out and pressed down on the mine.

Another Team Leader stated that he had disembarked when the explosion occurred.

The driver stated that the mines were on the dashboard and that when he was reversing the truck he inadvertently put his hand on one of them. He stated that his wound required three stitches.

Conclusion

The investigators concluded that the nature of the injury and the lack of damage to the dashboard disproved the driver's statement. They said that the supervisor and the three Team Leaders were negligent in allowing the mines to be transported by any other means than in the senior Supervisor's vehicle.

Recommendations

The investigators recommended that the senior Supervisor should always ensure that anything of an explosive nature is transported in his vehicle to and from the site. Also that the senior Supervisor must ensure that Team Leaders obey safety regulations, and that the use of mines as test-pieces should cease. They added that truck and ambulance drivers should not carry explosive items without following proper transportation procedures.

The Safety Officer stated that the victim received minor lacerations to the "mid-finger" of his right hand, with no bones broken.

Victim Report

Victim number: 236 **Name:** **Name removed**

Age: **Gender:** Male

Status: driver **Fit for work:** yes

Compensation: not made available **Time to hospital:** not recorded

Protection issued: Not recorded **Protection used:** none

Summary of injuries:

INJURIES

minor Hand

COMMENT

No medical report was made available.

Analysis

The primary cause of this accident is listed as a *"Management/control inadequacy"* because safety procedures were breached by field management with the knowledge of their senior Supervisor. The demining group management acknowledged this with their censure of the Supervisor and so took all reasonable measures to prevent a repetition. The secondary cause is listed as a “Field control inadequacy”.

Related papers

A "First Written Warning", dated 24th March 1999, addressed to the senior Supervisor was on file. It stated that he "caused" the accident because he failed to control the use of the test mine.

An internal "Accident Investigating Form", undated, signed by the Safety Officer, included the observation that there was negligence on the part of the Supervisor and three of his Team Leaders.