DDAS Accident Report

Accident details

Report date:	21/03/2006	**Accident number:**	62
Accident time:	07:05	**Accident Date:**	18/11/1996
Where it occurred:	Chipeta to Catabola power line, Bie	**Country:**	Angola
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Field control inadequacy (?)
Class:	Excavation accident	**Date of main report:**	19/11/1996
ID original source:	PH Internal	**Name of source:**	INAROEE
Organisation:	[Name removed]		
Mine/device:	PPM-2 AP blast	**Ground condition:**	hidden root mat
Date record created:	23/01/2004	**Date last modified:**	23/01/2004
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

inadequate medical provision (?)

no independent investigation available (?)

squatting/kneeling to excavate (?)

vegetation clearance problem (?)

visor not worn or worn raised (?)

Accident report

The demining group issued frontal protection and their drills assumed the deminer would kneel or squat while excavating.

An internal demining group (signed by the Programme Manager) was on file at the Angola MAC. The following summarises its content.

The demining group were using Ebinger 535 detectors at the time. 1,139 mines had been found on the site prior to the accident and the victim had cleared two on the morning [in half of one hour?] prior to the accident.

The report gave a timetable of events which indicated that the team started work at 06:00 and the accident occurred at 07:05 when the victim "prodded onto" a PPM-2. By 07:09 the victim had been carried to a safe area by two colleagues and was receiving treatment from the medic. The deminer "took deep blast wound to the area between the thumb and forefinger" of his left hand. The medic did not administer painkillers but "packs wound on the hand".

Painkillers were avoided because the victim was "unconscious and suffering head injuries" - described as "extensive injuries to his face". At 07:15 the ambulance picked up the victim and at 08:45 the victim arrived at Kuito hospital. Air evacuation to an eye clinic in Luanda was arranged and the victim arrived there at 15:15.

The first deminer on the scene reported that the victim's visor was lying close by with no damage. It was decided that the deminer had removed his visor prior to the accident. The mine was believed to have been buried to "around 3 to 6cm" in 1986. Many of those found were in "very poor condition". There were many roots in the area the deminer was working and the presence of the roots may have been the cause of the victim using "too much force….or an incorrect probe angle". The probe was bent into "a bow shape". The deminer's frag vest cover was not penetrated.

Conclusion

The investigators concluded that the accident occurred because the deminer was either prodding at the wrong angle, prodding aggressively, or combining both errors. They said that this was a breach of their SOPs. They found that the victim's injuries were "greatly exacerbated" by not wearing a visor. The Casevac was described as going "very well".

Recommendations

The report noted that this accident was "at least the fifth" that had occurred with PPM-2s while prodding in Angola. It recommended additional supervision with frequent refresher courses, more practice for Casevac, and that breaches of safety procedures should be dealt with as "extremely serious".

Victim Report

Victim number: 85

Name: [Name removed]

Age:

Gender: Male

Status: deminer

Fit for work: not known

Compensation: not made available

Time to hospital: 10 hours 10 minutes

Protection issued: Long visor
Short frontal vest

Protection used: Short frontal vest

Summary of injuries:

INJURIES

severe Eyes

severe Face

severe Hand

AMPUTATION/LOSS

Eye

COMMENT

No medical report was made available.

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because the deminer was working improperly and not wearing his visor despite the fact that the demining group involved claimed to wear closed visors at all times while in a mined area. Leaving the visor aside entirely implies that the victim was confident that he would not be observed by field supervisors, in which case supervision was unacceptably slack.

The delay before the victim reached surgical facilities illustrates both the difficulties or working in Angola and a management failing in making appropriate provision for CASEVAC. Better provision was possible because other groups made better provision at the same time.