DDAS Accident Report

Accident details

Report date:	18/05/2006	**Accident number:**	183
Accident time:	12:45	**Accident Date:**	22/08/1995
Where it occurred:	Ou Srolao Village, Battambang Province	**Country:**	Cambodia
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Inadequate equipment (?)
Class:	Detection accident	**Date of main report:**	[No date recorded]
ID original source:	none	**Name of source:**	CMAC
Organisation:	Name removed		
Mine/device:	PMN-2 AP blast	**Ground condition:**	metal fragments rocks/stones
Date record created:	14/02/2004	**Date last modified:**	14/02/2004
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

inadequate equipment (?)

no independent investigation available (?)

inadequate metal-detector (?)

disciplinary action against victim (?)

protective equipment not worn (?)

Accident report

At the time of the accident the demining group operated in three-man teams with a two-man drill. In this one deminer used the detector and marked any signals while another looked for tripwires, cut undergrowth and excavated any detector readings. A third deminer was resting. The three rotated at fixed intervals.

A country MAC accident report was located in January 1999 and translated from the original Khmer and French. The following summarises its content.

The mined area was 50m from the village and measured 34,926m^2. Clearance started on 11th May 1995 and on 21st August 1995 part of the section was redeployed, leaving ten deminers to complete the work by 8th September 1995. Of the mines found, about 98% were PMN-2s.

The victim was working as the detector man and he and his partners had found and destroyed three mines that day. The work was slowed by the large number of fragments in their lane. The prodder-man was investigating the source of a detector reading with a prodder, and called the victim to mark the reading again. The victim had difficulty centring the signal and in an attempt to bring the detector head closer to the surface of the ground he used the head to brush away soil and small stones.

At 12:45 he initiated a mine with his detector, causing him to stagger backwards and collapse about 4 metres behind. After first aid the victim left by ambulance, arriving at Battambang Provincial Hospital at 13:30. The victim was not wearing his safety spectacles, which were found in his hand (he claimed that he was about to put them on). The detector was "completely destroyed".

The victim subsequently admitted that he had been using the detector to brush away soil.

Conclusion

The investigators stated that the detector head should have been 5cm above the surface of the ground. Where there were stones and excess soil, they said it should be carefully removed by hand. The victim was found to have breached SOPs in his use of the detector and in failing to wear his safety spectacles.

Recommendations

The investigators recommended that the Site Manager and Supervisor should be held responsible for the mistakes of their subordinates and should each receive a written warning. The victim was aware of SOPs regarding the use of his detector and safety spectacles and breached them, so they recommended that his compensation should be reduced by 20%.

[See the accident in Cambodia that occurred on 2nd February 1996, when the investigator's advice was to use the detector very close to the ground.]

Victim Report

Victim number:	233	**Name:**	**Name removed**
Age:		**Gender:**	Male
Status:	deminer	**Fit for work:**	not known
Compensation:	US$3,175	**Time to hospital:**	45 minutes
Protection issued:	Safety spectacles	**Protection used:**	none

Summary of injuries:

INJURIES

minor Body

minor Face

minor Genitals

severe Eye

severe Leg

AMPUTATION/LOSS

Arm Above elbow

Eye

COMMENT

See medical report.

Medical report

A medical report listed the victim's injuries as:

- a large and deep wound to the left upper arm,
- large serious injuries on the left and right thighs complicated by destruction of the muscle,
- a serious injury to the right eye and small fragment wounds to the face
- a superficial fragment wound to the genitals
- multiple fragment wounds to the left side of the thorax and left arm.

The victim was operated on immediately on arrival in hospital, with further operations on 8th and 22nd September 1995. During these operations, his arm was amputated [presumably above the elbow]. On 27th November 1995 it was confirmed that the sight in his right eye could not be saved.

It is not clear from the file whether a recommendation to reduce the payout by 20% as a punishment for breaching SOPs was ever carried out. The victim was awarded $3,175 [how this figure was arrived at is not recorded but there appears to have been a reduction].

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* as recognised by the investigators who recommended written warnings for field supervisors who allowed the victim to work in an unsafe manner.

There is some evidence of a management failing because the detector was known to be inadequate but had not been replaced. The secondary cause is listed as *"Inadequate equipment"*.

The question of punishing the victim by reducing compensation deserves comment. The victim had paid out of his own salary into a compensation fund and was injured while working. The responsibility for field discipline rested with the field supervisors, who were criticised by the investigators. Punishment of victims occurs in other accidents involving this demining group.

Contradictory advice from investigators [see Cambodian accident on 2nd February 1996] regarding how close to the ground to use the detector implies that those responsible for SOPs and training were “confused”.