TO: THOSE CONCERNED


James D. Kelly
President

SAFETYAUDIT(MS):smf
November 14, 1986

James D. Kelly, President  
United Steelworkers of America  
Local Union 8031

Dear Jim,

SUBJECT: UNION SAFETY COMMITTEE AUDIT IN BUILDING 771

Comments on the task force audit are generally based on professional testimony, documented facts, and personal observations; brought forth in this audit by hourly personnel in Building 771. We must highly commend the hourly personnel that came forth to present this type of professional testimony and for their efforts to provide and enhance the safety in their work area. We certainly appreciate Gary Huffman, Co-Chairman of the Task Force Audit for his in-depth investigation, trying to obtain the facts; and for his consideration toward employees and their problems in a effort to provide a safer work environment.

This Department of Energy (DOE) Audit was constructed on the concept that the worker, being more familiar with the work area, would be more capable of providing pertinent information and a valid description of his/her working environment. The Union agrees with this method of investigation.

Many of the safety issues brought forth by the employees have been brought to the attention of management, prior to this particular audit, with no meaningful results. Such areas include, Training and Certification, Contamination Control, Procedures, HF System, Dosimetry, and morale.

All of the safety issues that were brought forth in this audit certainly need immediate attention and we feel this can be accomplished with the combined efforts of all parties concerned without curtailing any production activities.

The United Steelworkers of America (USWA) will now await the attention given to the many serious problems in Buildings 771 and 774 which have been raised in this audit. With the proper encouragement and help of ALL parties, success will be achieved. If as in the past, a whitewash is the result, then everyone and particularly the workers, will have lost.

Greg Overholt  
Union Safety Committee

Nancy James  
Union Safety Committee

Bruce Carr  
Union Safety Committee
October 16, 1986 -

1. 628 Safety complaint was presented at interview. Regarding possible criticality in Building 774 due to procedure in Research and Development Project.
2. [Redacted] will obtain Nuclear Criticality Specialist from Albuquerque.
3. Employee presented 13 other items relating to safety that was brought to the attention of management, but was never rectified approximately 2 years.

October 17, 1986 - Briefing with [Redacted]

1. Findings from first week of investigations, showing several deficiencies in operations.

October 17, 1986 -

1. Re-work of materials from outside contractors.
2. Bad welds - reworked by Rockwell, poor workmanship and penetration.
3. Many work orders issued to fix items obtained from outside contractors.
4. Possible low grade of stainless used by outside contractors.

October 20, 1986 -

1. General housekeeping of Building 771, (refer to Safety Concern 86-84.)
2. Report of Fire Department 100 pg. on Violation of Safety in Building 771.
3. Non compliance of Safety Concern resolution on positioning operation Air Heads on incoming new lines.
4. New lines are turned over to Production without proper training.
5. Asbestos in Room 146 has not been removed or identified creating possible health hazard. Operational Safety Analysis' being removed from lines and placed in managers office.

October 20, 1986 -

1. No shielding on East side of Line 3 creating excessive exposure to operators.
2. Due to TSA audit beautification of Building took precedence over real safety items.
3. Felt [Redacted] uses intimidation, and sexual discrimination as a means of management.

October 20, 1986 - pm shift -

1. Received HF inhalation during evaporator draining procedure due to water in HF evaporator.
2. Decisions on safety procedures to drain evaporators were made by [Redacted] and management.
3. These decisions were grossly negligent on the part of management and [Redacted]. Many medical effects were experienced by employee.
4. Personal Doctor confirms HF inhalation while on site. Doctor ridicules and negates diagnosis. Management took no corrective actions but instead intimidated and ridiculed employee, and continues to do so.

5. Employee feels  and  continuously harasses her because of this incident.

October 20, 1986 -

1. Management uses intimidation as form of management.

2.  uses sexual discrimination.

October 21, 1986 -

1. Perceives to have received an HF exposure.

2.  allowed her to use substandard safety equipment.

3. Chest hurt that night, headache. The next morning felt alright, probably had a HF inhalation said Dr. . In March had a pancreas attack, had vomiting in Medical then threw up blood. Went to Boulder community, felt movement in stomach. Liver spleen grossly enlarged in October. Became anemic in December of 1985 and had another pancreas attack. Checked for cancer, her spleen was inflamed in body. She had chronic illness in body and they needed a bone marrow. It was abnormal in December as well. December 13, 23, 1985 did a kidney liver biopsy, autogram liver, is fibrous it was not from drinking and/or drugs.

Used face shield and acid top covering without any respiratory protection. Removed 38 to 40 4-liter bottles of HF. During process employee had to run out of room twice because of toxic fumes.

October 21, 1986 -

1. Positioning of Gloves - Double or triple time of exposure as a result of glove position on Line #7.

2. No involvement available for Chemical Operators to participate in design.

3. Handling of parts in Line 4, too much exposure

4. Inventory receives too much exposure, input by operators most important

5. Attitude problems started upon arrival , "We don't work for management, we work for ourselves and the only pat on the back you get down here is from God."

6. Workers that do a good and safe job get crap work, creating higher exposure rates to certain individuals.

7. Three people stated most problems stem from .
Contamination Control
Immediate attention and action. Surveys are not being done, and contamination not being decontaminated in a timely manner.

Work Permits
Attention required. All responsible users are not going to the location to sign off the work permits.

Human Factor

Emergency Care
Attention required. A need for more medical personnel on off shifts.

Personnel Exposure
Immediate attention and action. There is no movement of personnel on lines so there is a more continuous exposure to certain employees for long periods of time.

Chemical Analysis

Equipment Design
Attention required. Employees, which have hands-on experience, are not being included or asked for suggestions on equipment design.

Operational Readiness
Immediate attention and action required. There is NO operational readiness program. A program needs to be implemented immediately for safety. New lines are not being checked before starting up.

External/Internal Dosimetry
Immediate attention and action required. Rocky Flats has state-of-the-art equipment necessary to provide proper analysis and results. However, due to the management techniques and attitudes these analysis and results are inappropriate, which results in a lack of confidence and trust in this program which is essential to the workforce.