

DDAS Accident Report

Accident details

Report date: 19/05/2006	Accident number: 369
Accident time: not recorded	Accident Date: 14/02/1992
Where it occurred: Oupale, Xangongo, Cunene Province	Country: Angola
Primary cause: Field control inadequacy (?)	Secondary cause: Inadequate equipment (?)
Class: Excavation accident	Date of main report: [None]
ID original source: none	Name of source: HE/HGK
Organisation: Name removed	
Mine/device: TM57 AT blast	Ground condition: agricultural (abandoned) bushes/scrub sparse trees
Date record created: 21/02/2004	Date last modified: 21/02/2004
No of victims: 1	No of documents: 1

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 (?)
protective equipment not worn (?)
use of pick (?)
standing to excavate (?)
inadequate investigation (?)

Accident report

No formal investigation of the accident was carried out. This record is derived from interviews with the site-managers, supervisors and deminers who were present.

Clearance was being carried out without knowledge of current best-practices in Humanitarian Demining. The demining group's management in Europe wilfully kept the ex-pat field staff ignorant of other HD efforts around the world. As a result, the clearance was taking place without concern for safety distances or PPE, and without the site-manager having strict control. The team was a small group of people who worked as a "team", sharing decision making and learning as they went.

A European TV camera team was present at the clearance site the day before the accident and the Victim had been selected to feature in their filming.

The demining site

The demining group were clearing an area laid with TM62B, TM57 and TM46 Anti tank mines with fuzes armed by clockwork. The machine dug holes at 3m spacing and the mines were placed either by men or machine. There were two (sometimes three) rows of tank mines. In this area, the AT mines were not protected with any AP blast mines.

Some mines in the area had been collected and removed by local people. This was in response to a "bounty" offered for mines across the border in Namibia. The bounty was paid by the South African armed forces based in Namibia at that time. They apparently believed that the mines would be collected inside Namibia and so they were reducing the local risk to their soldiers and vehicles. In fact they were encouraging civilians on both sides of the border to take risks, and several civilians are reported to have died collecting and transporting mines.

There was almost no vegetation. Thorny bushes had been placed on top of the mines to prevent cattle stepping on them. Mines were buried at a depth of 2-3 cm to the top of the mine, so the fuze was frequently exposed. The pattern was obvious.

The deminers located the mines by sight, removed the thorns, exposed the mines, removed the fuzes and carried the mines and fuzes to a collection point. Between 150 and 1200 mines were removed each day by a team of 30 deminers.

Events leading up the accident

On the day of the accident the Victim was attempting to uncover mines with his pickaxe in order to unscrew the fuze. This was against the rules, which stated that pickaxes were only to be used as crowbars to lift unfuzed mines from the ground. When the Angolan supervisor told him this was dangerous, he argued that he knew what he was doing. The attention of the camera crew on the previous day is believed to have led to him having an inflated ego: he thought that he was too "special" to die.

When the Victim ignored the Supervisor, the Supervisor sent him ahead 50 meters to work, telling him that he should not endanger others if he wanted to take risks.

The Victim initiated a TM-57 anti-tank mine with his pickaxe. He was killed instantly (see photograph in Medical report). His body was thrown 15 meters from the seat of the explosion. Medical staff were on site immediately, but could do nothing to assist the victim.

Recommendations

Site managers immediately issued clear and unambiguous instructions that deminers working dangerously should be ordered to stop work immediately.

Victim Report

Victim number: 473	Name: Name removed
Age:	Gender: Male
Status: deminer	Fit for work: DECEASED
Compensation:	Time to hospital:
Protection issued: None	Protection used: none

Summary of injuries:

INJURIES

severe Body

severe Chest

severe Head

AMPUTATION/LOSS

Arm Above elbow

Arm Above elbow

Leg Above knee

Leg Above knee

FATAL

COMMENT

The victim died immediately. See photograph in Medical report.

Medical report

No formal medical report was made available. The following photograph shows the victim immediately after the accident.



Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because the site-supervisor did not command the authority required to stop the victim working dangerously. The secondary cause is listed as *"Inadequate equipment"* because the lifting of live mines with a pick-axe seems obviously dangerous.

It seems likely that the responsibilities of those in the command chain were uncertain. However, the NGO's command and control methods were in their infancy, and Humanitarian Demining norms had not been established at this time so there were no approved SOPs to adopt.