

"Unloaded" Gun Wounds



A similar training session with a .50-caliber gun went astray when someone accidentally depressed the trigger while preparing to stow the weapon.

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It was early morning, and all 10 of a ship's .50-caliber gun mounts were manned for a live-firing exercise. The targets were Mk-58 smoke floats. As the ship approached the targets, the gun-control officer (GCO) ordered all mount captains to lock and load their weapons.

Moments before commencing fire, however, the GCO determined the mounts on the port side didn't have a clear range. He called, "Foul range, port side," and ordered all mounts on that side to clear their weapons, report when clear, and stand by. When the port-side mounts had carried out this order, the mounts on the starboard side engaged the target smoke floats.

The ship wasn't able to maneuver to provide a clear range for the port-side gun mounts, and the GCO ordered them to verify clear weapons. When all port mounts had reported weapons clear, the GCO told them to restow all gear and secure.

Members of a gun team had removed their weapon from its mount and were preparing to stow it in the 03-level locker. As they placed the gun on the deck, someone accidentally depressed the trigger and fired a round that penetrated an angle iron in the overhead and then sliced through the flight deck. Fragments from the round hit all six members of the gun team,

and they were treated for minor injuries.

Based on my personal experience, I know several controls are in place to prevent mishaps like this one. However, there's no way to control a factor like personnel error. The best we can do is try to limit the effects of such problems by using the five-step operational risk management (ORM) process.

Let's see how ORM could have been applied to this incident. In step one (*identify hazards*), we have to list inadvertent discharge. Step two (*assess hazards*) suggests we use the risk-assessment-code matrix. Using this matrix, we come up with a risk-assessment code of 1, based on a probability of B, and a severity of category I. One option in step three (*make risk decisions*) would be to assign a safety observer at each mount. For step four (*implement controls*), we could cycle the gun manually, then visually inspect the breech to make sure it is clear. In step five (*supervise*), we would be looking for any changes in the situation, and the mount captain would provide quality assurance.

The Sailors in this case escaped with only minor injuries. Many others in similar situations have died or suffered severe injuries. ☹

The author was assigned to the Naval Safety Center when he wrote this article. Send comments or questions on this article to afloat@safetycenter.navy.mil.