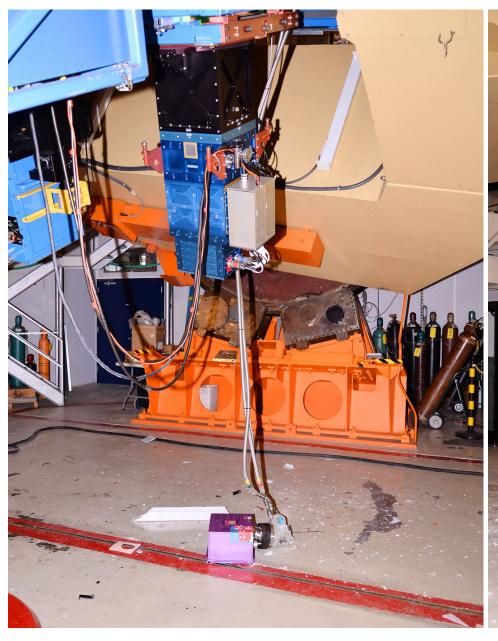
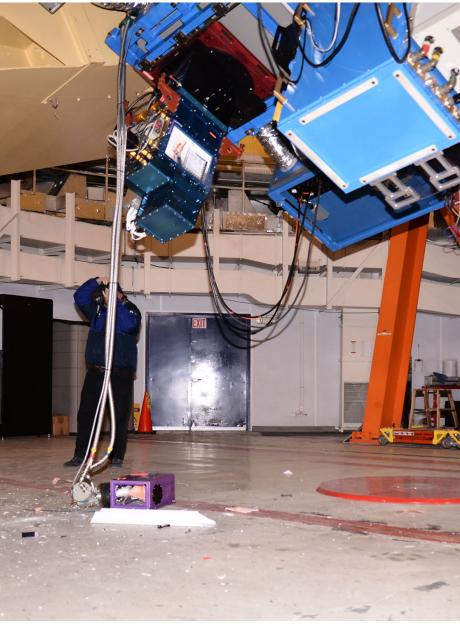
### **NSFCam Explosion**

What Happened and Lessons Learned
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#### Chain of Events

- Facility work used extra power, reducing effectiveness of water chillers.
- Not enough cooling capacity to keep 3
  instruments cold. Decided to warm NSFCam
  at 1 pm (not scheduled for a while).
- Exploded at 9 pm.

# Why Did NSFCam Explode

- Pre-charge can normally empty, used to cool NSFCam from ambient only.
- Cap used to keep air from cryopumping into can. O-ring seals with pressure release valve.
- Poor design allowed cap to be installed incorrectly.
- Design change to cap deleted tubes, which would have prevented incorrect install





## A few good things

- No one hurt
- Detector survived
- All filters survived
- Retired pre-charge can design
- We can warn others

### Lesson's Learned

- 1) Murphy's Law. Safety critical parts must be designed so they cannot be incorrectly assembled.
- Complex chain of events. Design of safety harware needs to be able to handle unforseen events.
- 3) Design changes must be carefully reviewed, especially for safety critical hardware.

#### **Actions Taken**

- External investigation and report
- Removed pre-cool box from CSHELL. Won't use this design again.
- Burst disk added to iSHELL design
- Other near-misses have lead to changes:
  - Different electrical connector sizes (color coding is NOT enough)
  - Instrument rotation stops