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Department of Energy
Washington, DC 20585

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DNF SAFETY BOARD

Honorable John T. Conway
Chairman
Defense Nuclear Facilities Safety Board
Suite 700
625 Indiana Avenue, N.W.
Washington, D.C. 20004

Dear Mr. Chairman:

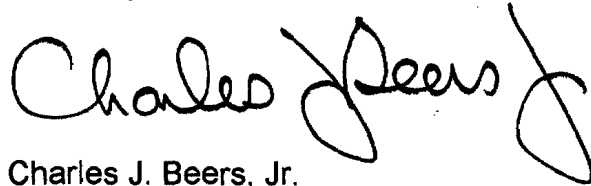
The July 1995 deliverables called for in the Department's Implementation Plan for Defense Nuclear Facilities Safety Board Recommendation 94-4 are enclosed.

Deliverables include: the criticality safety assessment program incorporating Commitments 2.1 and 3.4; Commitment 3.1, the Lockheed Martin Energy Systems Report Y/NO-00005, "Lockheed Martin Energy Systems Assessment Criteria for the Evaluation of the Oak Ridge Y-12 Plant Nuclear Criticality Safety Program;" and Commitment 7.1, the Quarterly Report containing an update of activities occurring between April 1 and June 30, 1995.

One outstanding deliverable, Commitment N.2.5(a), the Office of Environment, Safety and Health (EH) assessment of its role in oversight of Y-12 safety issues has been forwarded separately. Also included is Change 2 to the Implementation Plan.

If you have any questions, please contact me or have your staff contact Phil Aiken of my staff at (301) 903-4513.

Sincerely,

A handwritten signature in black ink that reads "Charles Beers, Jr." with a stylized flourish at the end.

Charles J. Beers, Jr.
Rear Admiral, U.S. Navy
Deputy Assistant Secretary for
Military Application and
Stockpile Support
Defense Programs

Enclosures

cc w/enclosures:
M. Whitaker, EH-9
D. Knuth, DP-30

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DNF SAFETY BOARD

Criticality Safety Assessment Program
for
Defense Nuclear Facilities Safety Board
Recommendation 94-4
*Deficiencies in Criticality Safety
at Oak Ridge Y-12 Plant*



July 1995

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DEFENSE NUCLEAR FACILITIES SAFETY BOARD

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Criticality Safety Assessment Program
for
Defense Nuclear Facilities Safety Board
Recommendation 94-4
*Deficiencies in Criticality Safety
at Oak Ridge Y-12 Plant*

Approved by:



Milton Haas, EH-34
Co-Team Leader

7/11/95
Date



Jim Winter, DP-31
Co-Team Leader

July 11, 1995
Date

ACRONYMS

ANL	Argonne National Laboratory
ANS	American Nuclear Society
ANSI	American National Standards Institute
CAAS	criticality accident alarm system
CoO	Conduct of Operations
CS	criticality safety
CSA	criticality safety approval
DNFSB	Defense Nuclear Facilities Safety Board
DOE	Department of Energy
DOE-HQ	Department of Energy Headquarters
DP	Office of Defense Programs
EH	Office of Environment, Safety and Health
ESS	Energy Systems Standard
LANL	Los Alamos National Laboratory
LMITCO	Lockheed Martin Idaho Technology Company
LLNL	Lawrence Livermore National Laboratory
LMES	Lockheed Martin Energy Systems, Inc.
M&O	Management and Operations
NCS	nuclear criticality safety
OSR	operational safety requirements
OR	Oak Ridge Operations Office
PNL	Pacific Northwest Laboratory
SAIC	Science Applications International Corporation
SAR	Safety Analysis Report
SNL	Sandia National Laboratory
SMS	Systematic Management Systems
USQD	unreviewed safety question determination
WHC	Westinghouse Hanford Company
WSRC	Westinghouse Savannah River Company
Y-12	Oak Ridge Y-12 Plant
YSO	Y-12 Site Office

Preface:

This Assessment Program is intended to support the Department of Energy (DOE) Implementation Plan in response to the Defense Nuclear Facilities Safety Board (DNFSB) Recommendation 94-4, *Deficiencies in Criticality Safety at Oak Ridge Y-12 Plant*. The program provides guidance for performing two independent evaluations. One involves operational safety requirements (OSR), criticality safety approvals (CSA), and procedures that support OSRs and CSAs. The other focuses on the Criticality Safety Program at Y-12. The reviews will examine the effectiveness of procedural controls, the utility of criticality safety approvals, and whether the root causes of noncompliances were correctly identified in the pre-resumption reviews. Team members should use this program to evaluate the actions completed to date at the Y-12 Plant and the long-term posture of the operating contractor, Lockheed Martin Energy Systems, Inc. (LMES) and the Department of Energy (DOE) Oak Ridge Operations Office (OR) related to the adequacy and execution of the upgraded CSA and OSR procedures and the Criticality Safety Program.

The primary purpose of these evaluations is to help the site identify deficiencies and corrective actions associated with OSR and CSA compliance and the Criticality Safety Program at Y-12. The recommendations identified in the final report should be useful, manageable and intended to support institutional improvements. The recommendations should promote a positive standards-based, compliance culture that corrects the root causes of previously identified deficiencies. Return visits to the site may be required in order to help the site determine the effectiveness of the corrective actions associated with these assessments.

All parties should recognize that the assessment is an integral part of the Department's commitment to ensure the safety of workers, the public and the environment. All personnel involved in the assessment activity should share that common goal.

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1.0 Assessment Overview

The DOE Office of Defense Programs (DP) and the Office of Environment, Safety and Health (EH) will conduct joint assessments of the Oak Ridge Y-12 Plant during the Fall and Winter of 1995-1996. The assessments are in response to DNFSB Recommendation 94-4, *Deficiencies in Criticality Safety at Oak Ridge Y-12 Plant*. DP and EH will be co-leaders of a team of expert Management and Operations (M&O) contractors and consultants, specializing in criticality safety and operations. The team members will evaluate how well the Oak Ridge facility is complying with the OSRs and CSAs, perform a comprehensive review of the Criticality Safety Program at Y-12, and evaluate how the experience gained from similar reviews at the Pantex Plant, Rocky Flats Site, the Sequoyah Fuels Corporation, and the Los Alamos TA-55 facility can be applied to the Y-12 plant. In addition, the team will review previous CSA and OSR compliance assessments including findings and root cause determinations and will independently assess these areas. This program defines the scope, outlines roles and responsibilities, provides appropriate project management, and supplies the performance objectives, review criteria and approach for the assessment. A peer review team of nationally recognized experts in the field of criticality safety and operations reviewed and commented on the Assessment Program.

The assessment will be conducted in two phases: an independent evaluation of OSRs, CSAs, and safety significant procedures; and a comprehensive review of the criticality safety program at Y-12. The results from each phase of the assessment will be documented in separate reports and provided to the DOE 94-4 Senior Steering Committee. Once that committee concurs with the reports, it will submit them to the Defense Nuclear Facilities Safety Board to satisfy a Recommendation 94-4 Implementation Plan commitment.

2.0 Introduction

On September 27, 1994, the DNFSB issued Recommendation 94-4, which involved criticality safety deficiencies observed at the Oak Ridge Y-12 plant. The Recommendation described a September 22, 1994, event in which members of the DNFSB staff noted discrepancies between the CSA requirements and the configuration of storage

arrays while observing the unloading and storage of a weapon component. In responding to this identified violation of nuclear criticality safety limits, DOE and contractor personnel failed to take appropriate corrective actions in accordance with site procedures. Following the event, the operating contractor, LMES, stopped all nuclear operations at the Y-12 Plant.

The DNFSB Recommendation stated that reviews of adherence to nuclear criticality safety limits at the Y-12 Plant revealed widespread noncompliance. The Recommendation also identified weaknesses in key areas of the criticality safety program including procedures and conduct of operations, as well as DOE and contractor experience, training, qualifications and performance. In response to the DNFSB Recommendation, DOE established a Senior Steering Committee and a Senior Working Group to develop an overall strategy. In February 1995, DP issued the *Department of Energy Implementation Plan for Defense Nuclear Facilities Safety Board Recommendation 94-4, Deficiencies in Criticality Safety at the Oak Ridge Y-12 Plant*. The Implementation Plan describes plans and schedules for the phased resumption of activities at the Y-12 Plant. The following tasks were identified as part of the Implementation Plan:

- Task 1 – Organization
- Task 2 – CSA/OSRs
- Task 3 – Criticality Safety
- Task 4 – Conduct of Operations
- Task 5 – Technical Competence
- Task 6 – Corrective Actions
- Task 7 – Reporting Requirements
- Task 8 – Change Control

This Assessment Program evaluates the long-term programmatic improvements associated with Task 2, CSA/OSRs, and Task 3, *Criticality Safety*. The activities of Tasks 2 and 3 will be coordinated with those of Task 4, *Conduct of Operations*, and Task 5, *Technical Competence*.

A glossary of definitions specific to this assessment are included at the end of this plan.

3.0 Purpose

This Assessment Program provides the approach and guidelines for the independent assessments

described in the Implementation Plan. The assessment evaluates whether the Oak Ridge facility is sustaining resumption oriented commitments and whether the facility's longer term plans are consistent with Recommendation 94-4 and related LMES commitments already specified in the Task 2 portion of the Implementation Plan. The assessment will focus on the site's implementation of CSAs, OSRs, and the effectiveness of the Criticality Safety Program. The performance objectives for the Criticality Safety Program review will include staffing levels and qualifications; maintenance and change control programs; criticality safety evaluation processes including administrative controls and implementing procedures; and compliance with applicable DOE Orders governing criticality safety. A part of this assessment will also address the effectiveness of specific training on criticality safety. For each phase of the assessment, the team will prepare a final report that documents observations and suggests corrective actions.

4.0 Objective and Scope

The objectives of the Assessment Program are to perform an independent assessment of OSRs, CSAs and safety significant procedures, and conduct a comprehensive review of the Y-12 Criticality Safety Program. The Implementation Plan addresses these objectives as Task 2 and Task 3. This program provides effective methodology for accomplishing these tasks. The activities of Task 4, *Conduct of Operations*, will be coordinated with activities in this plan. The training process (e.g., methodology, instructor qualifications, etc.) will not be addressed as part of this program because it is being addressed in Task 5. However, the assessment will evaluate the technical content and effectiveness of specific training on criticality safety.

The assessment team will achieve these objectives through observations of facility activities, interactions with site personnel, review of procedures, review of corrective actions, tours of facilities, and inspections of equipment. In addition, the team members will evaluate how experience gained from similar reviews conducted at the Pantex Plant, Rocky Flats Site, the Sequoyah Fuels Corporation, and the Los Alamos TA-55 facility can be applied to the Oak Ridge Y-12 Plant. Appendix A, *Proposed Facilities List*, provides a preliminary listing of the facilities to be included as part of this

Assessment Program. The team leaders will decide which facilities should be assessed.

The following additional items are part of the Assessment Program:

- DOE and contractor management of criticality safety programs
- Applicable portions of completed Readiness Assessments
- Evaluation of completed actions in Near-Term Initiatives for Nuclear Criticality Safety
- Evaluation of corrective actions related to probable causes documented in the Type C Investigation
- Evaluation of corrective actions related to causal factors in the LMES internal report, *Evaluation of Criticality Safety Discrepancy Data*
- Assessment of progress by LMES in Phase III and IV activities involving criticality safety as defined in Y/AD-623, *Plan for Continuing and Resuming Operations*
- Any Special Operations that may be in progress at the time of the site visits. These include both one-time operations and those that will become part of standard operations as they are resumed.

Upon completion of each assessment, the team will prepare a final report documenting the findings, concerns, and noteworthy practices.

5.0 Team Composition

PEER REVIEW TEAM

B. Briggs, LMITCO – Criticality Safety
I. Fergus, EH-34 – Criticality Safety
J. Grise, Consultant – Operations
J. Pearson, LLNL – Criticality Safety

5.1 Peer Review Team

A peer review team of nationally recognized experts in the field of criticality safety and

operations and the members of the assessment team reviewed and commented on the assessment program. Appendix B, *Peer Review and Assessment Team Members Biographical Summaries*, summarizes the technical qualifications of each team member. The peer review team helped develop the performance objectives, review criteria and approach. The peer review team members are listed in the box on the preceding page.

Additional attendees at the Peer Review meeting included

M. Haas, EH-34, Assessment Co-Team Leader
J. Winter, DP-31, Assessment Co-Team Leader
W. Andrews, DNFSB Staff
R. Felt, EH-34
S. Puchalla, DP-24, Working Group Representative
S. Rosenbloom, EH-34
P. Ward, Consultant - Sciencetech, Facilitator
M. Williams, EH-3, Steering Committee Representative

5.2 Assessment Team Members

Members of the assessment team were selected on the basis of technical expertise, assessment experience, and knowledge of specific disciplines. The use of team members from a number of DOE sites promotes the exchange of good practices, lessons learned and diverse perspectives. These individuals are familiar with assessment methodology and know-how to conduct interviews, observe in-progress activities, and perform walkdowns of facility systems and equipment. The assessment team includes DOE technical experts, senior M&O contractors, and highly qualified consultants.

In addition, personnel from DOE-HQ and Westinghouse Savannah River Company (WSRC) will participate in a training role and will be called upon to assist more experienced team members. Any observations or concerns that these DOE-HQ and WSRC team members raise will only be considered if validated by their senior mentor. These additional attendees include

M. Crouse, WSRC
D. Galvin, DP-34
S. Rosenbloom, EH-34

Ms. Barbara Kneece, PNL, will provide administrative coordination.

ASSESSMENT TEAM MEMBERS

D. Friar, WHC – Criticality Safety
D. Heinrichs, LLNL – Criticality Safety
W. Hogle, Consultant/PNL – Operations
D. Outlaw, Consultant/SAIC – Criticality Safety
T. Reilly, WSRC – Criticality Safety
(Sub-Team Leader)
L. Restrepo, SNL – OSRs
M. Sharpsten, LMITCO – Safety Analysis
T. Taylor, LMITCO – Criticality Safety
S. Vessard, LANL – Criticality Safety
D. Vogt, Consultant/SAIC – Operations
A. Williams, Consultant/SAIC – Operations
(Sub-Team Leader)

6.0 Roles and Responsibilities

6.1 Team Leaders

The team leaders will be responsible for implementing this program and for managing the assessments. Prior to the onsite assessment, the team leaders will coordinate with OR and LMES personnel on logistics, required training, security access requirements, identification of counterparts, selection of facilities to be assessed, and assessment schedule. The team leaders will also be responsible for conducting the entrance and exit meetings with OR, Y-12 Site Office (YSO), and LMES personnel. The team leaders will be responsible for preparing briefings and ensuring development of the final report.

The team leaders will be responsible for conducting daily briefings with OR and LMES personnel to review observations, concerns and findings, and approve the daily schedule of activities with YSO and LMES (e.g., interviews, walkdowns, observations, and technical discussions). Team leaders will also be responsible for determining the validity of a finding identified by the team and resolving any conflicts between team members and OR and LMES personnel. The team leaders are responsible for collecting for use in the final report photographs and any pertinent reference materials. They are also responsible for coordination with Tasks 4 and 5.

6.2 Sub-Team Leaders

The sub-team leaders will be responsible for managing, on a daily basis, the conduct of the assessment, the logistics of their sub-team, and the written input by their team members for both assessment forms and for the final report.

6.3 Assessment Team Members

The team members have the responsibility to conduct a comprehensive review based on the criteria specified in Appendix C, *Task 2 Performance Objectives, Review Criteria, Approach and Expectations*; and Appendix D, *Task 3 Performance Objectives, Review Criteria, Approach and Expectations*. The team members will review the results of prior assessments, focusing on LMES and Y-12 findings, corrective actions, interim actions and post-resumption activities. They will document their review on the Assessment Forms found in Appendix E, *Assessment Forms*.

During the onsite assessment associated with Task #2, the team will:

- evaluate facility compliance with the OSRs and CSAs,
- determine the root cause of any recently identified violations, and
- evaluate how the experience gained from similar reviews at the Pantex Plant, Rocky Flats Site, the Sequoyah Fuels Corporation, and the Los Alamos TA-55 facility can be applied to the Oak Ridge Y-12 Plant. (Refer to Appendix F, *Lessons Learned From Rocky Flats Building 771, Pantex, the Sequoyah Fuels Corporation, and Los Alamos*).

During the onsite assessment associated with Task #3, the team will:

- conduct a comprehensive review of the nuclear criticality safety program at the Y-12 Plant including procedural controls, the utility of nuclear criticality safety approvals, and the root cause analysis of the noncompliances found during recent reviews.

The team will accomplish these tasks by independent verification, direct observation of

facilities (walkdowns), interviews with facility personnel, and review of documents and programs. Examples of background materials to be made available to the team members include the results of relevant prior assessments, the corrective action database, occurrence reports, root cause analyses, facility SARs, USQDs, OSRs, CSAs, criticality safety procedures, maintenance records, training records, etc. Additional reference materials are provided for team members in Appendix G, *DNFSB Recommendations 94-4, 93-6, and 92-5*.

Team members will be responsible for a daily summary of activities that will be provided to the sub-team leaders and utilized during the daily site management briefs and team meetings. The summaries will also be the basis for preparation of the draft report.

Additional team member responsibilities include the following:

- prepare and sign assessment forms,
- prepare assigned report sections,
- provide written descriptions of dissenting issues, and
- provide concurrence with the final report.

6.4 OR and LMES Personnel

OR and LMES personnel will be responsible for providing team members with site specific training and with the information they need for a comprehensive assessment. OR and LMES personnel will also be responsible for providing office spaces for use by the team.

OR and LMES personnel will be assigned as counterparts, responsible for providing technical assistance as requested by the team leaders. OR and LMES personnel will review the approved Assessment Forms and provide a response acceptance in Section IV of Assessment Form 2 (reference Appendix E). A signature line is provided for acceptance of the observation, concern or finding.

OR and LMES personnel, in conjunction with the team members, will then be responsible for establishing what corrective actions are needed to close any identified findings. In addition, OR will

provide the team leaders with photographs of the site processes and other specified reference materials for use in the final report. OR and LMES personnel will arrange for secure environments and equipment to support reviews of classified documents and activities. This would include classification reviews of any materials that the team members take offsite during the course of the assessments or at the conclusion. This is discussed further in Section 7.4.

7.0 Site Assessment Team Process

7.1 Organization and Training

Prior to the onsite assessment activities, site personnel trained the assessment team so they have unescorted access to the Y-12 facility. Training included LMES General Employee Training, Radiation Worker II, Criticality Safety, Emergency Preparedness, and Hazard Communications. In addition, root cause analysis training will be provided to some of the team members. Team leaders will certify that each team member is technically competent and has no direct connection with Y-12 operations that could affect their independence.

7.2 Protocol

The assessment requires an open exchange of information between team members, OR, and LMES. Successful communication between these individuals should include the following:

- The team leaders should hold entrance meetings with OR and the contractor to discuss the objectives of the assessment and obtain OR and contractor perspectives on assessment activities. The team leaders will brief OR and site management on the scope, purpose, and objective of the assessments and will obtain the current status of Y-12 operations. OR should provide the team with a listing of technical and administrative contacts within the Field Office and contractor organization at the time of the meetings.
- The site should identify technical and administrative contacts within the Site Office and contractor organization to assist the assessment team. These contacts should

facilitate information flow and logistics for the team.

- Candid discussions involving all parties are encouraged. However, information flow related to the formulation of observations, concerns, or findings will be formalized. Appendix E provides forms for this purpose. These forms will be administratively controlled to facilitate information flow and ensure that responsible elements in the Site Office and contractor organization are fully aware of, and involved in, responses to potential issues.
- Daily meetings should be held between the team leaders and facility management throughout the assessment. These meetings will be used to review observations, concerns and findings, and to arrange and schedule activities (e.g., interviews, walkdowns, observations, and technical discussions). Team leaders and team members should have daily meetings at the close of the business day to review assessment status and potential issues. The site's representatives are invited to attend these evening meetings. Published schedules should be used and activities planned to the maximum extent practical.
- At the end of the assessment, an exit meeting should be held between team members, Field Office personnel, Site Office personnel and the contractor to ensure that the issues identified are correct and reflect the most up-to-date information available. The purpose is to identify any outstanding concerns and review any suggested corrective actions.
- All parties should recognize that the assessment is an integral part of the Department's commitment to ensure the safety of workers, the public and the environment. All personnel involved in the assessment activity should share that common goal.

7.3 Procedure

7.3.1 Planning Activities

The team has conducted a preliminary site visit (June 5-9, 1995) for training and to resolve any pre-assessment issues. During the preliminary visit, the team selected buildings to be assessed,

and established lists of interviews, references and site counterparts. Training included LMES General Employee Training, Radiation Worker II, Criticality Safety, Emergency Preparedness, and Hazard Communications. Team members reviewed DNFSB Recommendations 94-4, 92-5, and 93-6 (refer to Appendix G); the DOE Implementation Plan; Y/DD 500, *The Y-12 Plant Nuclear Criticality Safety Program Description*; Y/AD-622, *Type C Investigation of the Y-12 Plant Criticality Safety Approval Infractions Event*; and other background information.

Team members were tasked with specific responsibilities within the Task 2 and 3 assessments and given opportunity to provide comments on this program during the preliminary site visit. Team leaders and sub-team leaders coordinated that review process.

7.3.2 Performance Objectives, Review Criteria, Approach and Expectations

The Assessment Program provides the necessary guidance for conducting the evaluations associated with Tasks 2 and 3. The expected deliverables are noted in Section 8.0. Appendices C and D contain the performance objectives, review criteria, approach, and expectations for each assessment. The criteria developed provide the basis for the team to conduct their work within the defined scope of the assessments. The criteria were based on the expertise of team members and of the peer review group of nationally recognized experts. The review criteria provide for interviews with personnel, reviews of procedures and programs, walkdowns of systems, and observations of facility conditions. The team members will be provided with suggested lines of inquiry for each performance objective. These lines of inquiry are not part of this plan. Team members are to use them as guidance when conducting the assessment process but the suggestions are not to be construed as limiting areas of inquiry.

7.3.3 Assessment Forms

Appendix E contains the assessment forms to be used by team members for documenting their review. Assessment Form 1 will be used for documenting the detailed review of each objective. Assessment Form 2 will be used to identify findings, concerns, observations, or noteworthy practices. Team members will discuss with the team leaders and contractor representatives all

issues raised prior to classification as a finding, concern or observation. Definitions of these and other terms can be found in the glossary.

Completed forms should be clearly written and provide sufficient detail. Team members will submit assessment forms to the team leader for review and approval. The team leader will then submit the Assessment Form 2 to OR and LMES personnel for their response. OR and LMES personnel will be responsible for reviewing the approved Assessment Forms and providing a response and acceptance in Section IV of Assessment Form 2. In the event that OR or LMES does not accept a particular observation, concern, or finding, the team leaders will be responsible for facilitating resolution.

7.3.4 Document Reviews, Facility Walkdowns and Interviews

An initial tour of Y-12 facilities was conducted during the June 5, 1995 site visit to familiarize the team members with the layout of facilities. Team members reviewed some key documents during the site visit. During the assessments, team members may conduct additional walkdowns to identify and characterize issues and concerns. A facility representative knowledgeable of facility conditions or site counterpart should accompany team members during these walkdowns.

