

DDAS Accident Report

Accident details

Report date: 19/04/2006	Accident number: 59
Accident time: 11:10	Accident Date: 06/03/1997
Where it occurred: Ucuu, Bengo Province	Country: Angola
Primary cause: Field control inadequacy (?)	Secondary cause: Field control inadequacy (?)
Class: Missed-mine accident	Date of main report: 31/03/1997
ID original source: MB/HB	Name of source: INAROOE
Organisation: [Name removed]	
Mine/device: GYATA-64 AP blast	Ground condition: not recorded
Date record created: 23/01/2004	Date last modified: 21/07/2005
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 medical provision (?)
no independent investigation available (?)
squatting/kneeling to excavate (?)
inadequate investigation (?)
incomplete detonation (?)

Accident report

A letter from the demining group's country Manager was found on file at the Country MAC. The content gave details of the accident and is summarised here.

The victim had been a deminer for two years.

At 11:10 he initiated the device while kneeling on the ground "carrying out demining". He had "obviously not found" the device when he had cleared the area himself "some minutes

earlier". The mine was "very old and rusty which probably caused the malfunction of the mine". "Metal fragments at the scene confirm that the metal in the mine was almost completely corrugated" [presumably the word "corroded" was intended]. The deminer had been working with the "Ebex 420SI" detector [Ebinger] and either found metal near the mine and did not recheck after removing it, or did not calibrate his detector properly. The device was identified as the booster of a Gyata-64.

The victim received medical attention "quickly" and the injury was assessed as minor. The victim arrived at Luanda Military Hospital at 14:40 having been transported "by car".

The victim's foot was not broken. It was stitched and the hospital was of the opinion that "he would need a week in hospital and will hopefully make a full recovery within one month".

The demining group undertook to investigate the issue further, give all deminers a revision course on SOPs, and to treat the accident as very serious (because the lack of serious injury was fortuitous). The country MAC was invited to conduct an investigation. [If they did, it was not available in their files.]

Victim Report

Victim number: 81	Name: [Name removed]
Age:	Gender: Male
Status: deminer	Fit for work: not known
Compensation: not made available	Time to hospital: 3 hours 30 minutes
Protection issued: Frontal apron Long visor	Protection used: Frontal apron, Long visor

Summary of injuries:

INJURIES

severe Foot

COMMENT

See medical report.

Medical report

The demining group prepared a Medical Coordinator's report for this research. It stated that the victim's foot had suffered multiple fractures and an open wound on the sole. When he was discharged he was using crutches. He went back to Malanje and remained on sick leave.

By early 1998 the victim had been to Luanda for several "attempted" medical check-ups, although he told the assistant medical coordinator that he was not interested in further medical support. He could walk unaided by this time.

At a later meeting he said that he did not want to work for the demining group any longer and it was proposed that he have a final medical examination for compensation purposes. The victim had been receiving his salary to this point. The medical coordinator attempted a "post-traumatic stress syndrome debrief", but without much success. The final medical was carried out on May 8th 1998 at Alvalade Clinic by an orthopaedic specialist, who concluded that the victim would always experience pain if he used the foot for long periods, and that there was no treatment that would resolve this problem.

The victim had been doing some occasional work for the demining group "recently".

A meeting was set for 7th December 1998 with the victim, a nurse from the demining group and a representative of the Angolan Health Authority to determine the extent of his disability, after which the demining group was to make a compensation decision. The outcome of that meeting is not known.

Analysis

The primary cause of this accident is listed as a "*Field control inadequacy*" because it seems that the victim was working in an unsafe manner and was not corrected.

The evacuation of the victim "by car" may imply that an ambulance was not available. Alternatively, it may illustrate the difficulties of reporting in a second language. "By car" may have been used to indicate that he was evacuated by road rather than by air.

Related papers

An internal Demining group record of this accident was made available in 2005. It is reproduced below, edited for anonymity. In that report, the accident was recorded as having occurred on 17th March 1997.

1. Ucuá Task

Ucuá, located approximately 150 km from Luanda, was a heavily mined locality in Bengo province (north of Angola).

[The Demining group] started demining operations there on 5th October 1996, using manual deminers and finally machines and dogs. The metal content in the minefield was very high as it was battle area in the past.

On 17th March 1997, the operations started at 07.00 hours. [The Victim] was working in his working lane, using a Metal Detector EBEX PD 420. Suddenly, there was an explosion in the minefield. [The Victim] stepped on a Gyata 64 AP mine, some centimetres behind the base stick.

The metal detector was fine. According to [the Victim], it was well calibrated and he followed all the steps of manual clearance.

Accident occurrence:

After cutting the vegetation, the deminer started the search with detector that it gave a reading. [The Victim] excavated, found a piece of metal but he did not check again the ground with metal detector. Unfortunately, there was also a mine buried but he did not find during the excavation and when moving forward, he stepped on the mine.

Just to mention that he was wearing the normal protective equipment as boots, gloves, visor and vest.

Fortunately, the mine was initiated but the main charge did not explode because the booster was not in good conditions. This explosion injured seriously his right foot. The operations stopped immediately and the casualty was evacuated to Luanda by road due to lack of local landing area.

The operations restarted next day but the lane in which the accident happened was closed due to the investigations.

After the treatment, [the Victim] continued working for [the Demining group] as cook.

During the task, [the Demining group] removed 88 AP mines, 3 AT mines and 26 uxo's. This task was completed on 8th March 1998.