10-20-1993

DDASaccident198

Humanitarian Demining Accident and Incident Database
AID

DDAS Accident Report

Accident details

Report date:	18/05/2006	**Accident number:**	198
Accident time:	13:10	**Accident Date:**	20/10/1993
Where it occurred:	Phum Sdao, Battambang Province	**Country:**	Cambodia
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Inadequate equipment (?)
Class:	Missed-mine accident	**Date of main report:**	30/10/1993
ID original source:	WH [date inferred]	**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:**	2

Map details

Longitude:		**Latitude:**	
Alt. coord. system:	GR: 896303	**Coordinates fixed by:**	
Map east:		**Map north:**	
Map scale:	MF: M1096	**Map series:**	
Map edition:		**Map sheet:**	
Map name:			

Accident Notes

no independent investigation available (?)

inadequate area marking (?)

inadequate medical provision (?)

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

inadequate metal-detector (?)

Accident report

A country MAC report, written by expatriate advisors and dated 20th October 1993, was found in the country MAC's files in January 1999. The following summarises its content.

The victim stood on a mine at approximately 13:10 and was "injured with left leg amputated". He was given first aid and evacuated by ambulance to Rattnak Hospital at 13:25. The victim was then evacuated by helicopter to Mongkul Borei Hospital "at 15:00".

The Site Manager stated that he heard an explosion at 13:10 and was informed that an accident had occurred. He organised the Medevac to Rattanak Mondul hospital (1km away) for initial treatment. He was asked by the investigator about marking safe lanes daily and stated that they were marked daily, but then said that they were not marked on the day of the accident. He was of the opinion that "someone laid the fresh mine in the cleared area". ["Marking" in this instance appeared to mean checking with a detector.]

The Platoon Supervisor said that he heard an explosion at 13:10 about 100m away. He ordered a sweep of the area to make a safe lane towards the casualty. He stated that the accident had occurred in an area cleared two weeks before and felt that "someone laid the fresh mine in the cleared area". He confirmed that the lane had not been "marked" that day. When asked about relations with the locals he said that they were cordial but that they were jealous of the Platoon's handsome salaries.

The Platoon Commander stated that he heard the explosion at 13:19 (time possibly incorrectly transcribed) and tried to evacuate the casualty, but was stopped by the supervisor who insisted on sweeping a lane first.

Conclusion

The investigators noted that this was the second time within 10 days that an accident of this kind had happened in a cleared area. While it could not be proven whether the mine was freshly laid, it was felt that the facts that the mine was on a well used path, no "strip" [mine belt] was found in the vicinity, and it was the second such accident in 10 days, made fresh laying likely. They concluded that SOPs were violated by not "marking" the safe lane that day, but stated that Medevac was handled very well by the local staff (international staff had been recently withdrawn), although it was felt that the speed of the evacuation might have been affected by the absence of a helicopter after UNTAC withdrew.

Recommendations

The investigators recommended that the "marking" of safe lanes on a daily basis must be enforced. Deminers must be made aware that no cleared areas should be considered safe. Also that alternative evacuation arrangements should be made for the post-UNTAC period. They advised that disciplinary action should be taken against the supervisor for failing to mark the safe lane on that day and that operation [medical] facilities should be set up 1-2 hours drive away.

Victim Report

Victim number: 252	**Name:** **Name removed**
Age: 25	**Gender:** Male
Status: deminer	**Fit for work:** not known
Compensation: US$1,440	**Time to hospital:** 2 hours 20 minutes
Protection issued: Safety spectacles	**Protection used:** not recorded

Summary of injuries:

INJURIES

minor Leg

AMPUTATION/LOSS

Leg Above knee

COMMENT

Apparent "salami" surgical amputations. See medical report.

Medical report

A letter dated 26th October 1993, written by a military doctor stated that the victim was airlifted from Sdau Hospital at 14:45, arriving at Mongkul hospital at 15:30 on 20th October. At that point the victim had only lost his left foot at the ankle, and his upper and lower right leg was bandaged.

Further details of the injury were written in French and detailed amputation of the left tibia, superficial fragment injuries to right leg; significant bleeding. [A second surgical amputation must have occurred.]

Compensation of US$1440 (40% x 30 x $120) was awarded on 25th November 1993. The original payment was for US$1,296 (36% x 30 x $120), but a letter dated 13th December 1993 pointed out that the victim lost his leg above the knee and not below as originally thought.

Analysis

The primary cause of this accident is given as a *"Field control inadequacy"* because it seems that a mine was missed during clearance - a situation that should have been avoided by the use of appropriate methods and adequate field control.

Given subsequent difficulties locating Type 72 AP mines with the Schiebel detector in use at the time, it seems likely that the mine was missed because the detector was unable to locate the mine. The secondary cause is listed as “Inadequate equipment”.

The investigator’s recommendation for an improved Medevac provision is the “inadequate medical provision” referenced under “Notes”.

Related papers

The order for an investigation was found in the country MAC's files. In it the investigator was asked to ascertain whether the mine was missed or planted deliberately. Photographs of the accident site and the air evacuation were also on file.