Interviews may be required in order to gather information on a specific topic. Interviews will be scheduled after the document reviews and initial facility walkdowns. The assessment team will prepare suggested lines of inquiry that may be used for guidance in these interviews.

7.3.5 Lessons Learned Review

The observations and lessons learned presented in Appendix F are from similar criticality safety events and resumption efforts at Rocky Flats Building 771, the Pantex Site, the Sequoyah Fuels Corporation, and Los Alamos TA-55. Summaries of the events and lessons learned are presented in Appendix F so that team members may determine how the lessons learned at these facilities apply to the resumption activities at the Y-12 Plant. Team members will have available the full assessment reports in order to gain a better understanding of the applicability of these lessons learned to the Y-12 Site.

7.3.6 Root Cause Analysis and Corrective Action Review

Team members will review the results of the LMES near-term initiatives that have been completed for criticality safety, focusing on the adequacy of the root causes analysis and corrective actions. The team members will also evaluate the corrective actions related to the probable causes documented in the Type C investigation (Y/AD-622). In addition, team members will conduct a root cause analysis on all recently identified violations.

7.4 Classified Information Security

Some of the information needed to complete this assessment may be classified. This assessment will report as much information as possible in an unclassified form. All materials generated onsite (e.g., working notes, Assessment Forms, etc.) will be reviewed for classification.

The site will provide the necessary safeguards and security administrative support to the assessment team members. This will include providing secure environments and equipment. Areas approved for classified work should be identified during the site orientation, the week of June 5 - 9, 1995. The goal is to provide classified work support so that classified documents, notes, and discussions can be declassified through revision and interpretation so as to not impede the work of the assessment team. The scope of this administrative support includes:

- Secure work areas and areas outside security zones
- Access to unclassified and secure equipment (personal computers, laser printers, copiers, etc.)
- Unclassified and classified document storage
- Access to an authorized classifier
- Site classified documents
- Personnel access and badging
- Telephones (including access to secure telephones if needed)

The final report will also be reviewed for classification. To allow complete access to all

technical security areas, all assessment team members must have current Q clearances.

7.5 Required Reading List

The following required reading list has been developed to assist the team members in preparation for the assessments. Additional references are noted in Appendix H, *References*.

- Criticality Safety Assessment Program for Defense Nuclear Facilities Safety Board Recommendation 94-4, *Deficiencies in Criticality Safety at Oak Ridge Y-12 Plant* (latest revision)
- DNFSB Recommendation 94-4, *Deficiencies in Criticality Safety at Oak Ridge Y-12 Plant*.
- DNFSB Recommendation 93-6, *Maintaining Access to Nuclear Weapons Experience*
- DNFSB Recommendation 92-5, *Discipline of Operations in a Changing Defense Nuclear Facilities Complex*
- ESS-CS-101, *Nuclear Criticality Safety Program Elements*, Revision 0 (or latest revision)
- Implementation Plan for Defense Nuclear Facilities Safety Board Recommendation 94-4, *Deficiencies in Criticality Safety at Oak Ridge Y-12 Plant*, February 1995
- Y/DD-500, *The Y-12 Plant Nuclear Criticality Safety Program Description*
- Y/AD-622, *Type C Investigation of the Y-12 Plant Criticality Safety Approval Infractions Event at Building 9204-2E*
- Y/DD-623, *Plan for Continuing and Resuming Operations*, October 1994

8.0 Deliverables

Team members will prepare a draft report after the conclusion of the assessment. The report will document the review of the performance objectives and identify any observations, open concerns, and noteworthy practices. The report may contain corrective actions completed or proposed, along with implementation schedules. The Assessment

Forms will provide the basis for the final report and shall be completed and signed prior to departing from the site. Appendix I, *Final Report Outline*, provides the suggested format to be used for development of the final report.

Glossary

Concern – Any situation that is not in violation of any written procedure, but in the judgment of the assessment team member indicates less than optimal performance and could be an indicator of more serious problems.

Finding – A statement of fact documenting a deviation from an applicable Federal law, DOE Order, standard, safety requirement, performance standard, or approved procedure.

Noteworthy Practices – Practices that are notable and will have general application to other DOE facilities for the improvement of overall safety or performance.

Observation – Any situation that is not in violation of any written procedure or requirement, but in the judgment of the assessment team member is worthy of raising to the attention of site management in order to enhance overall performance.

Violation – For CSAs this would be considered a category IV classified incident or higher as defined in Y70-150, *Nuclear Criticality Safety*, (Change Directive May 18, 1993 or latest revision); for OSRs, this would be the threshold criteria defined in DOE 5000.3B, *Occurrence Reporting and Processing*.

APPENDIX A
PROPOSED FACILITIES LIST

Y-12 BUILDINGS INVOLVED IN RESTART

The following is a preliminary listing provided by LMES of buildings involved in the Y-12 restart program. Any and all facilities at the Y-12 site under DP cognizance that have CSAs and OSRs are subject to this review.

RECEIPT, SHIPMENT AND STORAGE OF URANIUM

9204-4
9720-5
9998
9204-2E

Y-12 DISASSEMBLY AND ASSEMBLY OPERATIONS

9204-2E
9204-2

Y-12 QUALITY EVALUATION OPERATIONS

9204-4

Y-12 ENRICHED URANIUM OPERATIONS

9720-32
9720-33
9723-25
9212
9995
9215
9206

Y-12 DEPLETED URANIUM OPERATIONS

9204-4
9201-SN
9201-5
9215
9996
9998
9212

APPENDIX B
PEER REVIEW AND ASSESSMENT TEAM MEMBERS BIOGRAPHICAL SUMMARIES

TEAM LEADERS

MILTON HAAS -- EH 34

Mr. Haas is a chemical engineer who began his career in 1960 as a leadman with the Coors Porcelain Company where enriched uranium-beryllia fuel elements were fabricated for the Tory II-C reactor, a part of Project Pluto. In addition to his operations responsibilities, he was designated as a nuclear criticality safety inspector. He subsequently joined the Chemical Engineering Division at Argonne National Laboratory and performed bench scale development in support of the fluidized-bed fluoride volatility reprocessing of reactor fuels. This work was performed with plutonium, uranium, and "mock" fission products. In 1973 Mr. Haas transferred to the EBR-II Project at Argonne West where initially he was special Projects Engineer for the restart of the Argonne Fuel Fabrication Line. Later, he led the driver fuel assembly group. At Los Alamos he participated in the shutdown of plutonium operations at DP West and the startup of aqueous plutonium/americium recovery operations and R&D at TA-55. Mr. Haas ultimately became the group leader of MST-12 (Nuclear Materials Process Technology), responsible for all aqueous plutonium processing at TA-55 and the Enriched Uranium Recovery Operations remaining at DP West. Concurrent to this assignment, Mr. Haas served on the Los Alamos Nuclear Criticality Safety Committee. In 1985 he moved to the Rockwell Hanford Operations (later Westinghouse Hanford Co.) and served in various capacities. These included management of three analytical laboratories in the 200 Area. Then at the Plutonium Finishing Plant, he served as Engineering Manager and later as the Deputy Plant Manager. Mr. Haas also served on the Safety and Environmental Advisory Council to the President of Westinghouse Hanford Company. Prior to joining the Department of Energy, EH-34, Mr. Haas was detailed to the Office of Facility Transition and Management, EM-60 at DOE Headquarters during 1993-1994, dedicated principally to the EM interests at Rocky Flats, and he served in the core group of the Plutonium Vulnerability as Deputy Team Leader for the Sandia and Argonne West assessments. He later co-authored the Plutonium Vulnerability Management Plan.

JAMES L. WINTER -- DP 31

Mr. Winter received a B.S. in Electrical Engineering from the U.S. Naval Academy, has continuing graduate education in the electrical power field, and is a registered Professional Engineer in the electrical field. He had over 11 years of diversified experience in Navy and commercial nuclear power prior to joining the Department of Energy in 1991. As a staff engineer in the Office of Engineering and Operations Support for Defense Programs, primary responsibilities have included managing upgrades and developing policy for DP facilities safety documentation (Safety Analysis Reports (SAR), Basis for Interim Operations, and Technical Safety Requirements (TSR)) and their implementation plans. Specific experience includes team leader responsibilities for the review and approval of the Replacement Tritium Facility FSAR, F-Canyon BIO and PHA, and FB-Line BIO and PHA. In addition, Mr. Winter contributed in the development of DOE Standards 3009 and 3011 associated with SAR and TSR content and implementation.

PEER REVIEW TEAM MEMBERS

J. BLAIR BRIGGS

Mr. Briggs is an Advisory Engineer at the Idaho National Engineering Laboratory (INEL). He has over 18 years experience in nuclear criticality safety. This experience includes over a year in operations at the Idaho Chemical Processing Plant with the remainder of his experience focused primarily on Nuclear Criticality Safety Analysis. Prior to the consolidation of contractors at INEL, Mr. Briggs was responsible for providing technical leadership in coordinating all criticality safety assessments provided by the EG&G Idaho Reactor and Radiation Physics Unit. This unit provided Criticality Safety support to all INEL contractors and to companies external to the INEL. During 1992/1993, he chaired a national working group that developed a DOE Standard entitled, *Guidelines for Preparing Criticality Safety Evaluations at Department of Energy Non-Reactor Nuclear Facilities -- DOE-STD-3007-93*. He has participated on the EG&G HS&E Transition Team for the takeover of the Rocky Flats Plant, and various other review teams at Rocky Flats, Hanford, and Lawrence Livermore National Laboratory. Since 1992, Mr. Briggs has served as the project manager of the International Criticality Safety Benchmark Evaluation Project (ICSBEP) that is chartered to identify benchmark critical data, verify and evaluate the data, and compile the data into a standardized format that will serve as an accurate basis document for future validation efforts.

IVON E. FERGUS

Mr. Fergus is a physical scientist in the Office of Engineering Assistance and Site Interface, Office of Nuclear and Facility Safety. He has nearly 25 years experience in nuclear criticality safety. He has worked in this capacity for approximately five years, performing assessments and reviews of various Department of Energy facilities and policies involving criticality safety. Mr. Fergus' prior experience includes being a member of the Three Mile Island-2 Safety Review Group while working for Bechtel National, Inc. He has 12 years additional experience as a criticality safety engineer/analyst, performing criticality safety evaluations and audits at both DOE and commercial nuclear facilities. This experience included eight years as a Criticality Safety Engineer, Idaho Chemical Processing Plant; one-and-a-half years as a Criticality Safety Analyst for Babcock and Wilcox Company at the Lynchburg Research Center; and two-and-a-half years as a Criticality Safety Analyst for General Electric Company at the Wilmington Fuel Fabrication Facility. Mr. Fergus holds a B.A. in physics and mathematics from the University of North Carolina at Wilmington and he has completed all course work toward a Masters of Nuclear Engineering from the University of Idaho.

JAMES E. GRISE

Mr. Grise is a Senior Executive Consultant with SMS Corporation. He holds a BS in Engineering and an MS in Marine Affairs. Mr. Grise has 34 years of experience in the engineering and nuclear fields. The first 29 years of his career were spent in the Navy, including 24 years in the Nuclear Propulsion Program. He spent six years as the Commanding Officer of two nuclear submarines. Post-submarine command tours included assignments in nuclear maintenance, operations, inspections, and training. As Commanding Officer of the Navy's largest afloat facility for nuclear plant repairs, he was responsible for the supply and repair of 13 submarines. In 1988, Mr. Grise retired from the Navy. Since that time, he has served as a consultant to the Department of Energy in the areas of training, inspection/appraisals, Operational Readiness Reviews, and as a Conduct of Operations monitor at various facilities. As a result of his Navy nuclear experience, he possesses expertise in most areas of nuclear operation and maintenance, particularly training, management, and inspection/oversight. Additionally, Mr. Grise has three years of experience at Savannah River Site, one and one-half years at Rocky Flats, and two years at Los Alamos National Laboratory. Mr. Grise has participated in Operational Readiness Reviews at K-Reactor, F-Canyon, and FB-Line at Savannah River Site, the Building 707 Corporate Operational Readiness Review at Rocky Flats and the Plutonium Facility Readiness Assessment at Los Alamos National Laboratory.

JOHN PEARSON

Dr. Pearson is a physicist and criticality safety specialist currently assigned as Deputy Division Leader of the Special Products Division of the Hazards Control Department at Lawrence Livermore National Laboratory. In this assignment, he also provides management oversight and technical leadership for the Criticality Safety Discipline at LLNL. Dr. Pearson has a B.S., M.A., and Ph.D. in physics from the University of California at Davis. He has fourteen years at the Critical Mass Laboratory at the Rocky Flats Plant designing, performing, and reporting critical assembly experiments for criticality safety use including three years managing the facility. In the ten years at LLNL he has performed criticality safety calculations and evaluations for nuclear facilities, nuclear weapons and nuclear components. He has served on the DOE Weapons Criticality Committee, the Executive Board of the Nuclear Criticality Safety Division of the American Nuclear Society (ANS), and an ANS consensus standards writing group. Dr. Pearson has also served as a criticality expert on numerous Transportation Safety Review Panels for the Department of Energy Albuquerque Office. He has authored or co-authored numerous journal articles and papers in the fields of nuclear physics, critical mass physics and nuclear criticality safety.

ASSESSMENT SUB-TEAM LEADERS

THOMAS A. REILLY

Mr. Reilly has 24 years of experience in the processes for the recovery of plutonium and uranium as implemented at the separation plants at the Savannah River Site. For the past 17 years Mr. Reilly has had both technical and managerial assignments concentrated on the nuclear criticality safety aspects of these operations. Mr. Reilly earned a Master of Chemical Engineering from the University of Delaware. Mr. Reilly is knowledgeable in the application of the DOE Orders and Standards and national consensus standards that are pertinent to nuclear criticality safety.

ALAN K. WILLIAMS

Mr. Williams has 43 years experience in design, development, operation, and management of chemical processes for the recovery of nuclear materials such as uranium, plutonium and americium. He is currently a consultant supporting DOE-HQ in conducting technical reviews. He has been a member of the ORR teams for B-559 startup and B-707 thermal stabilization at Rocky Flats, cold chemical runs for the Defense Waste Processing Facility and FB-Line at SRS, and restart of the Hanford 242-A Evaporator. He was a contributor to the DOE-DP study and criteria for interim storage of plutonium metal and oxide, a member of the working group for the ES&H Plutonium Vulnerability Study and Deputy Team Leader for the SRS assessment, is chairman of the EM-64 Surplus Materials Peer Panel, co-chair of the EM-60 Research Committee for response to DNFSB Recommendation 94-1, and member of the Technical Review Group for review of SARs for DWPF and West Valley Demonstration Project. Prior to joining SAIC, he was employed by Bechtel National as a project engineer and project manager on the SIS and PRMP projects, with Allied-General Nuclear Services where he was Vice President of Operations and Technical, and the Dow Chemical Co. at Rocky Flats Plant where he had increasingly responsible positions in process development, production support, and chemical operations for plutonium, americium and high enriched uranium.

ASSESSMENT TEAM MEMBERS

DENELLE E. FRIAR

Ms. Friar is a criticality safety specialist at Westinghouse Hanford Company (WHC). She has over 20 years experience in nuclear criticality safety. She has written criticality safety technical analyses and implementing documents for operations, conducted facility appraisals, and developed criticality safety programs and associated documentation. She has trained thousands of employees in criticality safety, including management, operations staff, crafts people, and administrative support personnel. She was acting manager of the WHC criticality engineering analysis group for over a year. Ms. Friar has been a member of the Executive Board of the Nuclear Criticality Safety Division of the American Nuclear Society, and a member of the writing group for ANS 8.20, the standard for criticality safety training. She has served on two assessment teams for DOE-HQ. Her current assignment is to assist the Rocky Flats site in developing a criticality safety program manual. Ms. Friar holds a BS in physics and a masters in business administration.

DAVID P. HEINRICHS

Mr. Heinrichs is a physicist, nuclear engineer, and criticality safety specialist in the Hazardous Control Department of the Lawrence Livermore National Laboratory (LLNL). Mr. Heinrichs performs nuclear criticality safety evaluations in support of fissile material operations at nine on-site nuclear facilities and three off-site operations at nuclear explosive facilities. His primary duties presently include the criticality safety of LLNL nuclear weapons, devices and components and liaison to the DOE Complex and DNA/military. Mr. Heinrichs is a member of the Weapons Criticality Committee, Nuclear Emergency Search Team and Accident Response Group. Mr. Heinrichs has over thirteen years of experience in the nuclear safety field with four and one-half years in his present position. Prior to joining LLNL, Mr. Heinrichs was a Senior Principal Criticality Safety Engineer at the Rocky Flats Plant and a Reactor Physicist for Middle South Utilities/Systems Services and Yankee Atomic Electric Company. Mr. Heinrichs holds a B.S. in physics and applied mathematics and an M.S.E. in nuclear engineering.

WILLIAM M. HOGLE

Mr. Hogle has over 20 years experience providing support in engineering, operations, maintenance, radioactive waste management, safety analysis, and management oversight for commercial nuclear power facilities and the Department of Energy. He is currently assigned as a principal consultant on various projects for the EH Office of Engineering Assistance and Site Interface and the EM Office of Safety and Health. Mr. Hogle has served on several assessment teams for DOE-HQ including HB Line, FB Line and F-Canyon at SRS, the Y-12 Plant at Oak Ridge, and the Portsmouth Gaseous Diffusion Plant. During these assessments, he was responsible for the areas of safety analysis, fire protection, maintenance and operations, configuration management, and engineering. He was a member of the ES&H Vulnerability Assessment Plutonium Working Group and the Savannah River Site Working Group Assessment Team. As part of the EM Worker Safety Improvement Program task team, Mr. Hogle worked with senior management at the Hanford, Idaho National Engineering Laboratory, Fernald, and Rocky Flats sites to improve workplace safety and health. He has authored several white papers for the Environmental Management Advisory Board on worker safety performance measures and has developed a worker safety indexing system for senior EM management. In addition, Mr. Hogle has participated in performance-based assessments for several commercial utilities and the Institute of Nuclear Power Operations. Prior to his work with DOE, Mr. Hogle was the Technical Support Systems Engineering Manager for Carolina Power & Light's Brunswick Nuclear facility. He holds a B.S. in Materials Science Engineering and a masters in business administration.

DOUGLAS A. OUTLAW

Mr. Outlaw is a PhD nuclear physicist with a broad safety-related background that includes university teaching, experimental nuclear physics research at a DOE accelerator laboratory and over 17 years of experience in safety analysis and assessment of non-reactor nuclear programs and activities for DOE, NRC, and NASA. Most recently, his efforts have included assisting DOE headquarters in development of nuclear safety guidance, review of specific nuclear safety concerns at DOE facilities, and serving as a nuclear facility safety expert to DOE for Technical Safety Appraisals and Operational Readiness Reviews of DOE facilities. Other recent related activities have included criticality safety evaluations, probabilistic risk assessments, hazards evaluations, accident consequence modeling, and the preparation of accident analysis portions of safety analysis reports, environmental assessments, and environmental impact statements for DOE, NASA, and others. He is currently serving as a Senior Program Manager and Senior Scientist at SAIC. Dr. Outlaw served as a technical expert in the areas of safety analysis, criticality safety, engineering support, and other safety-related areas for facility reviews of DOE Defense Programs facilities. Between 1991 and 1993, Dr. Outlaw served as a technical expert in eight DOE-HQ/DP-67 sponsored Technical Safety Appraisals of DOE major facilities, including Mound Laboratories, Lawrence Livermore National Laboratories, the Pantex Plant, the Nevada Test Site, and the Kansas City Plant. Since 1993, Dr. Outlaw has served on Operational Readiness Reviews for Zone 4 at Pantex and F-Canyon at the Savannah River Site. Among the areas Dr. Outlaw in which had the lead were safety analysis, criticality safety, emergency preparedness, and engineering support.

LOUIS F. RESTREPO

Mr. Restrepo has extensive experience and knowledge in implementing Code of Federal Regulations (10CFR), DOE Orders, Regulatory Guides, ANSI standards, and other industry standards in all areas of safety analysis, probabilistic risk assessment (PRA), and design of DOE nuclear facilities. He managed, contributed, and wrote close to two dozen safety analysis documents (SARs, SAs, OSRs, Tech. Specs, TSRs); prepared several other safety analysis documentation like USQs, ORRs; participated in DOE investigations and audits; and he has also developed guides on the implementation of DOE Orders including format/content guides to write safety analysis documentation. He also has experience as a graduate and undergraduate instructor in engineering physics and PRA. He is currently in charge of implementing and developing methods in PRA and preparing safety analysis documentation for various Sandia facilities. He has served as a consultant to the nuclear power industry, DOE facilities, and DOE in all phases of safety analysis and PRA activities, including training. He was the lead engineer at Rocky Flats, where he supervised and coordinated the technical work of the Safety Analysis organization, also developed and implemented state-of-the-art methods and calculations in PRA; he was a co-author and author of all the safety analysis documentation (SARs, SAs) and Operational Safety Requirements (OSRs) for their nuclear facilities respectively; and developed the guidelines for the design of high-hazard nuclear facilities. Mr. Restrepo is also familiar with over two dozen computer codes and tools to support PRA and safety analysis activities, he has over 40 publications and papers in these areas. Mr. Restrepo has a BS in mathematics/physics from Montclair State, a MS in nuclear engineering from Cornell University, a MS in health physics from Georgia Institute of Technology and is currently completing his dissertation for a Ph.D. in nuclear engineering at the University of New Mexico.

MICHAEL R. SHARPSTEN

Dr. Sharpsten is a senior technical staff member in the safety analysis unit supporting Lockheed Martin Idaho Technologies operations associated with nuclear fuel dispositioning at the Idaho Chemical Processing Plant (ICPP) at the Idaho National Engineering Laboratory (INEL). He has received a B.A. in chemistry from the State University of New York at Plattsburgh, NY and a Ph.D. in chemistry from Montana State University at Bozeman, MT. Dr. Sharpsten started work at the ICPP in 1985 as a process chemist in the operations support section of the technical department. Primary responsibilities included flowsheet development and support for counter-current solvent extraction reprocessing operations utilizing successive

purification cycles based upon tributylphosphate in n-dodecane and methylisobutyl ketone. Contributing work applied to head-end nuclear fuel dissolution flowsheets, uranium salvage processing, product denitration operations, and treatment/storage of high level wastes. Current work includes support to the generation of safety basis documents enveloping operations for nuclear fuel storage and high level waste treatment/storage. Major efforts being worked to transition the existing ICPP basis documents to currently required TSR DOE 5480.22 and SAR DOE 5480.23 formats. Dr. Sharpsten has participated in a number of safety assessment and vulnerability reviews and has been a member of the ICPP Radiation, Environment, Safety Committee since 1991. Contributing work has been provided to the Hanford Tank Waste Disposal Redefinition Peer Review (1991), the ICPP Tomsk-7 Lessons Learned Self Assessment Team (1993), and the ICPP dry product storage facility Operational Readiness Review (1995).

