

DDAS Accident Report

Accident details

Report date: 17/05/2006	Accident number: 168
Accident time: 08:30	Accident Date: 19/08/1997
Where it occurred: Mok Heoun, Route 502, Banteay Meanchey Province	Country: Cambodia
Primary cause: Management/control inadequacy (?)	Secondary cause: Inadequate equipment (?)
Class: Missed-mine accident	Date of main report: 21/08/1997
ID original source: NS (date inferred)	Name of source: CMAC
Organisation: Name removed	
Mine/device: Type 72 AP blast	Ground condition: hard metal fragments
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

inadequate equipment (?)
inadequate metal-detector (?)
no independent investigation available (?)

Accident report

At the time of the accident the demining group operated in a two-man drill whereby one deminer used the detector and marked any signals while the other looked for tripwires, cut undergrowth and excavated any detector readings. A third deminer may have been resting [it is not known whether the group had changed from three-man to two-man teams at this time].

Conflicting with the investigation report, this accident is listed on the country MAC Accident summary sheet as having occurred on the 18th August 1997. An internal report on the accident by the UN controlled demining group (in Khmer) was located at the country MAC. The following summarises its content.

The road had been used by a mining operation [the other kind] so there were a lot of metal fragments in the area, making the Schiebel detectors difficult to use. There had been no rain prior to the accident, so the ground was hard. The team had already cleared 5km of the road and a large number of mines and IEDs had been found.

That morning the team was drilled on using detectors in such areas and all detectors were tested thoroughly.

The victim was a prodder man and he and his partner had already cleared about 20m and had found about 30 fragments. At 08:30 the victim was returning along the lane after clearing some vegetation and trod on a mine that was about 11m into the lane.

The crater was 21cm wide and 13cm deep which the investigators interpreted as meaning that the mine was buried to a depth of about 10cm. The detector was tested and it was found that it could detect a Type 72A at 10cm in normal soil, but it could not detect the mine in areas with a high level of natural contamination.

Conclusion

The report concluded that the mine was missed by the detector man because he had adjusted his Schiebel to cancel out background readings and this meant that the mine was not detectable at that depth. He had been working carefully and according to current SOPs.

Recommendations

The investigators recommended that the victim should be fully compensated and that the SOPs for using a detector in a contaminated area should be re-examined. A different detector should be found that could cope with contaminated areas and that all cleared area of this kind should be checked again for Type 72a mines with the new detector.

Victim Report

Victim number: 213	Name: Name removed
Age:	Gender: Male
Status: deminer	Fit for work: not known
Compensation: US\$2,500	Time to hospital: 2 hours
Protection issued: Safety spectacles	Protection used: Safety spectacles

Summary of injuries:

AMPUTATION/LOSS

Leg Below knee

COMMENT

See medical report.

Medical report

A brief medical report was found but it lacked sketches of the injury [part of the format] and no discharge date was given. It recorded that the victim arrived at Mongkul Borey hospital at 10:30. His left foot was amputated at point 1/3 up on his lower leg. He had no other recorded injuries.

The victim was awarded compensation of US\$2,500 on 24th November 1997.

Analysis

The primary cause of this accident is listed as a "*Management/control inadequacy*" because the investigators concluded that the deminers were using a detector that could not do the job, and the supply of that detector was a management responsibility. The secondary cause is listed as "*Inadequate equipment*".

Management secured the funds to replace the detectors shortly thereafter.

Related papers

The file included a photograph of the victim after treatment (on crutches), photographs of the accident site (no context), and a table of the results from a detector trial held on 19th June 1996 when 15 different detectors were evaluated against a range of mines buried at various depths.