2-2-1996

DDASaccident180

Humanitarian Demining Accident and Incident Database
AID

DDAS Accident Report

Accident details

Report date:	18/05/2006	**Accident number:**	180
Accident time:	10:30	**Accident Date:**	02/02/1996
Where it occurred:	Kaup Prich, Battambang Province	**Country:**	Cambodia
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Inadequate equipment (?)
Class:	Missed-mine accident	**Date of main report:**	[No date recorded]
ID original source:	none	**Name of source:**	CMAC
Organisation:	Name removed		
Mine/device:	Type 72 AP blast	**Ground condition:**	not recorded
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 (?)

inadequate metal-detector (?)

no independent investigation available (?)

mine/device found in "cleared" area (?)

inadequate training (?)

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.

An internal MAC investigation was made and recorded in Khmer. The following summarises its translated content.

The demining team uncovered three Type 72a mines and called the supervisor to deal with them. The victim was walking over a cleared area at 10:30 when he detonated another Type 72a mine. He received injuries described in the field as "light". He was taken to Mong Kol Borey hospital arriving at 11.20.

The area where the victim was walking was well used, so the possibility of remining was considered.

The investigators tried using two of the detectors to check their ability to find the Type 72a mine at 8cm depth. They found the detector (Schiebel AN/19) capable of doing so at 7cm but with an unclear signal.

Conclusion

The investigators concluded that the detector was not suitable for detecting T72 mines at 8cm or more and that the mine had been missed for this reason. They thought it possible that the mine had been walked on many times before detonating.

Recommendation

The investigators recommended that the head of the detector should he held really close to the ground to try to improve its performance. It should also be moved slowly. [See the same demining group's accident in Cambodia on 22nd August 1995 when brushing the ground with a detector head initiated a mine and the recommendation was that it be kept at least 5cm from the ground.]

A photograph attached to the report showed the victim's lower right leg bandaged from the heel to 10cm below the knee and the left leg bandaged from mid thigh to below the knee.

A sketch of the mined area was included, showing that the mine missed was part of a pattern.

Victim Report

Victim number: 230	**Name:** **Name removed**
Age:	**Gender:** Male
Status: deminer	**Fit for work:** not known
Compensation: $2,500	**Time to hospital:** 50 minutes
Protection issued: Safety spectacles	**Protection used:** not recorded

Summary of injuries:

INJURIES

minor Legs

severe Foot

COMMENT

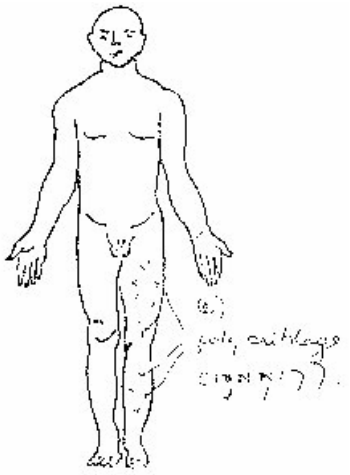
See medical report.

Medical report

A medical report stated that the victim was unable to use one leg, his right heel was damaged and his left calf was lightly injured.

By 5th February amputation of the lower leg was being considered. This was not done. He was discharged from hospital on 27th March 1996 when the doctor stated that his right leg injury has left him with an 80% disability with wounds that would take 6-7 months to heal. The left leg injury had already completely recovered. The doctor recommended that the leg injury be treated as a leg loss for compensation purposes.

The sketch below is reproduced from the compensation file.



Compensation of $2,500 was awarded on 4th June 1996.

Analysis

The primary cause of this accident is listed as *"Field control inadequacy"* because the victim stepped on a mine in an area that had been cleared. Either the clearance or survey work was done carelessly, or the detector was unsuitable. The detector was found to be incapable of locating the target mine at the required depth - a failing which the supervisors should have identified before the accident. The secondary cause is listed as *"Inadequate equipment".*

A measure of management failure pertains because the limitations of the detector were known to management and no decision to use another had been made. The investigator's ignorance of the group's previous recommendations about how to use the detector (see Accident report) may indicate a lack of appropriate training.