J. TODD TAYLOR

Mr. Taylor is the manager of the criticality safety group at the Idaho National Engineering Laboratory (INEL). Prior to his current position, Mr. Taylor was the Technical Group Leader for the criticality safety group at the Idaho Chemical Processing Plant (ICPP). Mr. Taylor has over 13 years of criticality safety experience, primarily with nuclear fuel processing and storage at the ICPP. Mr. Taylor was a member of the HS&E transition team for the Rocky Flats Plant and has been involved with evaluations/projects at Fernald and LLNL.

STUART G. VESSARD

Mr. Vessard is a criticality safety engineer at Los Alamos National Laboratory. His principal duties include the evaluation of criticality safety limits for LANL fissile materials operations and he is an instructor for the LANL nuclear criticality safety training course. Mr. Vessard received a BS in nuclear engineering from the University of Missouri at Rolla and an M.S.N.E. at the University of New Mexico. He began his career at General Electric in the fuel operations and testing unit. At the Los Alamos Plutonium Facility TA-55, he was responsible for plutonium waste management processes and was designated and served as the chairman of the Facility Safety Committee and the Criticality Safety Committee.

DOUGLAS K. VOGT

Mr. Vogt is a nuclear engineer with over 20 years experience in performing engineering analysis, safety analysis, and management oversight of commercial and government nuclear facilities. He has reviewed and analyzed activities at commercial nuclear fuel cycle facilities, nuclear power plants, and waste management facilities. He has experience with DOE research and production facilities. He has led or participated in safety analyses for numerous DOE facilities at Rocky Flats, LLNL and LANL. Mr. Vogt holds a Bachelor of Engineering Science and a Master of Science in Nuclear engineering, both from the Georgia Institute of Technology. Safety Analyses have included probabilistic risk assessments (PRA) for nuclear criticality accidents and the establishment of OSRs to prevent accidental nuclear criticality. He has assisted LLNL in developing and implementing an independent Conduct of Operations program.

SUPPORT

MICHAEL J. CROUSE

Mr. Crouse has three years of experience in nuclear criticality safety as it relates to the separation processes at the Savannah River Site. Recently, Mr. Crouse was involved in performing the criticality safety analysis in support of the SRS Solidification Facility Project (USF). The SRS USF is modeled on a similar facility as the Oak Ridge Y-12 plant. Mr. Crouse earned a Master of Nuclear Engineering degree from the University of Tennessee. Mr. Crouse has experience in the conduct of facility compliance assessments for site specific and DOE Order requirements.

DENNIS GALVIN

Mr. Galvin is a general engineer with the Office of Engineering and Operations Support for Defense Programs. He joined the Department of Energy as a technical intern in 1991. As an intern for two and one-half years, he assisted on several engineering assessments, including assisting facility representatives at Rocky Flats for five months and assisting the resident inspectors at the Susquehanna Steam Electric Station for nine months. For the past one and one-half years, he has provided criticality safety support to Defense Programs. Mr. Galvin has a BS in nuclear engineering from Penn State University.

BARBARA K. KNEECE

Ms. Kneece has over 20 years of experience in administrative management and support to various elements of public and private enterprises. She currently is assigned as a project analyst for the Office of Engineering Assistance and Site Interface (EH-34). Ms. Kneece has performed as the administrative support coordinator for numerous assessments for EH including Rocky Flats Building 707, Building 559, and Supercompaction and Repackaging facilities; Savannah River Site HB-Line, FB-Line, and Replacement Tritium facilities; Princeton Plasma Physics Laboratory Tokamak Fusion Test Reactor; Portsmouth Gaseous Diffusion Plant; the DOE Complex Spent Fuel Initiative; and the Plutonium Vulnerability Assessment. As administrative coordinator and office manager for Argonne National Laboratory, she established a satellite office for the DOE New Production Reactor program in Aiken, S.C.

SAMUEL ROSENBLOOM

Mr. Rosenbloom earned the degrees of Bachelor of Science in Biophysics and Master of Science in Nuclear Engineering from the University of Maryland. He has extensive training in electrical instrumentation. Mr. Rosenbloom completed an internship for his degree in Biophysics at the University of Maryland Medical School Teaching Facility. He has managed instrumentation and sensor development programs. Mr. Rosenbloom served the Defense Nuclear Agency as the principal point-of-contact during extremely controversial environmental litigation against the U.S. Government concerning alleged adverse environmental impact of Department of Defense facilities in Virginia and New Mexico. Mr. Rosenbloom has an academic knowledge of contracts and contract law. He is the author of DOE 5480.24, *Nuclear Criticality Safety*, and he has extensive knowledge of DOE policy development.

APPENDIX C

TASK #2

PERFORMANCE OBJECTIVES, REVIEW CRITERIA, APPROACH AND EXPECTATIONS

PERFORMANCE OBJECTIVE CO-1: OSRs

Performance Objective CO-1.1:

LMES has evaluated the adequacy of and compliance with OSRs, has established corresponding corrective actions, and is actively addressing those corrective actions.

Review Criteria:

There is an audit path from OSR to verification of compliance. The OSR compliance evaluation performed by LMES should identify all nonconformances and corresponding corrective actions. The long-term corrective actions should be consistent with Recommendation 94-4.

DOE personnel should review and approve OSRs.

Applicable criteria specified in DOE 5480.22, Section 9, *Technical Safety Requirements* or DOE 5480.5, *Safety of Nuclear Facilities*.

Approach:

Review the results of the LMES evaluation corrective action plan and closure documentation (N.1.1, N.1.2, and N.1.3), focusing on the scope, methodology of review, completeness, and corrective actions associated with OSR compliance.

Review applicable criteria specified in DOE 5480.22, Section 9, *Technical Safety Requirements* or cancelled Order 5480.5, whichever requirements are currently in place.

Review applicable portions of the following documents as they relate to OSR compliance:

1. Completed Readiness Assessments as a broad scope application to Y-12;
2. Evaluation of corrective actions related to probable causes documented in the Type C Investigation (Y/AD-622);
3. Evaluation of corrective actions related to causal factors in the report, "Evaluation of Criticality Safety Discrepancy Data," (LMES internal correspondence of October 12, 1994);
4. An assessment of progress by LMES in Phase III and IV activities involving criticality safety as defined in "Plan for Continuing and Resuming Operations," (Y/AD-623), or subsequent plans as revised; and
5. Lessons learned from resumption activities at the Pantex Plant and TA-55 facility at LANL will be developed and applied.

Evaluate whether resumption oriented commitments related to OSRs are being sustained and that longer term plans are consistent with Recommendation 94-4 and related LMES commitments already specified in the Task 2 portion of the Implementation Plan. Perform an assessment of DOE management, specifically focusing on YSO and OR responsibilities as they relate to OSR review and approvals.

Expectations:

Upon completing Performance Objective CO-1.1, team members should be able to determine with respect to OSRs, whether (1) resumption orientated commitments are being properly fulfilled and (2) the long term actions are consistent with Recommendation 94-4. Through the use of the suggested approach criteria, review of procedures and programs, and interviews, team members should develop an indication of the

programmatically structures, the corrective actions resulting from near term actions, and the infrastructure that support long term improvements with respect to OSR compliance. Specifically, team members should be able to determine the long-term posture of Lockheed Martin Energy Systems, Inc., the Y-12 Site Office, and the Oak Ridge Operations Office related to the adequacy and execution of the upgraded OSR procedures. Team members should be able to ascertain whether the root causes identified and corresponding corrective actions identified by LMES are correct and relevant, and will effectively provide long-term programmatic improvements (refer to Performance Objective CO-3.0).

Performance Objective CO-1.2:

Facility operations governed by OSRs have a process to ensure all surveillance procedures and administrative controls are adhered to in order to confirm facility safety system operability.

Review Criteria:

Procedural controls are in place to ensure compliance with OSRs. OSR statements are clear and concise. Compliance methodology is clearly defined and OSR noncompliances are being reported immediately. Surveillance procedures confirm safety system operability.

Approach:

Perform a representative vertical and horizontal slice for the defense nuclear facilities at Y-12. Consider the OSRs for the resumed facilities, those active OSRs for non-resumed facilities, and in-process revisions to OSRs. In-place revisions and active OSRs at non-resumed facilities should be considered from a lessons learned perspective.

Interview operations, maintenance, and related support staff, including LMES management and DOE area personnel, in both a resumption and non-resumption area. Review all OSRs at each facility location and compare with the central OSR control location. Review the Facility System Status files for each OSR related system and ensure that each of the required surveillances has been completed within the frequency requirements. Review each facility OSR matrix to ensure that a representative sample of each OSR has been addressed by a facility procedure, and that the referenced component or system is listed.

Verify the existence of a representative sample of administrative procedures establishing the administrative control programs committed in the OSR (among these a management system to track and schedule OSR surveillance procedures). Also ensure that equipment inspections are performed as required by the OSR. Observe facility operations (e.g., storage conditions, material handling, etc.) to ensure specific OSRs are being met.

Expectations:

Upon completing Performance Objective CO-1.2, team members should be able to determine with respect to OSRs, whether the statements are clear and concise and that the appropriate configuration management controls are in place. Team members should be able to determine if facility operations governed by OSRs have a process that (1) ensures surveillance procedures are completed within the frequency requirements and (2) confirm facility safety system operability. In addition, team members should also be able to determine whether a culture exists that encourages OSR noncompliances to be immediately reported.

Performance Objective CO-1.3:

Surveillance procedures are in place that test and/or calibrate OSR required facility safety systems, facility safety instrumentation, and other instrumentation monitoring limiting conditions for operation.

Surveillance, inspection, and testing activities should provide assurance that the equipment needed for safe and reliable facility operation performs within required limits and that preventive maintenance, defined as including periodic and planned maintenance, is utilized to maintain a piece of equipment within design operating conditions and to realize its maximum reasonable useful life.
(DOE 4330.4B, Section 3.6.1)

Review Criteria:

Approved surveillance procedures to test and/or calibrate OSR required facility safety systems, facility safety instrumentation, and other instrumentation monitoring limiting conditions for operation or that satisfy the OSR are in place.

As part of the maintenance surveillance program, functional tests of installed equipment and/or systems (such as standby equipment or nonoperating equipment scheduled for rotation) are conducted and documented.

Abnormalities found during surveillances or preventive maintenance are immediately reported to higher authority.

Approach:

Verify the surveillance requirements of the OSR are implemented by procedures and each facility safety system, facility safety instrumentation, and other instrumentation monitoring limiting conditions for operation or that satisfy the OSR has one or more procedures to demonstrate operability.

Verify that one or more surveillance procedures have been prepared and approved to address the requirements of each of the OSRs. Review at least one of the surveillance procedures to ensure that it completely addresses the testing requirements in the OSR.

Through sampling, verify that the instrumentation utilized to support limiting conditions of operation and surveillance procedures acceptance criteria have been included in the calibration program. Review a sample of performance validation records and verify that performance validations have been performed for the surveillance procedures.

Expectations:

Upon completing Performance Objectives CO-1.3 and CO-1.4, team members should be able to determine facility compliance with OSR surveillances. In addition, team members should be able to determine whether a system exists that encourages the reporting to a higher authority any abnormalities found during surveillances or preventive maintenance.

Performance Objective CO-1.4:

OSRs provide the safety envelope for the facilities being evaluated and support the respective safety basis.

Review Criteria:

OSRs are comprehensive and complete, and clearly define the safety envelope (or bounds) of operations in accordance with DOE 5480.5 or DOE 5480.22.

Approach:

Select representative OSRs for a facility operation and a set of OSR (i.e., LCOs for a selected group of facility operations) to verify that activities are performed within the approved OSRs. Interview safety analysts, criticality engineers, and related support staff including LMES management and DOE area personnel.

Expectations:

Upon completing Performance Objectives CO-1.3 and CO-1.4, team members should be able to determine facility compliance with OSR surveillances. In addition, team members should be able to determine that the facility OSRs are comprehensive and complete, and clearly define the safety envelope of operations in accordance with DOE 5480.5 or DOE 5480.22.

Performance Objective CO-1.5:

All OSRs and Class 1 and Class 2 procedures are consistent with each other.

Review Criteria:

OSRs and Class 1/Class 2 procedures are consistent and in agreement.

Approach:

Perform a vertical slice (facility specific) in a random sample of OSRs to determine consistency with associated Class 1 and Class 2 procedures. Check to ensure that configuration management controls are in effect for these procedures.

Expectations:

Upon completing Performance Objective CO-1.5, team members should be able to verify that the OSRs and Class 1 and 2 procedures properly compliment each other. They should be able to identify a process that ensures proper reviews are conducted in the event changes are made to either OSRs or procedures. In addition (along with Performance Objectives CO-1.2 and CO-1.6), team members should be able to determine whether the configuration management controls in place provide the proper measure of administrative control.

Performance Objective CO-1.6:

OSRs are controlled documents. Operations involving OSRs are controlled and activities are performed within the approved safety basis.

Review Criteria:

OSRs have been reviewed and approved by DOE in accordance with DOE 5480.22.

Approach:

Select all OSRs and review each for revision documentation (reviews, validation, approval forms, verification, etc.). Ensure that the appropriate configuration management controls are in place.

Expectations:

Upon completing Performance Objectives CO-1.2, CO-1.5, and CO-1.6, team members should be able to verify that the appropriate configuration control elements are in place (including reviews, validations, approvals, verifications, etc.). In addition, team members should be able to determine if the OSRs have been properly approved by DOE using the applicable DOE Orders.

Performance Objective CO-1.7:

Workers have a clear demonstrated understanding of the compliance requirements of OSRs. Personnel responsible for supervising and/or performing facility operations, surveillance testing, and maintenance understand the OSR and the facility safety systems controlled by the OSR.

Review Criteria:

Workers should be able to demonstrate a clear understanding of the compliance requirements of the new and revised OSRs in order to safely perform their respective duties. (DOE 5480.20A, Chapter I.7.d and Chapter IV.4)

Approach:

Interview operations, maintenance, and related support staff, including DOE area personnel, in both a resumed and non-resumed area concerning their understanding of compliance requirements. Interview an individual responsible for supervising and/or performing facility operations, surveillance testing, and maintenance to determine an understanding of the OSR and the facility safety systems controlled by the OSR. Determine how the importance of procedural compliance and understanding of safety requirements are addressed in training.

Expectations:

Upon completing Performance Objective CO-1.7, team members should be able to verify that workers have a clear understanding of the compliance requirements of the new and revised OSRs in order to safely perform their respective duties. Through the interview process, team members should be able to assess the effectiveness of any training concerning procedural compliance. In addition, team members should be able to determine whether a culture now exists that encourages compliance with OSRs and procedures.

Performance Objective CO-1.8:

All personnel have been trained on the new and revised OSRs.

Review Criteria:

All facility personnel have successfully completed training on the new and revised OSRs.

The programs shall be structured commensurate with specific position needs, and shall be administered on a cycle not to exceed two years. Continuing training shall include, at a minimum, training in significant facility system and component changes, applicable procedure changes, applicable industry operating experience, selected fundamentals with emphasis on seldom used knowledge and skills necessary to assure safety, and other training as needed to correct identified performance problems. (DOE 5480.20A, Section 7.d.(1))

Continuing training programs for certified operations personnel shall consist of preplanned classroom-type training, on-the-job training, and operational evaluations on a regular and continuing basis. Continuing training programs for certified operators and certified supervisors shall include, at a minimum, the following as related to job performance: Technical Specifications/Operational Safety Requirements. (DOE 5480.20A, Section 7.d.(3).8)

Approach:

Review lesson plans and interview several operations, maintenance, and support organization staff to ensure training has been completed and personnel have the required level of knowledge. Check training records against directory of facility personnel to ensure all personnel have satisfactorily completed training. Observe the performance of an OSR surveillance procedure(s) to verify they are performed as written or if they cannot be performed as written, the operator knows what actions to take (e.g., stop work and inform supervision). Compare observations against the aforementioned requirements of DOE 5480.20A.

Review training records for personnel trained to perform surveillance procedures and trained to conduct maintenance on instrumentation used to verify OSR.

Expectations:

Upon completing Performance Objective CO-1.8, team members should be able to determine whether the training program provides emphasis on procedure compliance. Team members should be able to verify that workers receive continuing training in significant facility system and component changes, applicable procedure changes, applicable industry operating experience, selected fundamentals with emphasis on seldom used knowledge and skills necessary to assure safety, and other training as needed to correct identified performance problems. Team members should also be able to determine whether a culture exists that encourages workers to stop work and inform supervision when a procedural noncompliance exists.

PERFORMANCE OBJECTIVE CO-2: CSAs

Performance Objective CO-2.1:

LMES has evaluated the adequacy of and compliance with CSAs, has established corresponding corrective actions, and is actively addressing those corrective actions.

Review Criteria:

There is an audit path from CSA requirements to verification of compliance. The CSA compliance evaluation performed by LMES should identify all nonconformances and corresponding corrective actions. The long-term corrective actions should be consistent with Recommendation 94-4.

DOE personnel should conduct periodic reviews and surveillances of CSAs.

Applicable requirements specified in ANSI 8.19.

Approach:

Review the results of the LMES evaluation corrective action plan and closure documentation (N.1.1, N.1.2, N.1.3 and N.1.4), focusing on the scope, methodology of review, completeness, and corrective actions associated with CSA compliance.

Compare the requirements specified in ANSI 8.19 (particularly Sections 4, 5, 6, 7 and 9) against the requirements specified in the CSAs.

Review applicable portions of:

1. Completed Readiness Assessments as a broad scope application to Y-12;
2. Evaluation of corrective actions related to probable causes documented in the Type C Investigation (Y/AD-622);
3. Evaluation of corrective actions related to causal factors in the report, "Evaluation of Criticality Safety Discrepancy Data," (LMES internal correspondence of October 12, 1994);
4. An assessment of progress by LMES in Phase III and IV activities involving criticality safety as defined in "Plan for Continuing and Resuming Operations," (Y/AD-623), or subsequent plans as revised; and
5. Lessons learned from resumption activities at the Pantex Plant and TA-55 facility at LANL will be developed and applied.

Evaluate whether resumption oriented commitments related to CSAs are being sustained and that the longer term plans are consistent with Recommendation 94-4 and related LMES commitments already specified in the Task 2 portion of the Implementation Plan. Perform an assessment of DOE management, specifically focusing on YSO and OR responsibilities as they relate to CSA reviews and surveillances.

Expectations:

Upon completing Performance Objective CO-2.1, team members should be able to determine with respect to CSAs, whether (1) resumption orientated commitments are being properly fulfilled and (2) the long term actions are consistent with Recommendation 94-4. Through the use of the suggested approach criteria, review of procedures and programs, and interviews, team members should develop an indication of the

programmatic structures, the corrective actions resulting from near term actions, and the infrastructure that support long term improvements with respect to CSA compliance. Specifically, team members should be able to determine the long-term posture of Lockheed Martin Energy Systems, Inc., the Y-12 Site Office, and the Oak Ridge Operations Office related to the adequacy and execution of the upgraded CSAs.

Performance Objective CO-2.2:

Safety related facility operations are governed by CSAs. The handling of CSA compliance and CSA noncompliances are governed by procedures.

Review Criteria:

Procedural controls are in place to ensure compliance with CSAs. CSA requirement statements are clear and concise. Compliance methodology is clearly defined and CSA noncompliances are being reported immediately.

Approach:

Perform a representative vertical and horizontal slice for the defense nuclear facilities at Y-12. Consider the CSAs for the resumed facilities, those active CSAs for non-resumed facilities, and in-process revisions to CSAs. In-place revisions and active CSAs at non-resumed facilities should be considered from a lessons learned perspective.

Interview a dedicated criticality safety engineer and operations counterpart in both a resumption and non-resumption area. Randomly select several CSAs and ensure that the requirements have been incorporated into the facility procedures. If significant problems are identified, expand the sample to confirm the initial findings. Where applicable, ensure that the limits specified in the CSAs and procedures are consistent. Also ensure that equipment inspections are performed as required by the CSA. Observe facility operations (e.g., storage conditions, material handling, etc.) to ensure specific CSA requirements are being met.

Expectations:

Upon completing Performance Objective CO-2.2, team members should be able to determine with respect to CSAs, whether the statements are clear and concise and that the appropriate procedural controls are in place. Team members should be able to determine if these controls are in place for both resumed and non-resumed facilities and that CSA requirements have been properly incorporated into facility procedures. In addition, team members should also be able to determine whether a culture exists that encourages the immediate reporting of CSA noncompliances.

Performance Objective CO-2.3:

All CSAs and Class 1 and Class 2 procedures are consistent with each other.

Review Criteria:

CSAs and Class 1 and Class 2 procedures are consistent and in agreement.

Approach:

Perform a vertical slice on a random sample of CSAs to determine consistency with associated Class 1 and Class 2 procedures with respect to implementing procedures of Near Term Initiative N.1.4. Check to

ensure that configuration management controls are in place for these procedures.

Expectations:

Upon completing Performance Objective CO-2.3, team members should be able to determine whether the CSAs and Class 1 and 2 are consistent and procedures properly compliment each other. They should be able to identify a process that ensures proper reviews are conducted in the event changes are made to either the CSAs or Class 1 or 2 procedures. In addition, team members should be able to determine whether the configuration management controls in place provide the proper measure of administrative control.

Performance Objective CO-2.4:

CSAs are controlled documents. Operations involving CSAs are controlled and activities are performed within the approved safety basis.

Review Criteria:

CSAs required for operation have been reviewed, corrected, validated, and approved per established procedures.

DOE personnel perform periodic independent surveillances of CSAs.

Approach:

Randomly select several CSAs and review each for revision documentation (reviews, validation, approval forms, verification, etc.). Review the facility index to ensure that all CSAs are included, or a justification exists for exclusion. Ensure that the appropriate configuration management controls are in place and that activities are performed within the approved safety basis. Review the CSA program to ensure a process exists that provides for the review, approval and validation of CSAs. Review a sample of surveillances that are conducted by DOE personnel which provide an independent oversight of CSA adequacy and compliance.

Expectations:

Upon completing Performance Objective CO-2.4, team members should be able to determine whether CSAs are controlled and that the activities are properly performed within the approved safety basis. Along with CO-2.3, team members should be able to determine whether the appropriate configuration control elements (including reviews, validations, approvals, verifications, etc.) are in place. In addition, team members should be able to determine if the CSAs have been properly reviewed by DOE personnel.

Performance Objective CO-2.5:

Workers have a clear demonstrated understanding of the compliance requirements of CSAs. Personnel responsible for supervising and/or performing facility operations understand the CSA and the facility safety systems controlled by the CSAs. The utility of the CSAs has been evaluated for clarity and user friendliness.

Review Criteria:

Workers should be able to demonstrate a clear understanding of the compliance requirements of the new

and revised CSAs. The CSAs should be clearly written, capable of being followed, and written such that the least experienced qualified operator can use them.

Approach:

Interview a dedicated criticality safety engineer, an operations counterpart, and a facility worker at both a resumed and non-resumed area concerning their understanding of compliance requirements. Interview an individual responsible for supervising and/or performing facility operations, surveillance testing, and maintenance to determine an understanding of the CSA and the facility safety systems affected by the CSA. Determine how the importance of procedural compliance and understanding of safety requirements are addressed in training. Determine if the CSAs are clearly written, capable of being followed, and written such that the least experienced operator can understand them and use them correctly.

