

DDAS Accident Report

Accident details

Report date: 18/05/2006	Accident number: 275
Accident time: not recorded	Accident Date: 17/02/2000
Where it occurred: Ploughshare minefield, Mozambique border	Country: Zimbabwe
Primary cause: Management/control inadequacy (?)	Secondary cause: Inadequate training (?)
Class: Excavation accident	Date of main report: [No date recorded]
ID original source: none	Name of source: Mounser/various
Organisation: Name removed	
Mine/device: R2M2 AP blast	Ground condition: woodland (bush)
Date record created: 18/02/2004	Date last modified: 18/02/2004
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 (?)
inadequate metal-detector (?)
mine/device found in "cleared" area (?)
visor not worn or worn raised (?)
long handtool may have reduced injury (?)
inadequate investigation (?)
inadequate training (?)

Accident report

No accident report was made available by the programme manager in January 2001. The demining group manager did provide a spreadsheet recording accident data on which this accident was recorded. Documents of any kind were only provided after pressure had been applied through the funder. To try to counter any omissions in the reports provided, statements were taken from a field supervisor in March 2001. The following summarises the content of the spreadsheet and includes detail from statements.

At the time of this accident the demining company operated in one-man teams using a one-man drill [from the start of 2000 this drill was adopted]. In this a single deminer looks for tripwires, cuts undergrowth, uses the detector and excavates finds. The group issued frontal protection and their drills assumed that the deminer would kneel or squat while excavating.

The accident occurred 50cm from the site of the accident that occurred on 15th February 2000 involving the same group. This was only two days after that accident, from which it is inferred that the area-reduction by Survey was continuing.

The area immediately around the site of the former accident had been swept by senior staff and the independent QA staff. They had searched over the mine involved in this accident and not located it. They concluded that the mine was not detectable with the detectors in use (Vallon and Guartel MD8).

The victim was continuing the breach begun by the earlier victim. He worked a further ten metres and checked the lane with his detector as he walked back towards the safe area. As he passed the site of the earlier accident, he got a slight detector reading and began to investigate with his prod. The mine detonated.

The site supervisor determined that the mine had been on its side and he had prodded directly onto it. This was decided because the crater showed "funnelling". The victim sustained minor injuries to his hand and a cut to his nose. His prodder was thrown back and struck the deminer on the collar of his apron above his neck, sideways on. The victim's neck was bruised.

Victim Report

Victim number: 350	Name: Name removed
Age:	Gender: Male
Status: deminer	Fit for work: yes
Compensation: not made available	Time to hospital: not recorded
Protection issued: Not recorded	Protection used: not recorded

Summary of injuries:

INJURIES

minor Face

minor Hand

minor Neck

COMMENT

See medical report.

Medical report

A brief medical report was obtained from another source. The victim was named in the medical report.

The victim was recorded as suffering “Neck bruises and swelling (haematoma), mild neurogenic [Sp?] shock”.

The victim’s field treatment was:

“Fluid replacement, ATT [illegible];

Patient reassurance;

Off duty 2 weeks – got home;

Patient managed at field.”

Procedures were recorded as: “Pressure bandages and cleaning of bruises”.

The victim was “reassured but discharged from project on his own voluntary effort”

Analysis

The primary cause of this accident is listed as a “*Management Control inadequacy*” because the preliminary survey of local people indicated that the area was mined. The Survey team then went in mine-hunting without using clearance drills or marking systems. This was an inappropriate method of “reducing” the suspect area by “Survey” and implies inadequate training. The secondary cause is listed as “*Inadequate training*”

The failure of the management group to provide details of the accident may be seen as implying that they wished to play down its significance or conceal the fact that it occurred so close to the previous accident. If the earlier accident investigation was made as recorded, the mine was missed by all the investigators – which could indicate that either the clearance method was inappropriate or the investigators were incompetent.

The victim’s facial injury was unexplained, and may indicate that his visor was worn raised or not worn.

The victim was using a purpose designed demining handtool that stayed in one piece during the accident. Although it struck him in a vulnerable area, it did not cause significant injury.

The accident investigation is considered inadequate because it was incomplete and had been edited prior to being made available.