

4-15-1998

DDASaccident218

Humanitarian Demining Accident and Incident Database
AID

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DDAS Accident Report

Accident details

Report date: 15/05/2006	Accident number: 218
Accident time: not recorded	Accident Date: 15/04/1998
Where it occurred: Near Ljubine	Country: Bosnia Herzegovina
Primary cause: Management/control inadequacy (?)	Secondary cause: Inadequate training (?)
Class: Victim inattention	Date of main report: [No date recorded]
ID original source: TA	Name of source: BiH MAC
Organisation: Name removed	
Mine/device: PMA-3 AP blast	Ground condition: rocks/stones
Date record created: 16/02/2004	Date last modified: 16/02/2004
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 investigation (?)

inadequate training (?)

Accident report

No formal accident report was made by the Country MAC. A brief report was made by an ex-pat Technical Advisor on behalf of the appropriate government office. Notification that the accident had occurred was delayed because the responsibility for reporting the accident was believed to lie with the QA group rather than the demining group. The content of the report and of a brief letter from the demining group to the UN MAC are summarised in what follows.

The victim was one of a team of QA monitors who the demining group's contract required to be present on site during all work.

The mined area was one of the "old defensive line held by Serbs against the Croats from the nearby town of Stolac. The demining group were conducting survey work in the area and had been on site for "several days". The area was described as very barren with open

countryside and many suspected minefields. The minefields being surveyed were expected to be faced by other minefields. The devices found had been "mostly" fragmentation mines.

The site was a "very large location" over rocky terrain. The mined area being surveyed was around 40m deep and over 600m in length. The surveyors had only located fragmentation mines and tripwires at that time. Mines could be seen to the left of the direction of survey, so a decision was made to change direction to follow the visible mines.

The monitor was reported to have walked the baseline to the end of the clearance site where a deminer was cutting a new lane in the revised direction. The deminer stopped work as the monitor approached (having completed around 5m). The monitor walked to the end of the clearance lane and on into the uncleared area, then on through an access route separating the fields.

The deminer challenged him and he said "no problem" and walked on. After 25 metres he trod on a PMA-3 and was injured. He had stepped on a rock that had a mine beneath it. [He may have been using the rocks as stepping stones.] The team conducted a CASEVAC operation. They believed that the victim had probably sustained broken bones in his foot.

The demining team stopped work and withdrew to base, leaving the site ready for the Accident investigation.

The victim had been working since June 1977 and had "recently attended a QA and Accident Investigation course".

Conclusions

The investigator concluded that the accident occurred as a result of the victim's "total disregard of the inherent dangers of the area and [his] failure to conform to normal work procedures.

Recommendations

The report made no recommendations.

A sketch of the site was on file - showing that that the victim was walking along a marked path (flanked by low stone walls) when the accident occurred.

Victim Report

Victim number: 282	Name: Name removed
Age:	Gender: Male
Status: supervisory	Fit for work: presumed
Compensation: not made available	Time to hospital: not recorded
Protection issued: Not recorded	Protection used: not recorded

Summary of injuries:

INJURIES

minor Foot

COMMENT

No medical report was made available.

Analysis

The primary cause of this accident is listed as a "*Management/control inadequacy*" because it seems likely that the victim ignored basic safety requirements and there was no one on the site with authority to stop him. It seems likely that he had been inadequately trained and did not understand the risk he was taking, so the secondary cause is listed as "*Inadequate training*".

The victim was a QA monitor on the site [provided by the government] to ensure that the operation was carried out in accordance with approved procedure.

It is possible that the victim was stepping on stones as he moved forward and was fortunate that the mine that initiated beneath the stone was small and the stone protected him from blast wave damage. Alternatively, he may have been fortunate and stepped on the side of the PMA-3 and so avoided treading on the HE charge in the centre.

The injuries resulting from stepping on a PMA-3 vary from traumatic amputation to minor bruising. The picture below shows why this happens. It shows a cut-away section through a PMA-3. The 35g Tetryl is in the top and centre of the mine. The area of pressure-plate surrounding the HE is actually larger than the area of pressure-plate over it. If a victim is fortunate, they step on the pressure plate but the explosive charge is not beneath their foot.