Expectations:

Upon completing Performance Objective CO-2.5, team members should be able to verify that workers have a clear understanding of the compliance requirements of the new and revised CSAs. Through the interview process, team members should be able to assess the utility of CSAs and the effectiveness of any training concerning procedural compliance and understanding of safety requirements. In addition, team members should also be able to determine (1) the utility of CSAs and (2) whether a culture exists that encourages CSA and procedural compliance.

Performance Objective CO-2.6:

All personnel have been trained on the new and revised CSAs.

Review Criteria:

All facility personnel have successfully completed training on the new and revised CSAs.

The programs shall be structured commensurate with specific position needs, and shall be administered on a cycle not to exceed two years. Continuing training shall include, at a minimum, training in significant facility system and component changes, applicable procedure changes, applicable industry operating experience, selected fundamentals with emphasis on seldom used knowledge and skills necessary to assure safety, and other training as needed to correct identified performance problems. (DOE 5480.20A, Section 7.d.(1))

Approach:

Review lesson plans and interview several operations staff and criticality safety engineer to ensure training has been completed and personnel have the required level of knowledge. Check training records against directory of facility personnel to ensure all personnel have satisfactorily completed training. Compare observations against the aforementioned requirement of DOE 5480.20A.

Expectations:

Upon completing Performance Objective CO-2.6, team members should be able to determine whether the training program provides emphasis on procedure compliance (specifically with regard to CSAs). Team members should be able to verify that workers receive continuing training in significant facility system and component changes, applicable procedure changes, applicable industry operating experience, selected fundamentals with emphasis on seldom used knowledge and skills necessary to assure safety, and other training as needed to correct identified performance problems. Team members should also be able to determine whether a culture exists that encourages workers to stop work and inform supervision when a procedural noncompliance occurs.

PERFORMANCE OBJECTIVE CO-3.0: ROOT CAUSE

LMES has identified the root cause of identified violations and established corresponding corrective actions.

Review Criteria:

The root cause determinations have identified corrective actions that will preclude recurrence of the deficiencies.

Approach:

Review the results of the LMES evaluation, focusing on the scope, methodology of review, completeness, identification of root causes of violations, and corrective actions associated with OSR and CSA compliance.

Review the results of the LMES near-term initiatives completed for criticality safety focusing on the adequacy of the root causes analysis and corrective actions. In addition, review the completed actions associated with the following documents and determine if the root cause evaluations have identified the appropriate corrective actions to preclude recurrence of the deficiency:

- Corrective actions associated with Y/AD-622, *Type C Investigation*
- Corrective actions related to causal factors in the internal LMES report, *Evaluation of Criticality Safety Discrepancy Data*, dated October 12, 1994
- Progress by LMES in Phases III and IV activities involving criticality safety as defined in *Plan for Continuing and Resuming Operations*
- Applicable portions of completed Readiness Assessments

Independent of the analysis completed by LMES, determine the root cause of CSA, OSR and criticality safety violations identified since stand down of the facility. The reviewer should use the ORPS and LMES databases to identify these CSA and OSR violations. Compare the results of the analysis, including the corrective actions, against the LMES results.

Expectations:

Upon completing Performance Objective CO-3.0, team members should be able to verify that LMES has identified the root cause of identified violations and established appropriate corresponding corrective actions that will preclude recurrence of the deficiencies. Team members should be able to ascertain whether the root causes identified and corresponding corrective actions identified by LMES are correct and relevant and whether the corrective actions will effectively provide long-term programmatic improvements.

PERFORMANCE OBJECTIVE CO-4.0: LESSONS LEARNED

The applicability of experience gained from lessons learned at Rocky Flats Building 771, Sequoyah Fuels Corporation, Pantex and Los Alamos TA-55 has been incorporated into Y-12 practices and procedures:

Review Criteria:

Lessons learned from similar events at Rocky Flats Building 771, the Sequoyah Fuels Corporation, Pantex and Los Alamos TA-55 has been evaluated for applicability to Y-12 practices and procedures. A program exists at Y-12 that evaluates lessons learned from operating experience and determines applicability and actions required to minimize the potential for similar occurrences.

Approach:

Review the lessons learned at Rocky Flats Building 771, Sequoyah Fuels Corporation, Pantex and Los Alamos TA-55 and determine if they have been evaluated for applicability to Y-12 practices and procedures. Determine if a program exists for incorporating lessons learned from operating experience from both internal and external events.

Review lessons learned items from Y-12:

- Resumption Buildings - within past 2 years
- Nonresumption buildings - within last year of operation
- Look for repeat incidents and sharing of information across facilities

Interview a sample of personnel for lessons learned experience from amongst the following:

- Criticality safety
- DOE facility representative
- Operations management
- Operators
- Maintenance
- Others as applicable

Questions to include how new employees are made aware of lessons learned, willingness to report infractions, working knowledge of CSAs.

Conduct document reviews for lessons learned

- Training program
- Required reading
- List of infractions for past year, looking for trends
- Conduct of operations with respect to criticality safety lessons learned
- How are infractions from one area transmitted to another area for lessons learned

Conduct walkdowns

- How much time do operators spend in other facilities
- Observe job specific performance based training

Based on the above activities, witness an evolution which demonstrates that one or more of the top infraction items have been addressed by the lessons learned program.

Expectations:

Upon completing Performance Objective CO-4.0, team members should be able to verify that LMES has identified the lessons learned from these off-site events and implemented the appropriate changes into site processes and procedures. Team members should be able to ascertain whether a continuing program exists for incorporating lessons learned from operating experience from both internal and external events.

APPENDIX D

TASK 3

PERFORMANCE OBJECTIVES, REVIEW CRITERIA, APPROACH AND EXPECTATIONS

PERFORMANCE OBJECTIVE CS-1

LMES organization responsible for criticality safety programs is in place and staffed, and there is an effective integration of the program elements.

Review Criteria:

The organizations responsible for implementation of the criticality safety program should be in place and staffed with experienced individuals (organizations include the criticality safety department, operations, emergency response, maintenance, etc.). Staffing levels should be determined and an aggressive recruitment program implemented for when a vacancy exists. The program elements are integrated for an effective program.

Applicable portions on ANSI/ANS 8.1, 8.19 and DOE 1324.2A and 5480.24.

Approach:

Review the program for the basic elements of criticality safety, and interview facility management personnel, criticality safety engineers, operations and maintenance personnel, and emergency preparedness personnel using the applicable requirements of ANSI/ANS 8.1 and 8.19 and DOE 1324.2A and 5480.24 as guidance.

Expectations:

Upon completion of Performance Objective CS-1, team members should be able to determine whether the criticality safety program meets the applicable requirements of ANSI/ANS 8.1 and 8.19 and DOE 1324.2A and 5480.24. In addition, team members should be able to determine the effectiveness of the integration of the various program elements.

PERFORMANCE OBJECTIVE CS-2

Management, operations, maintenance, and configuration control programs supporting storage of materials and criticality safety equipment together with the appropriate change control procedures are in place.

Review Criteria:

Applicable portions of ANSI/ANS 8.1, 8.3, 8.5, 8.7, and 8.19. Applicable conduct of operations requirements pertaining to criticality safety configuration control.

Approach:

Perform a vertical slice on both a resumed and non-resumed facility with active CSAs. Review the maintenance, operations, and configuration control procedures; interview management, operations and maintenance personnel; and walk down the portions of a resumption area using the applicable requirements of ANSI/ANS 8.1, 8.3, 8.5, 8.7, and 8.19 as guidance.

1. Verify that a program for maintaining the facility and equipment in accordance with DOE and ANS requirements is in place.
2. Observe at least two evolutions on criticality alarm systems such as the following:
 - a) Power outage and backup power supply
 - b) Alarm system test (quarterly)
 - c) Monthly system test to radiation
 - d) Test response performance of alarm system
 - e) Maintenance of alarm system
3. Observe criticality evacuation drill (note this drill may take place prior to the assessment). Selected assessment team members will make a special trip to observe the drill.
4. Document review:
 - a) Define if appropriate standards and DOE orders been referenced in applicable procedures.
 - b) Review the preventative maintenance program for the criticality system.
 - c) Perform a vertical slice of one resumed facility and one non-resumed facility with active CSAs regarding operating criticality alarm systems.
5. Interviews:
 - a) Interview maintenance personnel on maintenance of detector equipment.
 - b) Interview selected member(s) of criticality safety management committee on standards and overall performance of the criticality system (e.g., going from 2 decade to 5 decade detectors).
 - c) Interview operations personnel on the use of portable detectors.

Expectations:

Upon completion of Performance Objective CS-2, team members should be able to determine whether the management, operations, maintenance, and configuration control programs supporting storage of materials and criticality safety equipment together with the appropriate change control procedures meet the applicable portions of ANSI/ANS 8.1, 8.3, 8.5, 8.7, and 8.19, and conduct of operations requirements.

PERFORMANCE OBJECTIVE CS-3

A program for performing nuclear criticality safety evaluations has been developed and implemented.

- Nuclear criticality safety should be achieved by controlling one or more specified parameters of the system within subcritical limits. (ANSI/ANS 8.19, Sect. 8.2)
- Nuclear criticality safety evaluations of the design and operation of process equipment should ensure that subcriticality is maintained under normal and credible abnormal operating conditions. (ANSI/ANS 8.19, Sect. 8.1)

Review Criteria:

Applicable portions of ANSI/ANS 8.1, 8.3, 8.7, 8.19, and DOE 5480.24.

Approach:

Review sample criticality safety evaluations and USQDs associated with criticality safety and perform a walkdown of a sample of facilities to determine the status of configuration management. The utility of criticality safety evaluations and approvals should be assessed. In addition, independent reviews, independent analysis methodology, sample basis and sample expansion, and technical content of CSEs should be sampled. Use the applicable requirements of ANSI/ANS 8.1, 8.3, 8.7, and 8.19 and DOE 5480.24 as guidance.

Expectations:

Upon completion of Performance Objective CS-3, team members should be able to verify whether a program for performing nuclear criticality safety evaluations has been developed and implemented that meets the applicable portions of ANSI/ANS 8.1, 8.3, 8.7, and 8.19 and DOE 5480.24. In addition, team members should be able to determine the utility of criticality safety evaluations and approvals.

PERFORMANCE OBJECTIVE CS-4

Administrative controls and implementing procedures are in place.

Review Criteria:

Criticality safety procedures required for areas scheduled for resumption have been reviewed, validated, approved.

Applicable portions of ANSI/ANS 8.1, 8.3 and 8.19 and DOE 1324.2A and 5481.1.

Approach:

Ensure that the appropriate procedural controls are in place. Review several criticality safety procedures that have been recently revised. Ensure that the latest revision is validated (via walkthrough), approved, distributed to all controlled locations, is considered a controlled document, that the latest revision is included in the Index of Procedures, and previous revisions have been replaced. Interview several plant personnel and determine whether they (1) have been recently trained on these procedures, (2) can identify the latest revisions, and (3) know where to find controlled copies. Ensure that the corrective actions identified to date have been included in the program and procedures. Review a sampling of criticality safety procedures and criticality safety audits, and walkdown several resumption areas using the applicable requirements of ANSI/ANS 8.1, 8.3, and 8.19 and DOE 1324.2A and 5484.1.

Expectations:

Upon completion of Performance Objective CS-4, team members should be able to determine the effectiveness of procedural controls associated with the criticality safety program. In addition, team members should be able to determine whether the criticality safety program and supporting procedures meet the applicable requirements of ANSI/ANS 8.1, 8.3, and 8.19 and DOE 1324.2A and 5484.1.

PERFORMANCE OBJECTIVE CS-5

Criticality safety training program has been developed and implemented.

Review Criteria:

The criticality safety training program meets the requirements of ANSI/ANS 8.20. Where the program does not meet a particular requirement, either an exception has been granted or a compensatory measure is in place.

Approach:

Interview a sampling of facility personnel assigned to resumption areas to determine if the criticality safety training program meets the requirements of ANSI/ANS 8.20. Identify any deviations from the standards.

Expectations:

Upon completion of Performance Objective CS-5, team members should be able to determine how the criticality safety training program meets the requirements of ANSI/ANS 8.20.

PERFORMANCE OBJECTIVE CS-6

LMES has completed an evaluation of the effectiveness of the Y-12 criticality safety program, established corresponding corrective actions where needed, and is actively addressing these corrective actions.

Review Criteria:

The LMES evaluation of the criticality safety program should identify all noncompliances and corresponding corrective actions. The long-term corrective actions should be consistent with Recommendation 94-4.

DOE management should conduct periodic reviews of the criticality safety program at Y-12.

Approach:

Review the results of the LMES evaluation corrective action plan and closure documentation (N.1.1, N.1.2, N.1.3, and N.1.4), focusing on the scope, methodology of review, completeness, root cause determination and corrective actions associated with the criticality safety program.

Review applicable portions of the following documents as they relate to the programmatic issues associated with the criticality safety program:

1. Completed Readiness Assessments as a broad scope application to Y-12;
2. Evaluation of corrective actions related to probable causes documented in the Type C Investigation (Y/AD-622);
3. Evaluation of corrective actions related to causal factors in the report, "Evaluation of Criticality Safety Discrepancy Data," (LMES internal correspondence of October 12, 1994);
4. An assessment of progress by LMES in Phase III and IV activities involving criticality safety as defined in "Plan for Continuing and Resuming Operations," (Y/AD-623), or subsequent plans as revised; and
5. Criteria developed as part of Commitment 3.1, and the results of the LMES evaluation completed as part of Commitment 3.2, and the corrective action plans developed as part of Commitment 3.3 of the Implementation Plan.

Evaluate whether resumption oriented commitments related to the criticality safety program are being sustained and that longer term plans are consistent with Recommendation 94-4 and related LMES commitments already specified in the Task 3 portion of the Implementation Plan. Perform an assessment of DOE management, specifically focusing on YSO and OR responsibilities as they relate to the criticality safety program.

Expectations:

Upon completing Performance Objective CS-6, team members should be able to determine with respect to the criticality safety program at Y-12, whether (1) resumption orientated commitments are being properly fulfilled and (2) the long term actions are consistent with Recommendation 94-4. Through the use of the suggested approach criteria, review of procedures and programs, and interviews, team members should develop an indication of the programmatic structures, the corrective actions resulting from near term actions, and the infrastructure that support long term improvements with respect to the criticality safety program. Specifically, team members should be able to determine the long-term posture of Lockheed Martin Energy Systems, Inc., the Y-12 Site Office, and the Oak Ridge Operations Office related to the effectiveness and implementation of the long-term changes implemented to the criticality safety program at Y-12.

Also upon completing the performance objective, team members should be able to verify that LMES has identified the root cause of identified violations and established appropriate corresponding corrective actions that will preclude recurrence of previously identified deficiencies associated with the criticality safety program. Team members should be able to ascertain whether the root causes identified and corresponding corrective actions identified by LMES are correct and relevant and will effectively provide long-term programmatic improvements. Team members should be able to verify that a process is in place that properly identifies and corrects deficiencies such that a strong criticality safety program is established for the long-term.

APPENDIX E
ASSESSMENT FORMS

Assessment Form 1

Date:

<p>Assessment Form 1 No.:</p> <p>Review Area:</p> <p>Responsible Individual:</p>
<p>I. Performance Objective: (List the Performance Objective number and description from the Assessment Program)</p>
<p>II. Expectations: (Provide the expectations for the Performance Objective as stated in the Assessment Program)</p>
<p>III. Review Criteria: (Provide the criteria used for conducting the review.)</p>
<p>IV. Approach: (List the procedures and documents reviewed, names and titles of personnel interviewed, references used, and evolutions observed.)</p>
<p>V. Discussion of Results with Basis: (Document the results of the review in sufficient detail using both the review criteria and the expectation statement as guidance.)</p>

Assessment Form 1

Date:

Assessment Form 1 No.:
Review Area:
Responsible Individual:
VI. Conclusion: (Concluding statement based on the discussion of results. The statement should conclude whether the criteria of the objective was met.)
VII. Issues: (List any issues identified as part of this review. All issues should also be documented on Assessment Form 2.)
Originator _____ Date _____
Approved _____ Date _____

Assessment Form 2

Date:

Assessment Form 2 No.:
Review Area:
Responsible Individual:
<p>Finding -- A statement of fact documenting a deviation from an applicable Federal law, DOE Order, standard, safety requirement, performance standard, or approved procedure.</p> <p>Concern -- Any situation while not in violation of any written procedure, in the judgment of the assessment team member indicates less than optimal performance and could be the indicator of more serious problems.</p> <p>Observation -- Any situation while not in violation of any written procedure or requirement, in the judgment of the assessment team member is worthy of raising to the attention of site management in order to enhance overall performance.</p> <p>Noteworthy Practices -- Practices that are notable and will have general application to other DOE facilities for the improvement of overall safety or performance.</p>
<p>I. Identification Section</p> <p>A. Statement (Provide exact wording of the potential or final Finding, Concern, Observation or Noteworthy Practice):</p> <p>B. Information Requested (List any information needed to further evaluate this item):</p>
<p>II. Basis Section</p> <p>For Findings, identify the related requirements (e.g., applicable DOE Orders, Standards or Review Criteria). For Concerns, discuss how the situation results in less than optimal performance and is considered an indicator of more serious problems. For Observations, identify the situation worthy of raising to the attention of site management and discuss how it will enhance overall performance. For Noteworthy Practices, identify those practices considered notable and that have general application to other DOE facilities for the improvement of overall safety or performance.</p> <p>A. Description of Basis:</p> <p>B. Documents reviewed, activities performed, persons contacted (include titles):</p>

Assessment Form 2

Date:

Assessment Form 2 No.:
Review Area:
Responsible Individual:
III. Approval Section (Signatures)
Originator _____ Date _____
Approved _____ Date _____
Suggested Corrective Action:
IV. Contractor/DOE Response (Provide results of Contractor/DOE review with technical basis and references.)
Accepted By: _____ Date _____

APPENDIX F

**LESSONS LEARNED FROM ROCKY FLATS BUILDING 771, PANTEX,
SEQUOYAH FUELS CORPORATION, and LOS ALAMOS TA-55**

APPENDIX F
LESSONS LEARNED FROM ROCKY FLATS BUILDING 771, PANTEX,
SEQUOYAH FUELS CORPORATION, and LOS ALAMOS TA-55

The observations and lessons learned presented in this Appendix are from similar Conduct of Operations (CoD) and criticality safety events and resumption efforts at Rocky Flats Building 771, the Pantex Site, and Los Alamos TA-55. Summaries of the events and lessons learned are presented such that team members may determine applicability of the lessons learned at these facilities to the resumption activities at the Y-12 Plant. Team members should read the full assessment reports in order to gain a better understanding of the applicability of these lessons learned to the Y-12 Site.

ROCKY FLATS BUILDING 771 EVENT

On September 29, 1994, an incident occurred at the Rocky Flats Environmental Technology Site (RFETS) in Building 771. Operations personnel drained Tank 467 that contained 210 liters of solution with a plutonium concentration of 0.5 g/L into 54 four-liter bottles inside a glovebox. The process vacuum was left on for one hour to ensure complete removal of any remaining moisture in the tank and process lines. All personnel left the area except for one process specialist. Without authority or direction, the process specialist drained 5 liters of solution from the process line from Tank D973. The liquid was darker in color than the other solution drained from D467, which usually indicates a higher plutonium concentration. While the line was being drained, the foreman and production manager returned, witnessed the event, but did not stop the unauthorized activity. The three individuals diluted the solution among five four-liter bottles and falsified the entries on the glovebox nuclear material balance card. Several days later, the production manager had the unauthorized sample analyzed. The results indicated a concentration that violated the Nuclear Material Safety Limits for the glovebox. Upon notification of the event, the shift manager terminated nuclear operations in the building.

Examples of lessons learned from this event include the following:

- The incident primarily reflected the inability of the contractor management to establish an appropriate safety culture. This permitted risky behavior by operating personnel. Management was ineffective in putting corrective actions in place to prevent recurrence of events.
- There was a shortage of experienced Nuclear Criticality Safety Engineers. In addition, the training program was determined to be inferior and the Nuclear Criticality Safety Committee was ineffective.
- Rocky Flats was unable to maintain an effective authorization basis, thereby increasing the potential for an accidental criticality.
- There was a severe communications breakdown between management and workers.
- There was a large backlog of criticality safety evaluations requiring peer review and CSAs requiring review. Reviews were being conducted by CSEs with only a marginal knowledge of the operations.
- Operating personnel considered that their extensive process knowledge kept them safe despite such unknowns as tank stratification, valve leakage, etc.

PANTEX CONDUCT OF OPERATIONS ASSESSMENTS AND LESSONS LEARNED

Assessments were conducted during January 1994 to evaluate the Conduct of Operations practices at the Pantex Plant. One assessment was done to determine what additional actions should be taken within DOE to aid in the implementation of the Conduct of Operations at the Pantex site. A separate team assessed the contractor's actions. An action plan was developed by the contractor to address the weaknesses identified and the recommendations of the assessment teams.

The DOE Assessment Team identified the following weaknesses:

- Facility Representatives were weak in the fundamental concepts and practical implementation of SARs, OSR requirements, and Basis for Interim Operation for facilities for which they were responsible
- Facility Representatives spent a significant portion of the field time assessing facility material conditions while assessments of ongoing activities were less evident. While the overall understanding of facility operations was judged to be adequate, the understanding of the operational details was not as evident.
- Facility Representatives did not demonstrate ownership of the occurrence reporting system. Despite a belief that the contractor was under-reporting, they did not challenge classifications on a daily basis or elevate unresolved items to DOE management.

Other issues included:

- The Facility Representatives have little experience in operations that are performed in a disciplined and formal manner.
- The qualification program for Facility Representatives was halted by AAO when management identified program problems. However, there were no corrective actions established.
- Training qualifications standards did not exist to define the program expectations nor provide a method for consistency and objectivity in evaluations.
- Inadequate resources are being utilized to develop and implement an oversight program.
- There was no written guidance for a daily routine for Facility Representatives and there was no written guidance for a systematic assessment program. No formal method for tracking closure of issues raised by Facility Representatives was noted.
- There was a lack of oversight of operations from DOE groups other than Facility Representatives.

The following are examples of the observations of the contractor assessment team:

- Most senior level, middle level, and lower levels of management had a shallow understanding of Conduct of Operations requirements and did not adequately understand the comprehensiveness involved in successfully implementing the Order.
- The concept of, and requirements for Facility Management needed to be formulated and promulgated.
- The Lockout/Tagout system had many deficiencies and needed strengthening.
- The RADCON program needed improvement.

SEQUOYAH FUELS CORPORATION

On January 4, 1986, one worker was killed and several injured when an overfilled cylinder of UF₆ ruptured during heating at the Sequoyah Fuels Corporation in Gore, Oklahoma. The accident occurred despite the fact that heating of overfilled cylinders was recognized as dangerous and company procedures prohibited the practice.

