



The slide has a similar background to the title slide, with a textured, light brown surface. A diamond-shaped logo is visible in the bottom-left corner. The main content is contained within a white rectangular box with a brown border. At the top of this box, the text "LP Testing" is displayed in a large, bold, blue font. Below this, the text "Subject: testing of LP Shock Star 9000 ms, R&amp;D test after 30 days – 50 C in PAPE bag ." is written in a blue font. This is followed by two bullet points, each starting with a blue diamond symbol. The first bullet point reads "Cause – ST rupture close to the crimping point, operator did not follow precisely operating instructions". The second bullet point reads "Countermeasure – lesson learned from this event info to all employees / safety delay blocking of the door to the testing room 1 min. / change of testing procedure .".

## 2. LP Testing - data

- ◆ R&D department – build. 57
- ◆ R&D stability test of LP's
- ◆ 5 detonators Shock Star 9000ms
- ◆ Manual sequencing and operation
- ◆ Digital display to control the data
- ◆ R&D staff only
- ◆ January 2004 , right after winter SD

## 2.LP testing - flow

PREPARATION OF LP DETONATORS ( 5 pcs - 9000 ms )	<ul style="list-style-type: none"> <li>■</li> <li>■ Vokounová + Urbanová</li> <li>■</li> </ul>
INSERTING DET. INTO TESTING BOXES	<ul style="list-style-type: none"> <li>■</li> <li>■ Vokounová + Urbanová</li> <li>■</li> </ul>
MANUAL SEQUENSING : SHOT, TIME RECORD, SWITCH TO NEXT SHOT	<ul style="list-style-type: none"> <li>■ Urbanová operated the sequential testing while Vokounová was standing by the door</li> <li>■</li> </ul>
REMOVING OF RESIDUAL DETONATOR AND ST	<ul style="list-style-type: none"> <li>■</li> <li>■ Vokounová + Urbanová</li> <li>■</li> </ul>
VISUAL INSPECTION AND CUT OFF DET FROM ST - SEPARATION OF WASTE	<ul style="list-style-type: none"> <li>■</li> <li>■ Vokounová + Urbanová</li> <li>■</li> </ul>



## 2. LP testing- process

Operator inserted 5 LP's into testing boxes. Initiation start and switch for the next shot is sequential.

After 1st shot operator checks the delay time, records it and switches for next shot. This procedure repeats 5 times.

4th time delay at the display was 10,8 ms instead 9000ms. **The signal was taken from ruptured ST but 4th det was burning !** Operator recorded 10,8 ms , thought that it is misfire and switched for the next 5th detonator.



## 2. LP Testing- process

**Thinking that she is measuring 5th det – the last one, she registered time of detonation, but it was the 4th one with time 93 ms . The 5th one was burning at that time ! ) .**

Considering that the test is over ( she- they have heard 5 shots ) she entered the test room „ **earlier than she should** „ and by coincidence she started to pull out the detonators from the 5th – last position .

Than the last one exploded just when she was pulling it out of chamber.



## 2. LP Testing-process

She had light injury of the skin on fingers and paunch by Al shell fragments .

She was off 3 weeks .

Cause : ST rupture close to crimping point, operator did not pay enough attention to the testing activity ( different sound effect of ST and detonator is recognizable , she did not wait 1 min. after the test finished to enter the room , by coincidence she pulled out 5th detonator first.



## 1.LP testing- foto

LP testing event foto  
documentation .

## 2. LP testing- actions

### Countermeasures :

- Info to all employees
- Safety delay time switch on the test room door preventing to enter the room early than 1 min. after the test finished .
- Change the procedure with LP's in respect to min. time of next operation must be nominal time of the detonator + 1 sec . ( loading line, final assy, testing )

## THANKS FOR YOUR ATTENTION

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