

DDAS Accident Report

Accident details

Report date: 18/05/2006	Accident number: 178
Accident time: 09:00	Accident Date: 14/03/1996
Where it occurred: Samaki, Thmar Pourk District, Banteay Meanchey Province	Country: Cambodia
Primary cause: Field control inadequacy (?)	Secondary cause: Field control inadequacy (?)
Class: Excavation accident	Date of main report: 17/03/1996
ID original source: LK (date inferred)	Name of source: HT (field)
Organisation: Name removed	
Mine/device: PMN AP blast	Ground condition: agricultural (recent) residential/urban
Date record created: 14/02/2004	Date last modified: 18/05/2006
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 (?)
squatting/kneeling to excavate (?)
visor not worn or worn raised (?)

Accident report

At the time of the accident the demining group were using two-man teams and a one-man drill. In this, one deminer used the detector, searched for tripwires, cut undergrowth and excavated finds while his partner watched from a distance and "controlled" him. The demining group issued frontal protection and their drills assumed the deminer would kneel or squat while excavating.

An internal investigation was carried out on 16th March 1996 by an expatriate. The undated report was made available by the demining group's country manager. The following summarises its content.

The mined area was a village, recently repopulated by returning refugees, parts of which had been heavily mined by the Vietnamese in 1982. The demining platoon started clearance operations on 6th January 1996 and had been finding an average of three PMNs per day.

At approximately 09:00 the victim detonated a PMN while investigating a detector signal with his prod. He sustained a traumatic amputation of his left thumb and forefinger, grazing to his left upper arm and to the lower half of his face, and "a slight laceration to the cornea of his left eye" that caused 50% blindness in this eye. He was also bleeding from both ears. The victim was wearing body armour and a visor.

After receiving first aid he was taken to a hospital at Taphaya, Thailand about 8km away, and then to Aranyaprathet Hospital, Thailand. His hand could not be saved and was amputated at Aranyaprathet. His eyesight and his hearing on his left side gradually improved.

The investigators stated that the victim "was investigating a signal situated to the left side of his clearing lane. The signal could be heard when the locator was passed one head's width to the side of the one meter lane but the mine was about 15cm beyond that. The total distance from the left side of the lane is about 30cm". The victim had been investigating this signal for two minutes before the mine detonated, but did not know that it was a mine as he could neither see nor feel it.

"All injuries were sustained on the left side of the deminer only so it is unlikely that he had turned properly (contrary to the Section Commander's statement) to investigate the signal which would tend to suggest he didn't take the investigation seriously and thus prodded into the mine". [The parentheses are in the original.]

The chest protector performed well but the visor "shattered completely on impact with the shock wave and debris from the mine. After the accident only two large pieces from the top half of the visor could be recovered as the lower half disintegrated".

Statements were taken from the victim and the Section Commander, who was acting as the deminer's partner at the time. Full copies were not included in the report.

Conclusion

The internal investigators concluded that the accident was not avoidable. They thought that the mine was probably initiated by the prod touching the pressure pad and that it was "likely but not certain" that the mine had been tilted by the act of a farmer planting a banana tree nearby.

Recommendations

The internal investigators found that no changes in SOP were required but recommended that the strength of the visors in use should be investigated. They also said that when a deminer "requires treatment at a Thai hospital the staff there must be informed immediately.... that he is covered by insurance..... This will ensure that he receives the best treatment that the Hospital can offer".

Victim Report

Victim number: 227

Name: Name removed

Age:

Gender: Male

Status: deminer

Fit for work: not known

Compensation: not made available

Time to hospital: not recorded

Protection issued: Long visor
Short frontal vest

Protection used: Short frontal vest,
Long visor raised

Summary of injuries:

INJURIES

severe Eye

severe Hearing

AMPUTATION/LOSS

Hand

COMMENT

No medical report was made available.

Analysis

The primary cause of this accident is listed as a "*Field control inadequacy*" because it seems likely that the victim was either allowed to walk into an uncleared area, or a cleared area where a mine had been missed. It is possible that the area reduction and survey were poor and he entered a dangerous area unknowingly, which would be a higher management failing. The secondary cause is listed as a "*Management/control inadequacy*".