Review of the failure of Sequoyah Fuels Corporation also offered several significant lessons learned. Those of particular applicability to the Y-12 NCS program improvement activities include those centered on building a safety culture in which management and the workforce fully understand their regulatory environment. In particular, these include:

- A workforce culture that does not understand the need to conform to committed programs and procedures will erode regulator confidence and create a negative environment.
- Management and the workforce must believe in a safety culture that rewards compliance with established procedures. There must also be negative consequences for not supporting the safety culture.
- The safety culture must be based on absolute integrity and candidness by all employees. There must be an absolute mandate to be self-policing, to identify issues and problems, and to report violations and other information needed by regulators.

LOS ALAMOS DNFSB FINDINGS AND LESSONS LEARNED

On April 15, 1994, LANL management at TA-55 terminated normal operations within PF-4. Their actions followed two events caused by weaknesses in the implementation of OSR surveillance requirements. One involved the inoperability of the facility's diesel-driven fire pumps. Another event involved failure of an OSR surveillance regarding safe shutdown of the facility. These events emphasized deficiencies in the inadequacy of surveillance procedures, the failure of the technicians to perform surveillances, and the lack of notification of the facility management of the failure to meet surveillance acceptance criteria. LANL decided to continue the shutdown until tests intended to verify the surveillance requirements were assessed for their quality. The following items were identified as part of a DNFSB review of TA-55.

- The performance of a surveillance in support of OSRs revealed deficiencies in the verification that operations are conducted within the safety envelope.

Several operating parameters found to be out-of-specification were not reported as such.

The applicable procedures were not used. A checklist provided with a procedure was not filled out as required.

The procedures were not written such that verbatim compliance was possible.

- Review of LANL TA-55 Order Compliance Self-Assessment revealed inadequacies in documentation of objective evidence of compliance.

Requirements of DOE training Order 5480.20 were assessed as compliance based on the existence of a procedure with which the facility has not yet complied. This action delays consideration of corrective or compensatory measures for known noncompliances.

Compliance with some of the industry nuclear criticality standards required by DOE Order on criticality safety (5480.24) was based on previous assessments that actually indicated areas of noncompliance.

- Observation of a Cassini Line operation revealed deficiencies in the facility conduct of operations

The work instruction used to change parts of the procedure appears to circumvent the normal review and approval process for procedure changes

Critical steps requiring independent verification by a Quality Assurance Representative were signed off by the technician performing the step

- Review of the status and plans of the TA-55 training and qualification program revealed the need for several improvements, including the addition of fundamentals and systems training, in order to become compliant with DOE 5480.20. Many of the improvements have already been planned by

LANL and will correct deficiencies noted in the Board staff trip report forwarded to DOE in January 1994.

Additional lessons learned from similar events at other facilities can be obtained from a review of the Occurrence Reporting and Processing System (ORPS).

APPENDIX G

DNFSB RECOMMENDATIONS 94-4, 93-6 and 92-5

RECOMMENDATION 94-4 TO THE SECRETARY OF ENERGY
pursuant to 42 U.S.C. § 2286a(5) Atomic Energy Act of 1954, as amended.

Dated: September 27, 1994

The Defense Nuclear Facilities Safety Board (Board) has issued a number of recommendations concerning formality of operations, including Recommendation 92-5, Discipline of Operations in a Changing Defense Nuclear Facilities Complex. In that recommendation, the Board stated that facilities scheduled for continued operations should develop a style and level of conduct of operations which is comparable to that achieved at commercial nuclear facilities. Recommendation 92-5 further noted that, prior to achieving an acceptable level of formality, major improvements were required in a number of areas, including safety analysis reports, limiting conditions of operation, and training and qualification of personnel.

The Board and its staff have been monitoring the Department of Energy's (DOE) efforts to implement an acceptable level of conduct of operations at the Y-12 Plant in Oak Ridge, Tennessee, which is scheduled for continued operations. The Board has forwarded a number of reports to DOE during the last two years indicating the existence of safety-related concerns regarding operations at Y-12. DOE and its operating contractor, Martin-Marietta Energy Systems (MMES), have taken some actions to correct deficiencies; however, a number of recent events have led the Board to the conclusion that more aggressive and comprehensive management actions are required to bring the level of conduct of operations at Y-12 to a satisfactory level.

The Board notes that during the past four months a number of violations of Operational Safety Requirements and other safety limits have occurred at the Y-12 Plant. Most recently, the Board's staff identified a substantial violation of nuclear criticality safety limits within a special nuclear material storage vault at Y-12. When the staff identified this deficiency to on-site personnel, including a senior MMES manager, an MMES nuclear criticality safety specialist, and one of DOE's facility representatives, immediate corrective actions that were required by Y-12 procedures were not taken. In fact, proper corrective actions were not taken until the Board's staff informed the DOE Y-12 Site Manager. Subsequently MMES curtailed a number of operations at the Y-12 Plant. Reviews of compliance with nuclear criticality safety limits at the Y-12 Plant revealed that a widespread level of non-compliance exists.

In its Annual Report to Congress (February 1994) the Board noted that personnel and procedures are complementary elements in implementing conduct of operations. The report stated, "The health and safety of the public and workers rest on a properly trained workforce accomplishing tasks in a formal, deliberate fashion in accordance with reviewed and approved procedures." In responding to the Board's Recommendation 93-6, Maintaining Access to Nuclear Weapons Experience, DOE is evaluating the impact of expertise presently being lost through ongoing staff reductions on their ability to perform nuclear weapons dismantlement at Y-12.

The Board recognizes that DOE and MMES management have begun taking aggressive actions to correct the specific problems of adherence to nuclear criticality safety limits, since the nuclear criticality safety occurrence referred to above. However, the Board believes that more remains to be done. Accordingly, the Board recommends that:

- (1) DOE determine the immediate actions necessary to resolve the nuclear criticality safety deficiencies at the Y-12 Plant, including actions deemed necessary before restarting curtailed operations and any compensatory measures instituted. These actions should be documented, along with an explanation of how the deficiencies remained undetected by MMES and DOE (line and oversight).

- (2) DOE perform the following for defense nuclear facilities at the Y-12 Plant:
 - (a) An evaluation of compliance with Operational Safety Requirements and Criticality Safety Approvals (CSAs), including a determination of the root cause of any identified violations. In performing this assessment, DOE should use the experience gained during similar reviews at the Los Alamos plutonium facility and during the recent "maintenance mode" at the Pantex Plant.
 - (b) A comprehensive review of the nuclear criticality safety program at the Y-12 Plant, including: the adequacy of procedural controls, the utility of the nuclear criticality safety approvals, and a root cause analysis of the extensive level of non-compliance found in recent reviews.
 - (c) A comparison of the current level of conduct of operations to the level expected by DOE in implementing the Board's Recommendation 92-5.
 - (d) Development of plans, including schedules, to address any deficiencies identified in the analyses conducted above.
- (3) DOE evaluate the experience, training, and performance of key DOE and contractor personnel involved in safety-related activities at defense nuclear facilities within the Y-12 Plant to determine if those personnel have the skills and knowledge required to execute their nuclear safety responsibilities (in this regard, reference should be made to the critical safety elements developed as part of DOE's response to the Board's Recommendation 93-1).
- (4) DOE take whatever actions are necessary to correct any deficiencies identified in (3) above in the experience, training, and performance of DOE and contractor personnel.

/s/

John T. Conway, Chairman

RECOMMENDATION 93-6 TO THE SECRETARY OF ENERGY
pursuant to 42 U.S.C. § 2286a(5) Atomic Energy Act of 1954, as amended.

Dated: December 10, 1993

The ongoing reduction in size of the stockpile of nuclear weapons and the related changes in the defense nuclear complex have a number of safety-related consequences. The Board has addressed several of its sets of recommendations to such problem areas, including 92-5, which concerned discipline of operations in a changing defense nuclear facilities complex, and 93-2, which stated a continued need for capability to conduct critical experiments. We wish now to draw attention to the need to retain access to capability and capture the unique knowledge of individuals who have been engaged for many years in certain critical defense nuclear activities, in order to avoid future safety problems in these and related activities.

The first critical area requiring continued access to departing personnel is the disassembly of nuclear weapons at the Pantex site, an activity that will continue for a number of years. The second is the testing of nuclear explosives at the Nevada Test Site, an activity presently subject to a moratorium. However, the President, in establishing that moratorium, said that he has retained the possibility of later resumption of tests if that is needed, and that he expects the Department of Energy to maintain a capability to resume testing. In reaction to the recent Chinese underground test he has instructed the Department of Energy to take steps necessary to prepare for resumption, pending a decision as to whether further tests at the Nevada Test Site should be conducted.

A substantial amount of documentation exists on the design and safety aspects of nuclear weapons that will have to be dismantled at Pantex. This information is essential for the dismantlement program and is used in that program. Even so, the Board has pointed out that it is also important, for safety reasons, to involve individuals from the design laboratories of Los Alamos, Livermore, and Sandia in review of detailed dismantlement procedures and specialized procedures responding to problems encountered in the course of dismantlement. This practice has been initiated, and it has already been seen to be vital to safety assurance in the dismantlement program.

The design individuals from the laboratories most needed in connection with dismantlement of a specific weapon are those who had been active in the original design of that weapon. They are believed to possess information not recorded in documentation, such as reasons for specific design features, and personal knowledge of any problems that have arisen during design, fabrication, and stockpile life. Many of the remaining individuals with this background are being lost from the system, because of the University of California's recent retirement incentive, planned layoffs by contractors, and DOE downsizing and retirements. Some recent moves to prevent or discourage use of retired individuals as consultants compound the problem; they erect barriers that could prevent access to the needed expertise. Similar problems also arise in connection with maintaining capability for testing of nuclear explosives at the Nevada Test Site. On the assumption that the testing moratorium will continue, we foresee an impairment of capability to ensure the safety of tests if national priorities call for resumption of testing at some future time. This impairment will occur both through reduction in competence that naturally follows when a highly skilled operation is not conducted over a long period of time, and through loss of skilled and experienced personnel. The loss of skilled personnel will be especially troubling because there has traditionally been a high degree of dependence on administrative controls for safety in testing of nuclear explosive devices at the Nevada Test Site. Proper exercise of these administrative controls requires considerable background in past methods of test emplacement and test conduct, and extensive institutional memory.

The Board recognizes the Department's efforts to develop a "stockpile stewardship" program focused to ensure the continued safety and reliability of fielded weapons, to ensure maintenance of laboratory development capability, and to ensure a limited production capability. Our areas of concern complement

these necessary activities, but are focused instead on ensuring that capability is maintained to conduct testing operations safely if they must be done, and that all future dismantlement activities can be completed safely. Although it may be relatively straightforward to maintain these capabilities in the near term, ensuring their availability 5 to 20 years in the future may be very difficult.

In accordance with the above concerns, the Board makes the following recommendations:

- (1) That a formal process be started to identify the skills and knowledge needed to develop or verify safe dismantlement or modification procedures specific to all remaining types of U.S. nuclear weapons (retired, inactive, reserve, and enduring stockpile systems). Included among the skills and knowledge should be the ability to conduct relevant safety analyses.
- (2) That a similar formal process be started to identify the skills and knowledge needed to safely conduct nuclear testing operations at the Nevada Test Site, including the processes of assembly/disassembly, on-site transportation, insertion/emplacement, arming and firing, timing and control, and post-shot operations. Included among the skills and knowledge should be the ability to conduct relevant safety analyses.
- (3) That a practice be instituted of reviewing the personnel losses at the nuclear weapons laboratories and the Nevada Test Site, as well as the losses of key personnel from DOE's own staff engaged in nuclear defense activities, to ascertain which of the skills and knowledge are projected to be lost through departure of personnel.
- (4) That DOE and its defense nuclear contractors negotiate the continued availability (through retention, hiring, consulting, etc.) of those personnel scheduled to depart whose skills and knowledge have been determined to be important in accordance with the above.
- (5) That programs be initiated to obtain from these expert personnel (and to record) the as yet undocumented anecdotal technical information that would be of value in augmenting the technical knowledge and expertise of successor personnel. This should be done either prior to departure of the retiring personnel or shortly thereafter.
- (6) That procedures for safe disassembly of weapons systems be developed while the personnel with system-specific expertise on the original development of the weapons are still available. Likewise, analyses of the possibility of hazard from degradation of remaining nuclear weapons with time should be expedited, while these individuals are available. In addition, the current participation of design laboratory experts in the safety aspects of disassembly of weapons at the Pantex Site should be strengthened.
- (7) That a program be developed and instituted for maintaining expertise in operations key to safety of nuclear testing at the Nevada Test Site, to ensure that if testing is resumed at any future time, it can be performed with requisite safety. Possible components are those activities and experiments that would be permitted within limitations of treaties being discussed, for example: hydro-nuclear tests, backdrilling for isotopic analysis of residues from old shots, and exercises including steps in preparation for tests, up to actual emplacement.
- (8) Given the loss of experienced personnel, that a determination be made as to whether traditional dependence on administrative controls to ensure nuclear explosive safety at the Nevada Test Site would be adequate and appropriate if nuclear testing should be resumed at a later time. It may be found necessary to develop an approach for ensuring nuclear explosive safety in the testing program that is less dependent on the performance of highly experienced personnel, such as through the use of engineered safeguards similar to those used in fielded weapons as part of the arming and firing, and timing and control systems.

/s/

John T. Conway, Chairman

RECOMMENDATION 92-5 TO THE SECRETARY OF ENERGY
pursuant to 42 U.S.C. § 2286a(5) Atomic Energy Act of 1954, as amended.

Dated: August 17, 1992

The changes in defense-related plans in the Department of Energy are beginning to have a profound effect on the activities directed to systematic upgrading of the conduct of operations at defense nuclear facilities, plans that have often been discussed between the Board and its staff, on the one hand, and members of your staff on the other.

The Rocky Flats Plant presents an excellent example of the major changes being made by DOE while reconfiguring the nuclear weapons complex. It had been planned that as the Rocky Flats Plant moved toward resumption of production of plutonium components of nuclear weapons, a succession of facilities would be readied for renewed operation, beginning with Building 559 (the analytical chemistry laboratory), and followed by Building 707 and then others. This process was to include systematic upgrading of the quality of operations in each case, including Operational Readiness Reviews by the contractor and by DOE to verify that the desired improvements had been accomplished by line management. Resumption of operations is now proceeding in Building 559, in accordance with this process and following the path proposed in your Implementation Plan for the Board's Recommendations 90-4 and 91-4.

You have announced, however, that in light of international developments, plutonium production operations will not be resumed at the Rocky Flats Plant, and future activities there will be confined to cleanup and decontamination of the site, decommissioning of some facilities and parts of others, and placing of some facilities and parts of others in a state of readiness for resumption of operations in the future in the event such a step should be needed. Thus for most facilities at Rocky Flats there is now a major change from the mission and activities previously planned and for which the Board's Recommendations and your implementation plans specific to the Rocky Flats Plant were to be applied, for those recommendations were predicated upon resumption of plutonium production.

At a number of other defense nuclear facilities, similar changes are taking effect. Many facilities are now scheduled for cleanout, shutdown, and decommissioning. Some are to be devoted to aspects of cleanup and decommissioning of sites and of facilities located within sites. Some are slated to be placed in a standby mode, available for restart at a later date if needed. Some are to be continued in operation either in reduction of the stockpile of nuclear weapons or in the maintenance of a reduced stockpile and improvement of its safety.

Some of these facilities have been inactive for long periods of time. Some are to become involved in operations that differ from past usage. Experience shows that when operations are resumed at a facility that has been idle for an extended period, or a facility is operated in a new mode, there is an above-average possibility of mistakes, equipment failures, and violations of safety requirements, that could cause accidents. We believe that special attention is needed at such times. The appropriate measures to be followed depend on specific features of the facility, the nature of the planned campaign of use, and the long-term plan for the facility. For example, one needs to know if further campaigns are likely, of the same or different kinds; if the facility is to be decommissioned after the planned use; or if it is to be placed in a standby mode.

The Board has found, through experience at the Savannah River Sites and the Rocky Flats Plant and other defense nuclear facilities, that an extended period of time has been required at major facilities to develop an acceptable style and level of conduct of operations. Accomplishing the cultural changes you have required and meeting safety standards comparable to those required of the civilian nuclear industry remains an ongoing challenge. Major improvements have been necessary including development of configuration control, revised and acceptable safety analysis, revised Limiting Conditions of Operation derivative from the

safety analysis, operating procedures consistent with the configuration and the safety analysis, and training and qualification of operators for the new mode of operation. Continued improvement has been sought by the Board.

The Board has been informed that DOE does not intend to devote equivalent time and resources to improving the quality of operation at a facility being restarted only for a short campaign or intended for use only in a short campaign in a different mode, but would on a cost-benefit basis use a graded approach, always being sure, however, to take whatever compensatory and other measures are needed to ensure the acceptable level of safety.

The definition and exposition of a graded approach as it is meant to be used in ordering the conduct of operations have not been provided. In discharging its responsibilities in the context of the new defense-related plans of the Department of Energy, the Board intends to carefully review future operations at defense nuclear facilities on a case-by-case basis, starting in each instance from the best information as to the intended future use of the facility. Any proposals to use special measures or controls to compensate for deviations from those ordinarily used to achieve high quality conduct of operations will be closely scrutinized.

Therefore, it is requested that as you decide the future status of individual defense nuclear facilities you inform the Board, designating which ones are to continue in operation and their mission, which are to be shut down for decommissioning within a short time period, which are to be used for an extended time period and then shut down for decommissioning, and which are to be moved to a standby mode (along with the schedule for this).

Regardless of the category, the Board believes that operation and maintenance of defense nuclear facilities in all modes should be in accordance with the Nuclear Safety Policy statement that you issued on September 9, 1991 as SEN-35-91, and the safety goals stated therein.

The Board also believes that, to the extent practicable, facilities that are to be shut down and decommissioned should be cleaned up, and hazards from radiological exposures sufficiently reduced that access can be made freely without need for precautions against radioactivity, and facilities meant for standby status should be placed in such a condition that sudden need to reactivate them would not subject a new operating group to unacceptable radiation hazards.

In furtherance of this view it is recommended that:

1. For defense nuclear facilities scheduled for long term continued programmatic defense operations or for other long term uses such as in cleanup of radioactive contamination or in storage of nuclear waste or other nuclear material from programmatic defense operations, the Department of Energy should institute a style and level of conduct of operations comparable to that toward which DOE has been working at Building 559 at the Rocky Flats Plant and the K-Reactor at the Savannah River Site, and which is at least comparable to that required for commercial nuclear facilities, addressing at a minimum the areas referred to above in connection with style of conduct of operations.
2. Where a facility, after a long period of idleness for whatever reason, is being readied for new use or reuse, special care should be taken to ensure that the line organization, both DOE and contractor, has the technical and managerial capability needed to carry out its responsibilities. Appropriate and effective Operational Readiness Reviews should be conducted by the contractor and by DOE before restart of the facility, to establish confidence that line management has provided satisfaction of safety requirements. Where national security requirements lead to urgent need to restart such facilities before necessary upgrades can be fully completed, compensatory measures should be instituted and their adequacy in ensuring the desired level of safety should be confirmed through appropriate independent review.

3. For facilities designated for the various other future modes of use (such as standby), DOE should undertake to develop specific criteria and requirements that ensure meeting the safety goals enunciated in your Nuclear Policy Statement (SEN-35-91). Accomplishment of these criteria and requirements by line management should be confirmed by appropriate independent review.

/s/

John T. Conway, Chairman

APPENDIX H
REFERENCES

APPENDIX H – REFERENCES

The following required reading list has been developed to assist the assessment team members in preparation for the assessments.

- ANSI/ANS-8.1-1983, *Nuclear Criticality Safety in Operations with Fissionable Materials Outside Reactors*
- ANSI/ANS-8.3-1986, *Criticality Accident Alarm Systems*
- ANSI/ANS-8.5-1986, *Use of Borosilicate-Glass Raschig Rings as a Neutron Absorber in Solutions of Fissile Material*
- ANSI/ANS-8.6-1983, *Safety in Conducting Subcritical Neutron-Multiplication Measurements in Situ*
- ANS-8.7/ANSI N16.5-1975 (R1987), *Guide for Nuclear Criticality Safety in Storage of Fissile Materials*
- ANSI/ANS-8.9-1987, *Nuclear Criticality Safety Criteria for Steel-Pipe Intersections Containing Aqueous Solutions of Fissile Materials*
- ANSI/ANS-8.10-1983, *Criteria for Nuclear Criticality Safety Controls in Operations with Shielding and Confinement*
- ANSI/ANS-8.12-1987, *Nuclear Criticality Control and Safety of Plutonium-Uranium Fuel Mixtures Outside Reactors*
- ANSI/ANS-8.17-1984, *Criticality Safety Criteria for the Handling, Storage, and Transportation of LWR Fuel Outside Reactors*
- ANSI/ANS-8.19-1984, *Administrative Practices for Nuclear Criticality Safety*
- ANSI/ANS-8.20-1991, *Nuclear Criticality Safety Training*
- DNFSB Recommendation 94-4, *Deficiencies in Criticality Safety at Oak Ridge Y-12 Plant.*
- DNFSB Recommendation 93-6, *Maintaining Access to Nuclear Weapons Experience*
- DNFSB Recommendation 92-5, *Discipline of Operations in a Changing Defense Nuclear Facilities Complex*
- ESS-CS-101, *Nuclear Criticality Safety Program Elements*, Revision 0 (or latest revision)
- ESS-CS-102, *Nuclear Criticality Safety Approval*, Revision 1 (or latest revision)
- ESS-CS-103, *Nuclear Criticality Safety Calculations*, Revision 0 (or latest revision)
- Evaluation of the Nuclear Criticality Safety Program at the Y-12 Plant, March 21 through April 5, 1995 (draft or latest revision)
- Guidelines for Preparing Criticality Safety Evaluations at Department of Energy Non-Reactor Nuclear Facilities, September 1, 1992

- Implementation Plan for Defense Nuclear Facilities Safety Board Recommendation 94-4, *Deficiencies in Criticality Safety at Oak Ridge Y-12 Plant*, February 1995
- Martin Marietta Energy Systems, Inc. Readiness Assessment Implementation Plan for the Resumption of Receipt, Storage, and Shipment of Special Nuclear Materials at the Oak Ridge Y-12 Plant
- Nuclear Facility Operations Safety Assessment Team Report Draft for Rocky Flats Environmental Technology Site, March 27, 1995
- Operational Safety Requirements, Buildings 9204-2 and 9204-2E, Revision 1 (or latest revision)
- Pantex Conduct of Operations Review
- Preliminary Evaluation of the Y-12 Nuclear Criticality Safety Program, Criticality Safety Approvals, and Operational Safety Requirements Supporting Receipt, Storage, and Shipment of Special Nuclear Materials
- Readiness Assessments by LANL and the Department of Energy (DOE) for Resumption of TA-55 Operations
- The Initial Report of Martin Marietta Energy Systems Evaluation of the Oak Ridge National Laboratory, September 17-28, 1990
- Type C Investigation of the Y-12 Plant Criticality Safety Approval Infractions Event at Building 9204-2E
- Y-12 Plant Nuclear Criticality Safety Program Description
- Y50-66-CS-326, *Nuclear Criticality Safety Operational Review* (latest revision)
- Y50-66-CS-327, *Nuclear Criticality Safety Incidents* (latest revision)
- Y70-150, *Nuclear Criticality Safety* (latest revision)
- Y70-160, *Criticality Safety Approval System* (latest revision)
- Y70-01-150, *General Nuclear Criticality Safety Requirements -- Disassembly and Storage* (latest revision)
- Y70-37-19-071, *General Nuclear Criticality Safety Requirements -- Building 9215 Enriched Uranium Operations* (latest revision)
- Y/DD-623, *Plan for Continuing and Resuming Operations*, October 1994
- Y/DD-669, *Nuclear Criticality Safety Management Plan for 1995 Resumption* (latest revision)
- Y/DD-673, *Management Plan for Assessing Y-12 Plant Criticality Accident Alarm System Coverage* (latest revision)



APPENDIX I
FINAL REPORT OUTLINE

APPENDIX H – FINAL REPORT OUTLINE

To the extent practical, all supporting information should be typed in Word Perfect 5.1. Handwritten information such as relevant field notes from interviews or walkdowns, should be retained by the team members. The report will provide clearly defined technical bases for the conclusions, concerns, and findings. The following format is suggested for the final reports.

