

DEFENSE NUCLEAR FACILITIES SAFETY BOARD

April 24, 2020

TO: Christopher J. Roscetti, Technical Director
FROM: B. Caleca and P. Fox, Hanford Resident Inspectors
SUBJECT: Hanford Activity Report for the Week Ending April 24, 2020

Hanford Site: Hanford site DOE and contractor management continue to follow federal and state guidance to reduce the transmission of the novel coronavirus disease (COVID-19) (see 4/17/2020 report). The Richland Operations/Office of River Protection manager has extended the current essential mission critical operations posture through May 4, 2020. Partial stop work orders related to non-portable activities that cannot be performed in a safe and compliant manner due to COVID-19 pandemic response actions and applicable guidelines have been extended through May 23, 2020 unless rescinded earlier by DOE. Activity on site increased over the last week to support the planning necessary to enable the eventual resumption of work. Ongoing efforts also focus on developing criteria for phased work resumption, prioritization of work activities, and sequencing and coordinating work resumption activities, such as prioritization of worker training and personal protective equipment consumption, among the various site contractors.

In December, DOE awarded the Hanford Mission Essential Services Contract to Hanford Mission Integration Solutions LLC (HMIS) (see 12/6/2019 report); the HMESC contract covers site support activities similar to those performed under the expiring Mission Support Contract. Another bidder subsequently protested the award. This week, the U. S. Government Accountability Office denied that protest. That denial clears the path for DOE to move to the new contract and DOE will determine the appropriate time for the change after evaluating transition requirements and activities in light of the conditions that exist due to the current COVID-19 pandemic response.

Tank Farms: Tank Farms Operations Contractor (TOC) personnel completed their investigation related to a recent discovery of contamination on material in a radiological material area (RMA) that was not posted as a contamination area (see 3/6/2020 report). The event investigation also included an apparent cause analysis. The investigation determined that the material that was the source of the contamination found in the RMA went from a contamination area (CA) to a radiological buffer area to the RMA without receiving a radiological survey. It also determined that the material was not removed from the contamination area at the step off pad for the area. The causal analysis team subsequently determined that the relevant TOC radiological control procedures do not have formal criteria for material release at contamination area boundary locations other than at the CA step off pad. Consequently, the methods used by radiological control personnel at other boundary locations varies from individual to individual and can result in confusion regarding what material has been released or not released. Additionally, they noted that ad hoc practices in the field do not ensure rigorous segregation of material that has received a release survey from material that is awaiting survey. Corrective actions identified in the report focus on the development and communication of appropriate protocols to prevent similar future events.