

DDAS Accident Report

Accident details

Report date: 17/05/2006	Accident number: 174
Accident time: 10:55	Accident Date: 23/12/1996
Where it occurred: Ou Andoung, Battambang Province	Country: Cambodia
Primary cause: Field control inadequacy (?)	Secondary cause: Inadequate training (?)
Class: Other	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: grass/grazing area
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 training (?)
incomplete detonation (?)
mine/device found in "cleared" area (?)
inadequate investigation (?)
no independent investigation available (?)

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 not known whether the group had changed from three-man to two-man teams at this time].

No formal accident report was on record at the country MAC in January 1999. A short report on the accident written in Khmer was among the paperwork and the following summarises its content.

The victim was told to get a marking stick by his supervisor. While he was doing so, he stood on the "booster" of a PMN-2 that had been "destroyed" on 20th December 1996. The "booster" had lain hidden in a clump of grass 2m (or 4m on an attached sketch-map) from where the mine was "destroyed". The "booster" left a crater of 10cm diameter x 5cm deep.

[The PMN-2 booster is in a plastic well accessible from the underside of the mine. It is initiated by a detonator which must also have been in place. This implies that most of the lower half of the mine was in one piece after it had supposedly been destroyed.]

A poor quality photograph of the victim's boot, some photographs of the accident site and a sketch map of the area were in the file.

Victim Report

Victim number: 221	Name: Name removed
Age:	Gender: Male
Status: deminer	Fit for work: yes
Compensation: not made available	Time to hospital: 2 hours 5 minutes
Protection issued: Safety spectacles	Protection used: not recorded

Summary of injuries:

INJURIES

minor Legs

COMMENT

See medical report.

Medical report

A medical report recorded that the accident occurred at 10:55 and the victim arrived at Battambang Provincial Hospital at 13:00. The victim had a deep cut in the sole of his right foot measuring 1.5cm x 2cm x 1.7cm, a damaged toe, a superficial injury to his left shin (measuring 8cm x 6cm) and a deep cut on his right shin (measuring 7cm x 5cm x 1cm). The prognosis was that he would recover and go back to work.

Failure to award compensation may be inferred from the absence of a record. The Victim's return to work is inferred.

Analysis

The primary cause of this accident is listed as a "*Field control inadequacy*" because the supervisors failed to ensure that the device was properly destroyed or that the parts of a disrupted device were found and moved to the scrap area.

This accident illustrates the dangers involved in destroying/deflagrating mines. The PMN-2 is constructed with its main charge in one half of the body of the mine: placing a charge against the other side is unlikely to cause a sympathetic detonation.

If the mine had been detonated, the "booster" and detonator would have been initiated and no dangerous parts left. Complete deflagration achieves the same end. A plastic explosive

charge is much easier than TNT blocks to place in good contact with the side of the mine and so ensure a shock-wave transfer and a detonation of the mine.



The HE in the PMN-2 is cast into one side of the mine, then it is usually lacquered. It is black in the picture above.

The failure to ensure that the field supervisors and deminers knew how to destroy a PMN-2 mine is an apparent failure of training. The secondary cause is listed as *"Inadequate training"*.