TASK 2 FINAL REPORT

Executive Summary

- Assessment Purpose
- Major Conclusions
- Major Recommendations
- Summation

Introduction

Background

Assessments

CSA Compliance

- Issues
- Conclusions
- Recommendations

Utility of Nuclear Criticality Safety Approvals

- Issues
- Conclusions
- Recommendations

OSR Compliance

- Issues
- Conclusions
- Recommendations

Special Operations – CSA and OSRs

- Issues
- Conclusions
- Recommendations

Completed Readiness Assessments

- Issues
- Conclusions
- Recommendations

Completed Actions in Near-Term Initiatives for Nuclear Criticality Safety

- Issues
- Conclusions
- Recommendations

Corrective Actions Related to Probable Causes Documented in the Type C Investigation

- Issues
- Conclusions
- Recommendations

Corrective Actions Related to Causal Factors in the MMES Internal Report, *Evaluation of Criticality Safety Discrepancy Data*

Issues
Conclusions
Recommendations

Progress by MMES in Phase III and IV Activities Involving Criticality Safety as Defined in Y/AD-623, *Plan for Continuing and Resuming Operations*

Issues
Conclusions
Recommendations

Root Cause Analysis – Previously Identified CSA and OSR Deficiencies

Issues
Conclusions
Recommendations

Lessons Learned at Pantex Plant, Rocky Flats Site, the Sequoyah Fuels Corporation, and the Los Alamos TA-55 facility

Issues
Conclusions
Recommendations

Training Effectiveness

Issues
Conclusions
Recommendations

Summary of Conclusions and Recommendations

Glossary/Acronyms

Appendix A – Assessment Forms

Appendix B – Reference Document List

Appendix C – Biographical Summaries of Assessment Team

TASK 3 FINAL REPORT

Executive Summary

- Assessment Purpose**
- Major Conclusions**
- Major Recommendations**
- Summation**

Introduction

Background

Assessment of Task 3 – Criticality Safety Program Review

Staffing Levels and Qualifications

- Issues**
- Conclusions**
- Recommendations**

Maintenance and Change Control Programs

- Issues**
- Conclusions**
- Recommendations**

Criticality Safety Evaluation Processes (including administrative controls and implementing procedures)

- Issues**
- Conclusions**
- Recommendations implementing procedures**

Compliance with Applicable DOE Orders Governing Criticality Safety

- Issues**
- Conclusions**
- Recommendations**

Training Effectiveness

- Issues**
- Conclusions**
- Recommendations**

Criticality Safety Program Management

- Issues**
- Conclusions**
- Recommendations**

Summary of Conclusions and Recommendations

Glossary/ Acronyms

Appendix A – Assessment Forms

Appendix B – Reference Document List

Appendix C – Biographical Summaries of Assessment Team

United States Government

Department of Energy

Oak Ridge Operations Office

memorandum

DATE: July 28, 1995

REPLY TO: DP-B1:Wall
ATTN OF:

SUBJECT: DNFSS RECOMMENDATION 94-4 JULY DELIVERABLE

TO: RADM Charles J. Beers, Jr., Deputy Assistant Secretary for Military Application and Stockpile Support, DP-20, FORS

RECEIVED
1995 AUG -1 AM 11:31
DNF SAFETY BOARD

The attached document, Y/NO-00005, "Lockheed Martin Energy Systems Assessment Criteria for the Evaluation of the Oak Ridge Y-12 Plant Nuclear Criticality Safety Program," meets commitment 3.1 of the DOE implementation Plan for DNFSS Recommendation 94-4.

If you have any questions related to this matter, please contact David Wall of my staff at (615) 576-1989.


Robert J. Spence
Y-12 Site Manager

Attachment

- cc w/o attachment:
- John Rothrock, SE-33, ORO
- John Ford, EW-92, ORO
- Martin McBride, H-7, ORO
- John Rayside, 9116, NS 8223, Y-12

July 26, 1995

RECEIVED

1995 AUG -1 AM 11:31

DNF SAFETY BOARD

Mr. R. J. Spence
Department of Energy, Oak Ridge Operations
Post Office Box 2001
Oak Ridge, Tennessee 37831

Dear Mr. Spence:

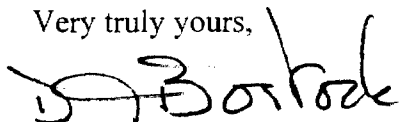
Commitment 3.1 from the Department of Energy (DOE) Implementation Plan for the Defense Nuclear Facilities Safety Board (DNFSB) Recommendation 94-4

The enclosed report, Y/NO-00005, "Lockheed Martin Energy Systems Assessment Criteria for the Evaluation of the Oak Ridge Y-12 Plant Nuclear Criticality Safety Program," was prepared to document completion of Commitment 3.1 from the DOE Implementation Plan for DNFSB Recommendation 94-4. The commitment states the following:

The LMES shall develop criteria based upon industry standards and DOE Order 5480.24. This activity should be worked in conjunction with the criteria development for independent review, discussed in 3.4.

If you have any questions regarding this report, please call R. V. Stachowiak at 4-9979.

Very truly yours,



D. J. Bostock
Vice President
Defense and Manufacturing

DJB:RVS:sc

Enclosure

Mr. R. J. Spence

Page 2

July 26, 1995

cc/enc: J. A. Allard
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S. R. Wilson
Y-12 Audit Response Center
Y-12 Central Files
A. K. Zava

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DEFENSE NUCLEAR FACILITIES SAFETY BOARD

Y-12

**OAK RIDGE
Y-12
PLANT**

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LOCKHEED MARTIN ENERGY SYSTEMS
ASSESSMENT CRITERIA FOR THE EVALUATION OF THE
OAK RIDGE Y-12 PLANT NUCLEAR CRITICALITY SAFETY PROGRAM

Commitment 3.1 of the Implementation Plan for
Defense Nuclear Facilities Safety Board Recommendation 94-4

July 1995

MANAGED BY
MARTIN MARIETTA ENERGY SYSTEMS, INC.
FOR THE UNITED STATES
DEPARTMENT OF ENERGY

APPROVED FOR PUBLIC RELEASE	
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ACRONYM LIST

ANSI	American National Standards Institute
ANS	American National Standard
CAA	criticality accident alarm
CAS	criticality alarm system (DOE 5480.24)
CAAS	criticality accident alarm system
DNFSB	Defense Nuclear Facilities Safety Board
DOE	Department of Energy
DOE-ORO	Department of Energy Oak Ridge Operations Office
LCO	Limiting Conditions of Operation document
LMES	Lockheed Martin Energy Systems, Inc.
NCS	nuclear criticality safety
ORIG	Oak Ridge (DOE-ORO) Implementation Guidance
OSR	Operational Safety Requirements document
SAR	Safety Analysis Report
TSR	Technical Safety Requirement
Y-12	Oak Ridge Y-12 Plant

1. INTRODUCTION

Defense Nuclear Facilities Safety Board (DNFSB) Recommendation 94-4 regarding deficiencies in nuclear criticality safety (NCS) and conduct of operations at the Oak Ridge Y-12 Plant (Y-12) was issued on September 27, 1994, and subsequently accepted by the Secretary of Energy on November 18, 1994. In response to this recommendation, the U. S. Department of Energy (DOE) Implementation Plan for DNFSB Recommendation 94-4 was developed to present a schedule of actions to address the recommendation. This report addresses Commitment 3.1 under Task 3 in the 94-4 Implementation Plan:

The LMES shall develop criteria based upon industry standards and DOE Order 5480.24. This activity should be worked in conjunction with the criteria development for independent review, discussed in 3.4.

Under Task 3 of the 94-4 Implementation Plan, the Y-12 Criticality Safety Program will be evaluated by a Lockheed Martin Energy Systems (LMES) Assessment Team and an independent DOE team. This report addresses the LMES portion of Task 3 (Commitment 3.1) by providing the performance objectives and associated assessment criteria. The objectives and criteria were derived from DOE Order 5480.24 and the directly referenced American National Standards Institute (ANSI) standards in this order. The development of these criteria was performed in conjunction with the efforts developing the criteria for Task 3 (commitment 3.4). The criteria contained herein will be used in the conduct of the Task 3 (commitment 3.2) evaluation.

2. PERFORMANCE OBJECTIVES

This section presents the six performance objectives to be used in the LMES evaluation of the Y-12 Criticality Safety Program and the assessment criteria associated with each objective.

2.1 NCS.1 ORGANIZATION/ADMINISTRATION

PERFORMANCE OBJECTIVE: The organizations responsible for nuclear criticality safety (NCS) at the site are in place, are adequately staffed, and are functioning in an effective manner.

ASSESSMENT CRITERIA:

1. Management shall accept overall responsibility for safety of operations. Continuing interest in safety shall be evident. ANSI/ANS-8.19, Sect. 4.1
2. Management shall formulate nuclear criticality safety policy and make it known to all employees involved in operations with fissile material. ANSI/ANS-8.19, Sect. 4.2
- 3.a. Management shall assign responsibility and delegate commensurate authority to implement established policy. Responsibility for nuclear criticality safety *shall* be assigned in a manner compatible with that for other safety disciplines. ANSI/ANS-8.19, Sect. 4.3; DOE Order 5480.24, ¶7.a.(1)
- 3.b. Management shall clearly establish responsibility for nuclear criticality safety. Supervision *shall* be made as responsible for nuclear criticality safety as for production, development, research, or other functions. Each individual, regardless of position, shall be made aware that nuclear criticality safety in his work area is ultimately his responsibility. ANSI/ANS-8.1, Sect. 4.1.1, ¶1; DOE Order 5480.24, ¶7.a.(1)
- 4.a. Management shall provide personnel familiar with the physics of nuclear criticality and with associated safety practices to furnish technical guidance appropriate to the scope of operations. This function *shall*, to the extent practicable, be administratively independent of operations. ANSI/ANS-8.19, Sect. 4.4; DOE Order 5480.24, ¶7.a.(1)
- 4.b. Management shall provide personnel skilled in the interpretation of data pertinent to nuclear criticality safety and familiar with operations to serve as advisors to supervision. These specialists *shall* be, to the extent practicable, administratively independent of process supervision. ANSI/ANS-8.1, Sect. 4.1.1, ¶2; DOE Order 5480.24, ¶7.a.(1)
5. Each supervisor shall accept responsibility for the safety of operations under his control. ANSI/ANS-8.19, Sect. 5.1
6. Each supervisor shall be knowledgeable in those aspects of nuclear criticality safety relevant to operations under his control. ANSI/ANS-8.19, Sect. 5.2
7. The (NCS) staff shall maintain familiarity with current developments in nuclear criticality safety standards, guides, and codes. Knowledge of current nuclear criticality information *shall* be maintained. ANSI/ANS-8.19, Sect. 6.2; DOE Order 5480.24, ¶7.a.(1)

ASSESSMENT CRITERIA: (continued)

(Criticality staff shall be able to demonstrate that they are able to obtain criticality safety information necessary to perform their duties. DOE-ORO ORIG N 5480.24, Attachment, Interpretation of ANSI/ANS-8.19, Sect. 6.2)

8. The (NCS) staff *shall* consult with knowledgeable individuals to obtain technical assistance as needed. ANSI/ANS-8.19, Sect. 6.3; DOE Order 5480.24, ¶7.a.(1)
[See (ANSI/ANS) 8.19 (Sect.) 6.2. May be demonstrated by Criticality Safety Committee Meeting minutes and/or letters to file documenting consultations with other criticality experts. DOE-ORO ORIG N 5480.24, Attachment, Interpretation of ANSI/ANS-8.19, Sect. 6.3]
9. The (NCS) staff shall maintain familiarity with all operations within the organization requiring nuclear criticality safety controls. ANSI/ANS-8.19, Sect. 6.4

2.2 NCS.2 DEVELOPMENT OF NCS REQUIREMENTS

PERFORMANCE OBJECTIVE: NCS requirements for site fissionable material operations are established on the basis of industry standards [ANSI/ANS (American National Standards Institute/American National Standard) standards] and any additional requirements of DOE Order 5480.24.

ASSESSMENT CRITERIA:

1. Management shall establish the criteria to be satisfied by nuclear criticality safety controls. Distinction may be made between shielded and unshielded facilities, and the criteria may be less stringent when adequate shielding and confinement assure the protection of personnel. ANSI/ANS-8.1, Sect. 4.1.1, ¶3
2. All controlled parameters and their limits shall be specified. ANSI/ANS-8.1, Sect. 4.2.1, ¶2
3. Contractors shall establish a monitoring and surveillance program to prevent accumulations of fissionable materials in, but not limited to, process equipment and storage, pipe, and ventilation systems. If unsafe accumulations are detected, corrective measures shall be taken to prevent criticality hazards.
DOE Order 5480.24, ¶ 7.d
(The contractor shall conduct monitoring and surveillance in support of an accumulation prevention program.
DOE-ORO ORIG N 5480.24, Attachment, Interpretation of DOE Order 5480.24, ¶ 7.d)
- 4.a. Access to areas where fissile material is handled, processed, or stored shall be controlled. ANSI/ANS-8.19, Sect. 9.4
- 4.b. Access to storage areas shall be controlled. ANSI/ANS-8.7, Sect. 4.1.4
- 5.a. The movement of fissionable materials shall be controlled. ANSI/ANS-8.1, Sect. 4.1.4
- 5.b. The movement of fissile materials shall be controlled. ANSI/ANS-8.19, Sect. 8.4
- 5.c. The requirements of this Order (DOE 5480.24) shall apply to all activities where fissionable material is transferred from one operation to another within a facility and from one on-site location to another. DOE Order 5480.24, ¶ 7.e.(1)
6. For on-site transportation, contractors shall be required to follow the guidelines of an approved on-site transportation safety manual. DOE Order 5480.24, ¶ 7.e.(2)
["Approved on-site transportation safety manual" interpreted as "established on-site transportation procedures".
DOE-ORO ORIG N 5480.24, Attachment, Interpretation of DOE Order 5480.24, ¶ 7.e.(2)]

ASSESSMENT CRITERIA: (continued)

7. The requirements of DOE 5480.3 shall be complied with regarding offsite shipment of fissionable material. DOE Order 5480.24, ¶ 7.e.(3)
8. DOE 5610.1 shall apply for the safe transportation of weapon components and special assemblies shipped in national defense. DOE Order 5480.24, ¶ 7.e.(4)
9. Control of spacing, mass, density, and geometry of fissile material shall be maintained to assure subcriticality under all normal and credible abnormal conditions. ANSI/ANS-8.19, Sect. 9.5
10. Operations to which nuclear criticality safety is pertinent shall be governed by written procedures. All persons participating in these operations shall understand and be familiar with the procedures. The procedures shall specify all parameters they are intended to control. They *shall* be such that no single, inadvertent departure from a procedure can cause a criticality accident. ANSI/ANS-8.1, Sect. 4.1.3; DOE Order 5480.24, ¶7.a.(1)
11. New or revised procedures impacting nuclear criticality safety shall be reviewed by the nuclear criticality safety staff. ANSI/ANS-8.19, Sect. 7.5
12. 4.2.2 Double Contingency Principle. Process designs shall incorporate sufficient factors of safety to require at least two unlikely, independent, and concurrent changes in process conditions before a criticality accident is possible. Protection shall be provided by either (a) the control of two independent process parameters (which is the preferred approach, if practical) or (b) a system of multiple (at least two) controls on a single parameter. In all cases, no single failure shall result in the potential for a criticality accident. The basis for selecting either approach shall be fully documented. DOE Order 5480.24, ¶7.a.(2)(a) replacement for ANSI/ANS-8.1, Sect. 4.2.2
[A "criticality accident" is interpreted as a "credible criticality accident." All other occurrences of the phrase "criticality accident" shall be interpreted as "credible criticality accident." The basis used to demonstrate that no single event can lead to a criticality accident shall be documented. DOE-ORO ORIG N 5480.24, Attachment, Interpretation of DOE Order 5480.24, ¶7.a.(2)(a)]
13. 4.2.3 Geometry Control. As a first priority, reliance shall be placed on equipment design in which dimensions of the contained fissionable material and spacing between equipment are limited via passive engineering controls. Where geometry control is not feasible, the preferred order of controls is other passive engineering controls, active engineering controls, and administrative controls. Feasibility is determined by weighing risk versus practicality/cost. Full advantage may be taken of any nuclear characteristics of the process, materials and equipment. All dimensions, nuclear properties, and

ASSESSMENT CRITERIA: (continued)

features upon which reliance is placed shall be verified prior to beginning operations, and control shall be exercised to maintain them. The basis for not selecting geometry control shall be fully documented.

DOE Order 5480.24, ¶7.a.(2)(b) replacement for ANSI/ANS-8.1, Sect.-4.2.3

[Where a significant quantity of fissionable material is being processed and criticality safety is a concern, the passive engineering controls such as geometry control will be considered as a primary control method. for existing operations where it can be shown that protection is provided as per paragraph 7.a.(2)(a) of this order, the double contingency analysis can be used as the risk vs cost analysis. DOE-ORO ORIG N 5480.24, Attachment, Interpretation of DOE Order 5480.24, ¶7.a.(2)(b)]

- 14.a. Reliance may be placed on neutron-absorbing materials, such as cadmium and boron, that are incorporated in process materials or equipment, or both. Control shall be exercised to maintain their continued presence with the intended distributions and concentrations. Extraordinary care shall be taken with solutions of absorbers because of the difficulty of exercising such control. ANSI/ANS-8.1, Sect. 4.2.4
- 14.b. If boron glass raschig rings are used as a neutron absorber, ANSI/ANS-8.5 shall be followed.
- 15.a. Before a new operation with fissionable materials is begun or before an existing operation is changed, it shall be determined that the entire process will be subcritical under both normal and credible abnormal conditions. Care shall be exercised to determine those conditions which result in the maximum effective multiplication factor (k_{eff}). ANSI/ANS-8.1, Sect. 4.1.2
- 15.b. Before starting a new operation with fissile materials or before an existing operation is changed, it shall be determined that the entire process will be subcritical under both normal and credible abnormal conditions. ANSI/ANS-8.19, Sect. 8.1
16. The nuclear criticality safety evaluation shall determine and explicitly identify the controlled parameters and their associated limits upon which nuclear criticality safety depends. ANSI/ANS-8.19, Sect. 8.2
17. The nuclear criticality safety evaluation shall be documented with sufficient detail, clarity, and lack of ambiguity to allow independent judgment of results. ANSI/ANS-8.19, Sect. 8.3
18. Before starting operation, there shall be an independent assessment that confirms the adequacy of the nuclear criticality safety evaluation. ANSI/ANS-8.19, Sect. 8.4

ASSESSMENT CRITERIA: (continued)

- 19.a. Where applicable data are available, subcritical limits shall be established on bases derived from experiments, with adequate allowance for uncertainties in the data. In the absence of directly applicable experimental measurements, the limits may be derived from calculations made by a method shown by comparison with experimental data to be valid in accordance with 4.3. ANSI/ANS-8.1, Sect. 4.2.5
- 19.b. Limits for the storage of fissile material shall be based on experimental data or the results of validated computational techniques. ANSI/ANS-8.7, Sect. 4.2.1
- 20.a. Operations with fissile materials may be performed safely by complying with any one of the limits given in (ANSI/ANS-8.1) 5.1, 5.2, 5.3, and 5.4 for single units provided the conditions under which the limit applies are maintained; these limits were calculated by methods satisfying the requirements of (ANSI/ANS-8.1) 4.3. A limit shall be applied only when surrounding materials, including other nearby fissionable materials, can be shown to increase the effective multiplication factor (k_{eff}) no more than does enclosing the unit by a contiguous layer of water of unlimited thickness. A limit may be applied to a mixture of fissile nuclides by considering all components of the mixture to be the one with the most restrictive limit. Process specifications shall incorporate margins to protect against uncertainties in process variables and against a limit being accidentally exceeded. ANSI/ANS-8.1, Sect. 5
- 20.b. Operations (with special actinide nuclides) may be performed safely by complying with the appropriate subcritical mass limits given in (ANSI/ANS-8.15) 5.1 and 5.2. Other limits for mixtures of fissile and non-fissile isotopes of the same element wherein water has not been excluded are treated in (ANSI/ANS-8.15) 6.1, 6.2, and 6.3. NOTE: Process specifications shall incorporate margins to protect against uncertainties in process variables and against a limit being accidentally exceeded. ANSI/ANS-8.15, Sect. 5
21. Bias (in a calculational method) shall be established by correlating the results of criticality experiments with results obtained for these same systems by the method being validated. ANSI/ANS-8.1, Sect. 4.3.1
22. The area(s) of applicability of a calculational method may be extended beyond the range of experimental conditions over which the bias is established by making use of the trends in the bias. Where the extension is large, the method *shall* be supplemented by other calculational methods to provide a better estimate of the bias in the extended area(s). ANSI/ANS-8.1, Sect. 4.3.2; DOE Order 5480.24, ¶7.a.(1)

ASSESSMENT CRITERIA: (continued)

23. A margin in the correlating parameter (for a calculational method), which margin may be a function of composition and other variables, shall be prescribed that is sufficient to ensure subcriticality. This margin of subcriticality shall include allowances for the uncertainty in the bias and for uncertainties due to any extensions of the area(s) of applicability. ANSI/ANS-8.1, Sect. 4.3.3
24. If the (calculational) method involves a computer program, checks shall be performed to confirm that the mathematical operations are performed as intended. Any changes in the computer program shall be followed by reconfirmation that the mathematical operations are performed as intended. ANSI/ANS-8.1, Sect. 4.3.4
25. Nuclear properties such as cross sections *should* be consistent with experimental measurements of these properties. ANSI/ANS-8.1, Sect. 4.3.5; DOE Order 5480.24, ¶7.a.(1)
(Remain as "should." Exact consistency would rule out adjusted cross sections. Consistency can be demonstrated by comparison with experimental data or other calculations. DOE-ORO ORIG N 5480.24, Attachment, Interpretation of ANSI/ANS-8.1, Sect. 4.3.5)
26. A written report of the validation shall be prepared. This report shall: (1) Describe the method with sufficient detail, clarity, and lack of ambiguity to allow independent duplication of results; (2) State computer programs used, the options, recipes for choosing mesh points where applicable, the cross section sets, and any numerical parameters necessary to describe the input; (3) Identify experimental data and list parameters derived therefrom for use in the validation of the method; (4) State the area(s) of applicability; and (5) State the bias and the prescribed margin of subcriticality over the area(s) of applicability. State the basis for the margin. ANSI/ANS-8.1, Sect. 4.3.5

2.3 NCS.3 IMPLEMENTATION OF NCS REQUIREMENTS

PERFORMANCE OBJECTIVE: NCS requirements for site fissionable material operations are adequately implemented through flowdown, NCS training, and configuration management practices.

