12-5-1996

DDASaccident175

Humanitarian Demining Accident and Incident Database

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Recommended Citation

DDAS Accident Report

Accident details

Report date: 17/05/2006
Accident time: 08:00
Where it occurred: Road 696, Banteay Meanchevy Province
Primary cause: Field control inadequacy (?)
Class: Missed-mine accident
ID original source: none
Organisation: Name removed
Mine/device: AP blast (unrecorded)

Accident number: 175
Accident Date: 05/12/1996
Country: Cambodia
Secondary cause: Inadequate equipment (?)
Date of main report: [No date recorded]
Name of source: CMAC
Ground condition: bushes/scrub electromagnetic grass/grazing area

Date record created: 14/02/2004
No of victims: 2
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 (?)
inadequate metal-detector (?)
safety distances ignored (?)
no independent investigation available (?)
inadequate investigation (?)
disciplinary action against victim (?)
**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 believed that the group operated in three-man teams at this time].

This accident was recorded as having occurred on 6th December 1996 on the country MAC Accident summary sheet. An internal UN controlled demining group report (in Khmer) was found on file in January 1999. The following summarises its content.

The demining team were clearing land so that an NGO could build a road. There was a deserted house at the site. The area was densely vegetated and strewn with a large number of fragments. Victim No.1 was a detector man. His partner cleared some vegetation and then returned to the rest area. Victim No.1 tested the detector a second time and went to sweep the area.

At 8:00 the Team Leader heard an explosion and ran towards it. He stated that he saw Victim No.2 on his back about 15m away from the accident site. He carried Victim No.1 to a safe area where the medic treated them. Both victims were then taken to Aranyaprathet Hospital in Thailand, arriving 40 minutes later. The Team Leader returned to the accident site and found the detector making a constant noise.

Victim No.2 was a supervisor who was inspecting the work. The report gave no further details but states that the nature of his injuries indicated that he was close to the prodder man at the time of the accident and then walked to a point 15m away.

The investigators went to the site and found a crater inside the clearance lane measuring 15cm wide and 4cm deep. Around the crater were metal fragments, including four nails 50cm in front, but there was no evidence that they had been investigated by the victim.

The victim's detector was slightly damaged but was able to be tested, and it was found that it was not working. The detector was sent to Schiebel for further tests to determine the fault, but at the time of compiling the report, no result was known.

<table>
<thead>
<tr>
<th>Victim number: 222</th>
<th>Name: Name removed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
<td>Gender: Male</td>
</tr>
<tr>
<td>Status: deminer</td>
<td>Fit for work: not known</td>
</tr>
<tr>
<td>Compensation: US$4,000</td>
<td>Time to hospital: 40 minutes</td>
</tr>
<tr>
<td>Protection issued: Safety spectacles</td>
<td>Protection used: not recorded</td>
</tr>
</tbody>
</table>

**Summary of injuries:**

INJURIES

severe Arm

AMPUTATION/LOSS

Leg Below knee

Leg Below knee

COMMENT

See medical report.
Medical report

A medical report recorded that the accident occurred at 08:00 and the two victims were first taken to Aranyaprathet Hospital in Thailand where they were stabilised, and then transferred to Mongkul Borey Provincial Hospital the following day, arriving at 17:00.

Victim No.1 suffered traumatic amputation of both feet and had a large wound on the underside of his wrist, as indicated on the medical sketch reproduced below.

![Medical sketch](image)

He left hospital on 18th December 1996 but was scheduled to return for another operation on 20th February 1997. In the meantime the victim would continue to receive treatment at the country MAC’s clinic.

He was awarded $4,000 compensation on 17th March 1997, and received it on 29th April 1997.

On Victim No.1’s application for compensation it was mentioned that his monthly salary was $184.

**Victim Report**

<table>
<thead>
<tr>
<th>Victim number: 223</th>
<th>Name: Name removed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
<td>Gender: Male</td>
</tr>
<tr>
<td>Status: supervisory</td>
<td>Fit for work: yes</td>
</tr>
<tr>
<td>Compensation: none</td>
<td>Time to hospital: 40 minutes</td>
</tr>
<tr>
<td>Protection issued: Safety spectacles</td>
<td>Protection used: not recorded</td>
</tr>
</tbody>
</table>

**Summary of injuries:**

INJURIES

- minor Arm
- minor Eyes
- minor Face
- minor Hand

COMMENT
Medical report

A medical report recorded that the accident occurred at 08:00 and the two victims were first taken to Aranyaprathet Hospital in Thailand where they were stabilised, and then transferred to Mongkul Borey Provincial Hospital the following day, arriving at 17:00.

Victim No.2 suffered an 8cm gash across the bicep of the left arm, minor multiple fragment injuries to his face and his eyes were filled with dust and sand. The prognosis was that he would probably recover fully but that it was too early to be sure about his eyes.

He left hospital on 11th December 1996, fully recovered, and the doctor recommended that he be allowed to return to work.

At a Compensation Board meeting on 17th March 1997 it was decided to allow Victim No.2 to return to work but not to award him compensation.

Analysis

The primary cause of this accident is listed as a "Field control inadequacy" because the field supervisors failed to ensure that the equipment issued was working adequately and allowed safety distances to be breached. The secondary cause is listed as “Inadequate equipment” because the detector was not working.

The report contained no record of whether the safety spectacles were worn, but in the case of Victim No.2 (who was at some distance from the blast) this seems unlikely.

There is some evidence of a management failing by virtue of the detectors having been known for some time to be inadequate.

The question of punishing Victim No.2 by not paying compensation deserves note. 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 and he was one, but the official punishment of victims in this manner is unique to this demining group.