ASSESSMENT CRITERIA:

1. Nuclear criticality safety programs shall be fully documented. DOE Order 5480.24, ¶ 7.c, 1st paragraph
(Documentation of the nuclear criticality safety program shall include policies and procedures implementing the elements of the ANSI/ANS standards specified in DOE Order 5480.24, ¶ 7.a. DOE-ORO ORIG N 5480.24, Attachment, Interpretation of DOE Order 5480.24, ¶ 7.c)
2. Additionally, the limiting conditions of operation for criticality safety shall be included in the facility TSRs. DOE Order 5480.24, ¶ 7.c, 2nd paragraph
(Additionally, the safety limits, limiting control settings, limiting conditions of operation, administrative controls, and administrative program for criticality safety shall be included in the facility TSRs as applicable and dictated by a commitment made in the SAR. DOE-ORO ORIG N 5480.24, Attachment, Interpretation of DOE Order 5480.24, ¶ 7.c)
3. The nuclear criticality safety staff shall provide technical guidance for the design of equipment and processes and for the development of operating procedures. ANSI/ANS-8.19, Sec. 6.1
4. Operations to which nuclear criticality safety is pertinent shall be governed by written procedures. All persons participating in these operations shall understand and be familiar with the procedures. The procedures shall specify all parameters they are intended to control. ANSI/ANS-8.1, Sect. 4.1.3
5. Methods of storage control and operational practices approved by management shall be described in written procedures. Persons participating in the transfer and storage of material shall be familiar with these procedures. ANSI/ANS-8.7, Sect. 4.1.2
6. Supervisors shall develop or participate in the development of written procedures applicable to the operations under their control. Maintenance of these procedures to reflect changes in operations shall be a continuing supervisory responsibility. ANSI/ANS-8.19, Sec. 5.4
7. Procedures *shall* be organized and presented for convenient use by operators. They *shall* be free of extraneous material. ANSI/ANS-8.19, Sect. 7.1; DOE Order 5480.24, ¶ 7.a.(1)
[Contractor line management is responsible for the organization and presentation of procedures for convenient use by operators.]

ASSESSMENT CRITERIA: (continued)

A directive to line management in the facility (and NCS) safety manual would meet this requirement. The same is true for the making sure procedures are clear of extraneous material. DOE-ORO ORIG N 5480.24, Attachment, Interpretation of ANSI/ANS-8.19, Sect. 7.1]

8. Procedures shall include those controls and limits significant to the nuclear criticality safety of the operation. ANSI/ANS-8.19, Sect. 7.2
- 9.a. Appropriate materials labeling and area posting shall be maintained specifying material identification and all limits on parameters that are subjected to procedural control. ANSI/ANS-8.1, Sect. 4.1.4
- 9.b. Appropriate material labeling and area posting shall be maintained specifying material identification and all limits on parameters that are subject to procedural control. ANSI/ANS-8.19, Sect. 9.2
10. Limits for storage shall be posted. ANSI/ANS-8.7, Sect. 4.1.2
11. Procedures *shall* be supplemented by posted nuclear criticality safety limits or limits incorporated in operating check lists or flow sheets. ANSI/ANS-8.19, Sect. 7.6; *DOE Order 5480.24, ¶7.a.(1)*
12. Each supervisor shall require conformance with good safety practices including unambiguous identification of fissile materials and good housekeeping. ANSI/ANS-8.19, Sec. 5.6
13. Each individual, regardless of position, shall be made aware that nuclear criticality safety in his work area is ultimately his responsibility. This may be accomplished through training and periodic retraining of all operating and maintenance personnel. ANSI/ANS-8.1, Sect. 4.1.1, ¶1
14. Operations to which nuclear criticality safety is pertinent shall be governed by written procedures. All persons participating in these operations shall understand and be familiar with the procedures. ANSI/ANS-8.1, Sect. 4.1.3
15. Each supervisor shall be knowledgeable in those aspects of nuclear criticality safety relevant to operations under his control. Training and assistance *shall* be obtained from the nuclear criticality safety staff. ANSI/ANS-8.19, Sect. 5.2; *DOE Order 5480.24, ¶7.a.(1)*
16. Each supervisor shall provide training and shall require that the personnel under his supervision have an understanding of procedures and safety considerations such that they may be expected to perform their functions without undue risk. Records of training activities and verification of personnel understanding shall be maintained. ANSI/ANS-8.19, Sec. 5.3
17. The (NCS) staff shall assist supervision, on request, in training personnel. ANSI/ANS-8.19, Sect. 6.5

ASSESSMENT CRITERIA: (continued)

18. Personnel in the area to be evacuated (in event of a nuclear criticality accident) shall be trained in evacuation methods and informed of routes and assembly stations. ANSI/ANS-8.19, Sect. 10.5
19. Supplementing and revising procedures as improvements become desirable shall be facilitated. ANSI/ANS-8.19, Sect. 7.3
20. Active procedures shall be reviewed periodically by supervision. ANSI/ANS-8.19, Sect. 7.4
21. New or revised procedures impacting nuclear criticality safety shall be reviewed by the nuclear criticality safety staff. ANSI/ANS-8.19, Sect. 7.5
22. All dimensions, nuclear properties, and features upon which reliance is placed shall be verified prior to beginning operations, and control shall be exercised to maintain them. DOE Order 5480.24, ¶7.a.(2)(b) replacement for ANSI/ANS-8.1, Sect. 4.2.3
23. Supervisors shall verify compliance with nuclear criticality safety specifications for new or modified equipment before its use. Verification may be based on inspection reports or other features of the quality control system. ANSI/ANS-8.19, Sec. 5.5
24. If reliance is placed on neutron absorbing materials that are incorporated into process materials or equipment, control shall be exercised to maintain their continued presence with the intended distributions and concentrations. ANSI/ANS-8.19, Sect. 9.3

2.4 NCS.4 ASSESSMENTS

PERFORMANCE OBJECTIVE: Procedures covering both operational NCS compliance and NCS program assessments are in place and are being performed at the site in an effective manner.

ASSESSMENT CRITERIA:

1. Management shall establish a means for monitoring the nuclear criticality safety program. ANSI/ANS-8.19, Sec. 4.5
2. Management shall periodically participate in auditing the overall effectiveness of the nuclear criticality safety program. ANSI/ANS-8.19, Sec. 4.6
3. Management may use consultants and nuclear criticality safety committees in achieving the objectives of the nuclear criticality safety program. ANSI/ANS-8.19, Sec. 4.7
4. Management shall provide for inspections to verify compliance with established (fissile material storage) procedures. ANSI/ANS-8.7, Sect. 4.1.3
5. Each supervisor shall require conformance with good safety practices including unambiguous identification of fissile materials and good housekeeping. ANSI/ANS-8.19, Sec. 5.6
6. The (NCS) staff shall maintain familiarity with all operations within the organization requiring nuclear criticality safety controls. ANSI/ANS-8.19, Sect. 6.4
7. The (NCS) staff shall conduct or participate in audits of criticality safety practices and compliance with procedures as directed by management. ANSI/ANS-8.19, Sect. 6.6
- 8.a. Operations shall be reviewed frequently (at least annually) to ascertain that procedures are being followed and that process conditions have not been altered so as to affect the nuclear criticality safety evaluation. These reviews shall be conducted, in consultation with operating personnel, by individuals who are knowledgeable in nuclear criticality safety and who, to the extent practicable, are not immediately responsible for the operation. ANSI/ANS-8.1, Sect. 4.1.6
- 8.b. Operations shall be reviewed frequently (at least annually) to ascertain that procedures are being followed and that process conditions have not been altered so as to affect the nuclear criticality safety evaluation. ANSI/ANS-8.19, Sect. 7.8

2.5 NCS.5 NCS INCIDENT REPORTING, TRACKING, TRENDING, RESOLUTION, and LESSONS LEARNED

PERFORMANCE OBJECTIVE: A program is in place and functioning effectively at the site to handle NCS incident reporting, tracking, trending, resolution, and lessons learned.

ASSESSMENT CRITERIA:

- 1.a. Deviations from procedures and unforeseen alterations in process conditions that affect nuclear criticality safety shall be reported to management and shall be investigated promptly. Action shall be taken to prevent a recurrence. ANSI/ANS-8.1, Sect. 4.1.5
- 1.b. Deviations from operating procedures and unforeseen alterations in process conditions that affect nuclear criticality safety shall be documented, reported to management, and investigated promptly. Action shall be taken to prevent a recurrence. ANSI/ANS-8.19, Sect. 7.7
2. The (NCS) staff shall examine reports of procedural violations and other deficiencies for possible improvement of safety practices and procedural requirements, and shall report their findings to management. ANSI/ANS-8.19, Sect. 6.7

2.6 NCS.6 CRITICALITY ACCIDENT ALARM SYSTEM AND EMERGENCY PLANNING

PERFORMANCE OBJECTIVE: Programs are in place at the site to assure criticality accident alarm (CAA) coverage where it is required by DOE Order 5480.24 and ANSI/ANS-8.3 and to assure proper emergency response in event of a criticality accident.

ASSESSMENT CRITERIA:

1. The requirements in ANSI/ANS-8.3 relating to the needs for an alarm system are not applicable to this Order. For the purpose of this Order, Criticality Alarm Systems (CAS) and criticality detection systems shall be required as follows: (1) In those cases where the mass of fissionable material exceeds the limits established in paragraph 4.2.1 of ANSI/ANS-8.3 and the probability of criticality is greater than 10^{-6} per year (as documented in a DOE approved SAR), a CAS meeting ANSI/ANS-8.3 shall be provided to cover occupied areas in which the expected dose exceeds 12 rads in free air, where a CAS is defined to include a criticality accident detection device and a personnel evacuation alarm. (2) In those cases where the mass of fissionable material exceeds the limits established in paragraph 4.2.1 of ANSI/ANS-8.3 and the probability of criticality is greater than 10^{-6} per year, (as documented in a DOE approved SAR), but there are no occupied areas in which the expected dose exceeds 12 rads in free air, a criticality detection system shall be provided where a criticality detection system is defined to be an appropriate criticality accident detection device but without an immediate evacuation alarm. The criticality accident detection system response time should be sufficient to allow for appropriate process-related mitigation and recovery actions. While an immediate evacuation alarm is not required under these circumstances, evacuation shall be implemented (i.e. evacuation notification or delayed alarm) if potential doses to occupational workers could be effectively limited by such actions in accordance with DOE 5480.11. (3) In those cases where the mass of fissionable material exceeds the limits established in paragraph 4.2.1 of ANSI/ANS-8.3, but a criticality accident is determined to be impossible due to the physical form of the fissionable material, or the probability of occurrence is determined to be less than 10^{-6} per year (as documented in a DOE approved SAR), neither a CAS nor a criticality detection system is required. In addition, neither a CAS nor a criticality detection system is required to be installed underwater when fissionable material is handled or stored beneath water shielding that is adequate to protect personnel; however a means to detect fission product gasses or other volatile fission products should be provided in occupied areas immediately adjacent to such underwater storage areas except for fuel systems where no fission products are likely to be released. Also, neither a CAS nor a criticality detection system are required for fissionable material during shipment of fissionable material packaged in approved shipping containers, or fissionable material packaged in approved shipping containers awaiting transport provided no other operation involving fissionable material not so packaged is permitted on the

ASSESSMENT CRITERIA: (continued)

dock or in the shipment area. (4) The decision to install a criticality detection system rather than a CAS, and the decision that neither a CAS nor a criticality detection system is necessary, must be justified based upon a documented DOE approved Safety Analysis. DOE Order 5480.24, ¶ 7.b

{The use of 10^{-6} does not necessarily mean that a PRA has to be performed. Reasonable grounds shall be presented on the basis of commonly accepted engineering judgment. [see interpretation for 7.a.(2)(a)] DOE-ORO ORIG N 5480.24, Attachment, Interpretation of DOE Order 5480.24, ¶7.b.(1)(2)(3)}

[A criticality detection system may be any device capable of alerting operations staff that a criticality (accident) has occurred. It does not have to be a criticality alarm system or necessarily have an associated alarm. It does not necessarily have to be instantaneous, but should be timely such that processes can be shut down, if necessary, or other mitigating action taken. Any determination concerning a criticality alarm/detection system via this order will be documented in a DOE-approved SAR or DOE-approved SAR addendum.

DOE-ORO ORIG N 5480.24, Attachment, Interpretation of DOE Order 5480.24, ¶7.b.(4)]

2. Where alarm systems are installed, emergency plans *shall* be maintained. ANSI/ANS-8.3, Sect. 4.1.2; DOE Order 5480.24, ¶7.a.(1)
3. In areas in which criticality alarm coverage is required, a means shall be provided to detect excessive amounts or intensities of radiation and to signal personnel evacuation. The type of radiation to be detected and the mode of detection and the alarm signal *shall* be uniform throughout the system. ANSI/ANS-8.3, Sect. 4.3; DOE Order 5480.24, ¶7.a.(1)
(The contractor will define the type of system most appropriate for the operation to be monitored. The system will be uniform to the operation for which it was designed. DOE-ORO ORIG N 5480.24, Attachment, Interpretation of ANSI/ANS-8.3, Sect. 4.3)
4. The alarm signal shall be for immediate evacuation purposes only and of sufficient volume and coverage to be heard in all areas that are to be evacuated. ANSI/ANS-8.3, Sect. 4.4.1
5. The signal shall be a mid-frequency complex sound wave that may be amplitude modulated at a subsonic frequency. The fundamental frequency *shall* not exceed 1000 Hz. Modulation *shall* be at a rate less than 5 Hz. ANSI/ANS-8.3, Sect. 4.4.2; DOE Order 5480.24, ¶7.a.(1)
6. The signal generator *shall* produce an overall sound pressure level which is not less than 10 dB above the overall maximum typical ambient noise level, and in any case not less than 75 dB (referenced to $20 \mu\text{N}/\text{m}^2$) at every location from which immediate evacuation is deemed essential. ANSI/ANS-8.3, Sect. 4.4.3; DOE Order 5480.24, ¶7.a.(1)

ASSESSMENT CRITERIA: (continued)

7. Since excessive noise levels can be injurious to personnel, the signal generator *shall* not produce an A-weighted sound level in excess of 115 dB (referenced to 20 μ N/m²) at the ear of an individual. ANSI/ANS-8.3, Sect. 4.4.4; DOE Order 5480.24, ¶7.a.(1)
8. A sufficient number of signal generators *shall* be installed so that the recommendations of 4.4.3 and 4.4.4 are met. ANSI/ANS-8.3, Sect. 4.4.5; DOE Order 5480.24, ¶7.a.(1)
9. The signal generating system(s) shall be automatically actuated by an initiating event without requiring human action. ANSI/ANS-8.3, Sect. 4.4.6
10. The alarm trip point *shall* be set high enough to minimize the probability of an alarm from sources other than criticality. The level shall be set low enough to detect the minimums accident of concern. ANSI/ANS-8.3, Sect. 4.4.7; DOE Order 5480.24, ¶7.a.(1)
11. Evacuation shall be signaled promptly upon detection of an accident. ANSI/ANS-8.3, Sect. 4.4.8
12. After initiation, the signal shall continue to sound as required by emergency procedures, even though the radiation falls below the alarm point. Manual resets, with limited access, *shall* be provided outside the areas to be evacuated. ANSI/ANS-8.3, Sect. 4.4.9; DOE Order 5480.24, ¶7.a.(1)
13. Consideration shall be given to the avoidance of false alarms. This may be accomplished by providing reliable single detector channels or by requiring concurrent response of two or more detectors to initiate the alarm. In redundant systems, failure of any single channel shall not prevent compliance with the detection criterion specified in 5.6. ANSI/ANS-8.3, Sect. 4.5.1
14. A means that will not cause an evacuation *shall* be provided to test the response and performance of the alarm system. The system shall be returned to operating condition immediately following tests. ANSI/ANS-8.3, Sect. 4.5.2; DOE Order 5480.24, ¶7.a.(1)
15. Process areas in which activities will continue during a power outage shall have emergency power supplies for alarm systems or such activities shall be monitored continuously with portable instruments. ANSI/ANS-8.3, Sect. 4.5.3
16. Detectors shall not fail to initiate an alarm when subjected to a radiation field of at least 10 rad/s. ANSI/ANS-8.3, Sect. 4.5.4
17. The system shall be designed for high reliability and *shall* utilize components which do not require frequent servicing such as lubrication or cleaning. The system *shall* be designed to minimize the effects of non-use, deterioration, power surges, and other

ASSESSMENT CRITERIA: (continued)

adverse conditions. ANSI/ANS-8.3, Sect. 5.1 ¶1,2; DOE Order 5480.24, ¶7.a.(1)

(Contractor shall provide definitions of their period or frequency of service. Approved service frequency will satisfy the "non-use" design requirements. Adequate testing, as per paragraphs 6.3 and 6.4 of this standard, will assure there is not an extended period of non-use. When new systems are installed or existing systems are reactivated after being out of service longer than the set testing period, they shall be tested for proper operation. DOE-ORO ORIG N 5480.24, Attachment, Interpretation of ANSI/ANS-8.3, Sect. 5.1 ¶1,2)

18. The design of the system *shall* be as simple as is consistent with the single objective of reliable activation of the alarm. ANSI/ANS-8.3, Sect. 5.1 ¶3; DOE Order 5480.24, ¶7.a.(1)
(Tested criticality alarm designs shall be used. New criticality alarm system designs are subject to field office review and PSO approval. DOE-ORO ORIG N 5480.24, Attachment, Interpretation of ANSI/ANS-8.3, Sect. 5.1 ¶3)
19. All components of the system *shall* be located to minimize damage in case of fire, explosion, corrosive atmosphere, or other extreme conditions. ANSI/ANS-8.3, Sect. 5.2; DOE Order 5480.24, ¶7.a.(1)
(The technical basis for placement of alarms shall be documented for new installations of criticality alarm systems. Consideration to shielding, damage due to fire, corrosive atmosphere, etc., shall be included. DOE-ORO ORIG N 5480.24, Attachment, Interpretation of ANSI/ANS-8.3, Sect. 5.2)
20. The design and installation of the system shall be such as to resist earthquake damage. The system *shall* remain operational in the event of seismic shock equivalent to the site specific design basis earthquake, or the equivalent value specified by the Uniform Building Code. ANSI/ANS-8.3, Sect. 5.3; DOE Order 5480.24, ¶7.a.(1)
[The detection unit and primary annunciator of new criticality alarm systems or major modifications to existing system(s) shall remain operational in the event of seismic shock equivalent to the seismic qualification of the building, if such exists, or in the absence of same the lesser of a) the site specific design basis earthquake, b) the value specified by the Uniform Building Code or, c) the threshold ground acceleration value to which the building was designed. DOE-ORO ORIG N 5480.24, Attachment, Interpretation of ANSI/ANS-8.3, Sect. 5.3]
21. The system shall not produce an evacuation signal due to component failure; however, a visible or audible warning signal shall be provided at some normally occupied location to indicate system malfunction or the loss of primary power. ANSI/ANS-8.3, Sect. 5.4
22. The system shall be designed to produce the desired signal within one half second of activation by the minimum accident of concern. ANSI/ANS-8.3, Sect. 5.5

ASSESSMENT CRITERIA: (continued)

23. Criticality alarm systems shall be designed to detect immediately the minimum accident of concern. For this purpose, in areas where material is handled or processed with only nominal shielding, the minimum accident may be assumed to deliver the equivalent of an absorbed dose in free air of 20 rad at a distance of 2 m from the reacting material within 60 s. The alarm signal shall activate promptly when the dose rate at the detectors equals or exceeds a value equivalent to 20 rad/min at 2 m from the reacting material.
ANSI/ANS-8.3, Sect. 5.6
24. In the design of radiation detectors, it may be assumed that the minimum duration of the radiation transient is 1 ms. Systems shall be designed so that instrument response and alarm latching shall occur as a result of transients of 1 ms duration. ANSI/ANS-8.3, Sect. 5.7.1
25. To minimize false alarms, the trip point may be set in the rad/h range as long as the criterion of (ANSI/ANS-8.3, Sect.) 5.6 is met. The alarm trip point of a rate-sensing device *shall* be more than 10 mrad/h above normal or operational background at the monitoring point. ANSI/ANS-8.3, Sect. 5.3; DOE Order 5480.24, ¶7.a.(1)
26. The location and spacing of detectors *shall* be chosen to avoid the effect of shielding by massive equipment or materials. Low-density materials of construction, such as wood framing, thin interior walls, hollow brick tiles, etc., may be disregarded. The spacing of detectors shall be consistent with the selected alarm trip point and with the detection criterion. ANSI/ANS-8.3, Sect. 5.8; DOE Order 5480.24, ¶7.a.(1)
27. Initial tests, inspections, and checks of the system shall verify that the fabrication and installation were made in accordance with design plans and specifications. ANSI/ANS-8.3, Sect. 6.1
28. Following significant modification or repair to a system, there shall be tests and checks equivalent to the initial installation tests.
ANSI/ANS-8.3, Sect. 6.2
29. System response to radiation shall be measured periodically to confirm continuing instrument performance. The test interval may be determined on the basis of experience; however, tests *shall* be performed at least monthly. Records of tests shall be maintained.
ANSI/ANS-8.3, Sect. 6.3; DOE Order 5480.24, ¶7.a.(1)
30. The entire alarm system shall be tested periodically. Each audible signal generator *shall* be tested at least once every three months. Field observations shall establish that the signal is audible above background throughout all areas to be evacuated. All personnel in affected areas shall be notified in advance of an audible test.
ANSI/ANS-8.3, Sect. 6.4; DOE Order 5480.24, ¶7.a.(1)

ASSESSMENT CRITERIA: (continued)

31. When tests reveal inadequate performance, corrective action shall be taken without unnecessary delay. ANSI/ANS-8.3, Sect. 6.5
32. Procedures shall be formulated to minimize false alarms which may be caused by testing and to return the system to normal operation immediately following the test. ANSI/ANS-8.3, Sect. 6.6
33. All tests and corrective actions shall be recorded in a logbook maintained for each system. This record will provide information on the system operability and help to identify sources of failure. ANSI/ANS-8.3, Sect. 6.7
34. Instructions regarding response to signals shall be posted throughout the area from which there is provision for evacuation. ANSI/ANS-8.3, Sect. 7.1
35. All employees whose work may necessitate their presence in an area covered by the signal shall be made familiar with the sound of the signal. ANSI/ANS-8.3, Sect. 7.2.1
36. Before placing the system into operation, all employees normally working in the area shall be acquainted with the signal by actual demonstration at their work locations. ANSI/ANS-8.3, Sect. 7.2.2
37. To refresh memories and acquaint new employees and transferees into an area, the signal *shall* be sounded during working hours at least once quarterly after notifying all concerned. Non-regular-shift employees shall be included. ANSI/ANS-8.3, Sect. 7.2.3; DOE Order 5480.24, ¶7.a.(1)
- 38.a. Visitors to an area covered by a system *shall* be familiarized with the evacuation signal and advised of the proper response. ANSI/ANS-8.3, Sect. 7.2.4; DOE Order 5480.24, ¶7.a.(1)
(Unescorted visitors to an area shall be familiarized with the evacuation signal and advised of proper response. DOE-ORO ORIGIN 5480.24, Attachment, Interpretation of ANSI/ANS-8.3, Sect. 7.2.4)
- 38.b. Provision shall be made for the evacuation of transient personnel. ANSI/ANS-8.19, Sect. 10.5
- 39.a. Evacuation drills shall be conducted at least annually, and *shall* be preceded by written notice, posted signs, or voice announcement over a public address system. Surprise test evacuations shall not be employed because of the possibility that accident or injury may result. ANSI/ANS-8.3, Sect. 7.3; DOE Order 5480.24, ¶7.a.(1)
- 39.b. Drills shall be performed at least annually to maintain familiarity with the emergency procedures. Drills shall be announced in advance. ANSI/ANS-8.19, Sect. 10.5

ASSESSMENT CRITERIA: (continued)

- 40.a. Emergency procedures shall be prepared and approved by management. Organizations, local and offsite, that are expected to respond to emergencies shall be made aware of conditions that might be encountered, and they *shall* be assisted in preparing suitable procedures governing their responses. ANSI/ANS-8.1, Sect. 4.1.7; DOE Order 5480.24, ¶ 7.a.(1)
(Contractors will make available assistance that might be requested by local and offsite organizations expected to respond to emergencies in preparing suitable procedures. A letter to their respective Emergency Preparedness Offices so stating would be appropriate. Any assistance provided to these organizations shall be documented. DOE-ORO ORIG N 5480.24, Attachment, Interpretation of ANSI/ANS-4.1, Sect. 4.1.7)
- 40.b. Emergency procedures shall be prepared and approved by management. Organizations, on and off-site, that are expected to provide assistance during emergencies shall be informed of conditions that might be encountered. They *shall* be assisted in preparing suitable emergency response procedures. ANSI/ANS-8.19, Sect. 10.2; DOE Order 5480.24, ¶ 7.a.(1)
(See 8.1 4.1.7. DOE-ORO ORIG N 5480.24, Attachment, Interpretation of ANSI/ANS-4.19, Sect. 10.2)
41. Emergency procedures shall clearly designate evacuation routes. Evacuation *shall* follow the quickest and most direct routes practicable. These routes shall be clearly identified and *shall* avoid recognized areas of higher risk. ANSI/ANS-8.19, Sect. 10.3; DOE Order 5480.24, ¶ 7.a.(1)
(Interpreted to mean that egress shall be made by the quickest exit. DOE-ORO ORIG N 5480.24, Attachment, Interpretation of ANSI/ANS-4.19, Sect. 10.3)
42. Personnel assembly stations, outside the areas to be evacuated shall be designated. Means to account for personnel shall be established. ANSI/ANS-8.19, Sect. 10.4
43. Personnel in the area to be evacuated (in event of a nuclear criticality accident) shall be trained in evacuation methods and informed of routes and assembly stations. ANSI/ANS-8.19, Sect. 10.5
44. Arrangements shall be made in advance for the care and treatment of injured and exposed persons. The possibility of personnel contamination by radioactive materials shall be considered. ANSI/ANS-8.19, Sect. 10.6
45. Planning shall include a program for the immediate identification of exposed individuals and *shall* include personnel dosimetry. ANSI/ANS-8.19, Sect. 10.7; DOE Order 5480.24, ¶ 7.a.(1)

ASSESSMENT CRITERIA: (continued)

46. Instrumentation and procedures shall be provided for determining the radiation at the assembly area and in the evacuated area following a criticality accident. Information *shall* be correlated at a central control point. ANSI/ANS-8.19, Sect. 10.8; DOE Order 5480.24, ¶7.a.(1)
47. Emergency procedures shall address re-entry procedures and the membership of response teams. ANSI/ANS-8.19, Sect. 10.9
48. Contractors shall establish guidelines for permitting fire fighting water or other moderating materials used to suppress fires within or adjacent to moderation controlled areas. These guidelines shall be based on comparisons of risk and consequences of accidental criticality with the risks and consequences of postulated fires for the respective area(s). The basis for the guidelines shall be fully documented in a DOE approved Safety Analysis. DOE Order 5480.24, ¶7.f (Risk and consequence comparison may be a qualitative evaluation. DOE-ORO ORIG N 5480.24, Attachment, Interpretation of DOE Order 5480.24, ¶7.f)

3. CONCLUSIONS

Detailed performance objectives and assessment criteria have been developed to assess the adequacy of the Y-12 NCS Program. The objectives and criteria are based on DOE Order 5480.24 and directly referenced ANSI standards. These criteria will be used in the conduct of the Task 3 (commitment 3.2) evaluation.

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DNF SAFETY BOARD

QUARTERLY REPORT 2

DEPARTMENT OF ENERGY

IMPLEMENTATION PLAN

FOR

DEFENSE NUCLEAR FACILITIES SAFETY BOARD

RECOMMENDATION 94-4

**DEFICIENCIES IN CRITICALITY SAFETY
AT THE OAK RIDGE Y-12 PLANT**

**REPORTING PERIOD
APRIL 1 THROUGH JUNE 30, 1995**

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EXECUTIVE SUMMARY

This Report for the Defense Nuclear Facilities Safety Board (Board) Recommendation 94-4 Implementation Plan (Plan) covers the period from April 1 through June 30, 1995.

The Y-12 Plant is proceeding toward resumption of the Receipt, Shipping, and Storage (RSS) mission area. Lockheed Martin Energy Systems (LMES) has completed their management self-assessment (MSA). The MSA has identified a significant number of deficiencies. A total of 122 findings and 84 observations were identified in eight functional areas.

The LMES is developing and implementing corrective actions for each identified deficiency. Approximately 60 percent of these deficiencies have been designated "prestart," requiring correction prior to restart. As of July 25, 1995, 54 prestart deficiencies have been closed. The remaining prestart deficiencies are scheduled to be corrected before the LMES readiness assessment begins on August 7, 1995.

The Y-12 Plant experienced schedule delay in their preparations for readiness. During May 1995 it became apparent to both the Department of Energy (DOE) and LMES management that the process for establishing evidence files was inadequate. The schedule was revised at that time to allow additional time to ensure evidence files were correct and contained the right information. The schedule was revised again in July 1995 in response to the number of deficiencies identified during the MSA, and to account for required special operations which were not included in the restart schedule. The schedule for restart of the RSS mission area has been revised to September 18, 1995. Depleted Uranium Operations is scheduled to resume on September 25, 1995. Disassembly/Assembly is now scheduled to resume in December 1995.

All activities scheduled for completion during the reporting period were completed as planned, with the exception of Commitment N.2.5. For the quarter ending June 30, 1995, the Criticality Safety (Task 2/3) and Training (Task 5) Programs are proceeding on schedule and all commitments have been met. Changes in the Y-12 resumption schedule have resulted in revisions to the dates for the Conduct of Operations (Task 4) Program assessments. A change to the Plan has been promulgated to address the impact of the revised resumption schedule.

Activities completed during the second quarter calendar year (CY) 1995 are as follows:

<u>Commitment</u>	<u>Description</u>
N.1.1	Lockheed Martin Energy Systems (LMES) conducted an evaluation of the nuclear criticality safety program and Criticality Safety Approvals (CSAs)/Operational Safety Requirements (OSRs) supporting the first resumption area and Special Operations to date. This evaluation identified specific deficiencies, including their potential application to other areas, root cause(s), training deficiencies, and lessons learned.
N.1.2	The LMES provided a Corrective Action Plan (CAP) addressing the corrective actions for the deficiencies identified in their evaluation report of N.1.1 above. This CAP included the requirement to continue the implementation of an upgrade program through the resumption process.
N.2.2	The Department of Energy/Oak Ridge Operations Office (DOE/OR) provided a CAP addressing the deficiencies outlined in their investigation assessment report of October 13, 1994.
N.2.4	Defense Programs (DP) evaluated the Deputy Assistant Secretary for Military Application and Stockpile Support (DP-20) line management and its role in Y-12 safety issues. This evaluation was conducted by a team of facility operations experts outside the DP-20 line organization. Defense Programs provided a report which identified line management weaknesses and recommended corrective actions. The DP-20 line management then developed a CAP.
N.3.1	The LMES prepared an assessment of the current Conduct of Operations (COOP) performance posture including proposed near-term corrective and/or compensatory actions. Identified actions included those necessary to insure satisfactory formality of operations in facilities undergoing upgrade for near-term resumption, as well as those

facilities which continue to carry on a limited degree of activity, such as Special Operations. The assessment considered the following:

1. Investigations and action plans prepared as a result of the September 22, 1994, event;
2. Lessons learned from Special Operations;
3. Feedback and observations from mentors; and
4. Implications of occurrences and other events illustrating COOP weaknesses.

5.1 The Training Assistance Team developed a program to implement the evaluation of key Federal personnel involved with safety-related activities at defense nuclear facilities at the Y-12 Plant.

The following Commitment, scheduled for completion during the second calendar quarter, has not been delivered.

N.2.5 The Office of Environment, Safety and Health (EH) shall assess its role in oversight of Y-12 safety issues and provide appropriate recommendations and a CAP.

Activities scheduled for the third quarter CY 1995 are as follows:

Commitment

Description

N.1.3 The LMES will provide a closure report to the Restart Authority validating and summarizing the closure of deficiencies in the CAP associated with the first resumption area. As a minimum, LMES will confirm that all safety significant procedures, CSAs, and OSRs identified to support the first resumption for use within the next 12 months have been reviewed, revised as necessary, and validated. Procedures and CSA/OSRs which fall outside the 12 month window will be controlled such that they are subject to the upgrade program prior to their use.

N.1.5 The LMES shall document, within the LMES Line Management

Certification Letter, the use of compensatory measures related to CSA/OSR implementation. The documentation will discuss the nature of the compensatory measure and the conditions necessary for its removal. Other descriptive requirements for compensatory measures include the identification of roles and responsibilities, training and qualification requirements, a monitoring process for effectiveness, and a long-term needs assessment for all personnel related compensatory measures.

- N.2.3 The DP line organization shall provide a report documenting its continued participation in the resumption process; discuss the line organization review activities onsite; the scope and method of assessment; the results as determined with the Office of the Deputy Assistant Secretary for Facility Transition and Technical Support (DP-30) technical assistance; the use of independent experts; and Readiness Assessment support.
- N.3.2 The use of mentors as compensatory measures for COOP requirements shall be documented in the LMES Line Management Certification Letter. Qualifications, experience, and responsibilities for mentors shall be established. Minimum requirements necessary for mentor removal shall be defined.
- N.4.2 The LMES/OR shall demonstrate the successful planning and execution of Readiness Assessments per DOE Order 5480.31, "Startup and Restart of Nuclear Facilities," and their implementing procedures.
- 2.1 The DOE Assessment Team will prepare an Assessment Program to evaluate CSA/OSR implementation.
- 3.1 The LMES shall develop criticality safety review program criteria based upon industry standards and DOE Order 5480.24, "Nuclear Criticality Safety." This activity should be worked in conjunction with the criteria development for independent review discussed in Commitment 3.4.

- 3.4 The DOE Assessment Team will develop a criticality safety review program to assess the performance objectives discussed in the DOE 94-4 Implementation Plan Task 3 Purpose section. Specific assessment criteria will be generated for each objective.

- 5.4 The Department will develop a Training Assistance Team Program to implement the evaluation of key contractor personnel involved with safety related activities at defense nuclear facilities at the Y-12 Plant.

TASK 1, ORGANIZATION

Task 1 established the leadership and management structure for the development and execution of the Plan.

Deliverable 1.1, which provided a strawman Plan , and Deliverable 1.2, which identified the Senior Steering Committee, the Senior Working Group, and Task Leaders, were forwarded to the Board on February 24, 1995.

The following are the changes to the Department's management as depicted in Deliverable 1.2. These changes will occur in the third CY quarter.

<u>Position</u>	<u>Outgoing</u>	<u>Incoming</u>
Secretariat to the Senior Steering Committee	Radm Beers	Maj Gen Joersz
Department Manager and Working Group Coord.	Stan Puchalla	Phil Aiken
Tasks 2 & 3 Lead	Jim Winter	Lcdr Jon MacLaren
Task 4 Lead	Dave Chaney	Cdr John Colville

TASKS 2 & 3, CSA/OSR IMPLEMENTATION AND CRITICALITY SAFETY PROGRAM

During the quarter ending June 30, 1995, the following items were accomplished:

A peer review of the draft assessment plan, utilizing criticality safety and operations experts from Lawrence Livermore National Laboratory, Idaho National Engineering Laboratory, and DOE Headquarters was conducted on May 11, 1995.

The Department's Assessment Team for Tasks 2 and 3 was assembled during the week of June 5, 1995, at Oak Ridge for site training, final review of the Assessment Program Plan, facility familiarization, and to establish site counterparts.

Activities planned for the next quarter include:

The Department's Criticality Safety Assessment Program Plan will be approved and issued. This plan incorporates Commitments 2.1 and 3.4, both scheduled for delivery by July 31, 1995.

The LMES Criticality Safety Review Program criteria will be approved and issued by July 31, 1995, (Commitment 3.1).

Selected team members will be trained in Root Cause Analysis by Yankee Engineering Services subject matter experts.

The Task 2 assessment (Commitment 2.2) is currently scheduled to begin on October 16, 1995, and last two weeks.

TASK 4, CONDUCT OF OPERATIONS

During the quarter ending June 30, 1995, the following items were accomplished:

The Office of Site Operations personnel visited the Y-12 Site Office (YSO) on May 16, 1995. Dave Chaney met with YSO personnel to discuss the scope of the Task 4 assessment of Federal conduct of operations processes, and to get feedback on a set of draft performance objectives and criteria for this assessment that are based on those used at the Pantex Plant. Additionally, he met with personnel from the LMES Oak Ridge Compliance, Evaluation, and Policy Group to discuss the scope of the Task 4 assessment of LMES conduct of operations processes.

Dan Branch, Division Manager, Compliance and Performance Assurance, Kaiser-Hill (Integrating Contractor), Rocky Flats, was selected and has agreed to lead the COOP assessment team evaluating LMES. Dan Branch successfully lead both Pantex COOP contractor independent assessments in 1994. Dave Chaney will lead the assessment team evaluating the Federal COOP processes. Dave Chaney served as Pantex COOP Program Manager coordinating recent Pantex COOP upgrades, has extensive commercial and naval nuclear experience, and recently assumed the Pantex Team Lead position within DP-24.

As a result of changes in the resumption schedule at the Y-12 Plant, a revision to the Task 4 schedule was presented by the Department and discussed with the Board staff (Mr. James McConnell). The Task 4 assessment plans, Commitment 4.1, will be due 30 days following the second resumption or November 1995, whichever is earlier; and the assessment reports, Commitment 4.2, will be due 60 days following the second resumption or December 1995, whichever is earlier. This rescheduling has been documented as Change 2 to Revision 0 and is attached to this Quarterly Report.

TASK 5, TECHNICAL COMPETENCE REVIEW

During the quarter ending June 30, 1995, the following items were accomplished:

May 8-9, 1995, Mr. Tom Evans, the Technical Personnel Program Coordinator (TPPC) visited Oak Ridge to meet with DOE and LMES management to discuss the upcoming Training Assistance Team Program and subsequent visits. As the TPPC, Tom Evans has overall responsibility for the Training Assistance Team Program including the selection of the Team Leader, approval of Team members, and approval of the Team Program and Final Report. Tom Evans, who also serves on the 94-4 Senior Steering Committee, was accompanied by Stan Puchalla and Richard Wolfe, both members of the Senior Working Group.

Roy Schepens was selected and approved as Training Assistance Team Leader for the assistance visit. Roy Schepens is the Deputy Assistant Manager for High Level Waste at the Savannah River Site. He was previously a key member in the K-Reactor restart efforts and possesses commercial nuclear expertise, having served as a Nuclear Regulatory Commission site resident inspector. He is an expert in training and qualification, is familiar with Oak Ridge, and supported the development of many of the functional area qualification standards. He previously visited Oak Ridge to provide support for the Facility Representative Program.

June 19-20, 1995, Mr. Ray Hardwick (Deputy TPPC) visited with Roy Schepens and his staff to finalize the draft Training Assistance Team Program, identify prospective Team members, and set a tentative date for the visit. He was accompanied by Stan Puchalla and Richard Wolfe.

The "Training Assistance Team Program For Key Federal Personnel at the U.S. Department of Energy Oak Ridge Y-12 Plant," was approved by Roy Schepens and Tom Evans on June 30, 1995.

Activities planned for the next quarter include the following:

Preliminary visit to Headquarters by Roy Schepens to discuss the upcoming visits with the Board staff and finalize logistics for the visit.

Conduct the assistance visit including reviews at Headquarters and the Oak Ridge Site. The visit is currently scheduled for the week of August 14, 1995, (Commitment 5.2).

Develop a program to implement the evaluation of key contractor personnel involved with safety-related activities at defense nuclear facilities at the Y-12 Plant (Commitment 5.4).

TASK 6, CORRECTIVE ACTIONS

Task 6 provides for the management and tracking of issues and corrective actions and periodic status reports to the Board.

In this task, the Senior Working Group integrates findings from previous task areas and oversees development of corrective action plans.

Attachment C provides corrective action status for all corrective action plans submitted to date, which include Commitments N.1.2, N.2.2, N.2.4, and N.3.1. This status will be formally reported in each Quarterly Report. Also, working versions will be provided to the Board staff on a monthly basis.

ATTACHMENT A: COMMITMENT STATUS

COMMITMENT	DUE DATE	ACTUAL DATE	COMMENTS
N.4.2(a)	1st START		
N.4.2(b)	TBD		Follow-on resumptions
1.1	DEC 94	2 DEC 94	
1.2	JAN 95	JAN 95	
2.1	JUL 95		
2.2	DEC 95		Or within 60 days of 2nd resumption, whichever is earlier.
2.3	FEB 96		
3.1	JUL 95		
3.2	DEC 95		Or within 60 days of 2nd resumption, whichever is earlier.
3.3	FEB 96		
3.4	JUL 95		
3.5	MAR 96		Within 30 days of LMES CAP (Commitment 3.3).
3.6	MAY 96		Within 60 days of report from Commitment 3.5.
4.1	NOV 95		30 days following 2nd resumption or Nov 95, whichever is earlier. Two separate program plans.
4.2	DEC 95		60 days following 2nd resumption or Dec 95, whichever is earlier. Teams evaluating DOE and LMES each report.
4.3	FEB 96		60 days following issuance of reports in 4.2. One combined CAP.
5.1	JUN 95	30 JUN 95	

ATTACHMENT A: COMMITMENT STATUS

COMMITMENT	DUE DATE	ACTUAL DATE	COMMENTS
5.2	OCT 95		
5.3	DEC 95		
5.4	SEP 95		
5.5	FEB 96		
5.6	APR 96		
6.1	QTRLY		Submit with Quarterly Reports of Commitment 7.1.
7.1(a)	APR 95	28 APR 95	Interim report.
7.1(b)	QTRLY		Submit quarterly commencing in July 95.
8.1	AS REQ'D		

ATTACHMENT B: MONTHLY SCHEDULE OF DELIVERABLES

Schedule of Deliverables

* = Target Date

Mo/Yr	Near Term Initiatives	Tasks
Mar 95	1.4*, 4.1*	
Apr	1.1*, 2.2, 2.4(a), 2.5(a)	7.1
May	1.2*, 2.5(b), 3.1*	
Jun	2.4(b)	5.1
Jul		2.1, 3.1, 3.4, 7.1
Aug	1.3*, 1.5, 2.3*, 3.2*, 4.2	
Sep		5.4
Oct		5.2, 7.1
Nov		4.1
Dec		2.2, 3.2, 4.2, 5.3
Jan 96		7.1
Feb		2.3, 3.3, 4.3, 5.5
Mar		3.5
Apr		5.6, 7.1
May		3.6
Jun		
Jul		7.1

ATTACHMENT C: CORRECTIVE ACTION TRACKING

TABLE I

N.1.2: CORRECTIVE ACTION PLAN FOR LMES EVALUATION OF CRITICALITY SAFETY PROGRAM AND CSA/OSRs. (LMES Report Y/NO-00002)

REFERENCE NUMBER	CORRECTIVE ACTION PLAN (CAP) ITEM	PLANNED CLOSURE	ACTUAL DATE
Y/NO-00002 SECTION 2	CORRECTIVE ACTIONS FOR FIRST MISSION AREA RESUMPTION		
LESSON LEARNED 1	CSA/OSR requirement statements must be clear and concise.		
ACTION LL 1-1	Revise Procedure Y70-160, <i>Criticality Safety Approval System</i> , Training Module 8836, <i>Nuclear Criticality Safety Training for Y-12 Supervisors</i> , and Procedure Y50-66-CS-325, <i>Nuclear Criticality Safety Analysis, Approval, and Control System</i> .		22 MAY 95
ACTION LL 1-2	Additional changes in the CSA process have been made to improve clarity and conciseness of CSA requirements. RSS related CSAs have been revised. Revise Procedure Y70-160.	RSS RESTART	
ACTION LL 1-3	Develop new OSRs for RSS facilities and submit to DOE for approval.		8 MAY 95
LESSON LEARNED 2	The compliance methodology must be clearly articulated in CSAs/OSRs.		
ACTION LL 2-1	Develop and implement a CSA verification and validation process and a CSA implementation process to ensure compliance with the newly revised CSA administrative standards. These are procedurally controlled by Y70-01-150 (DSO) and Y70-37-19-071 (EUO).		22 MAY 95
LESSON LEARNED 3	Operating and technical support personnel must understand safety implications which require strict compliance with CSAs/OSRs.		

ATTACHMENT C: CORRECTIVE ACTION TRACKING

TABLE I

N.1.2: CORRECTIVE ACTION PLAN FOR LMES EVALUATION OF CRITICALITY
SAFETY PROGRAM AND CSA/OSRs. (LMES Report Y/NO-00002)

REFERENCE NUMBER	CORRECTIVE ACTION PLAN (CAP) ITEM	PLANNED CLOSURE	ACTUAL DATE
LESSON LEARNED 4	There must be an auditable path from CSA/OSR requirements to documentation which demonstrates compliance.		
ACTION LL 4-1	Issue a standing order by the DSO Manager identifying the required compensatory measures when using procedures that do not incorporate CSA requirements. (Action 3-4 addresses the long term corrective actions.)		22 MAY 95
LESSON LEARNED 5	An implementation plan which permits continuous compliance with effective CSAs/OSRs is required for new and revised CSAs/OSRs.		
ACTION LL 5-1	Revise Procedure Y70-160 to provide a period for implementation of new or revised CSAs.	RSS RESTART	
ACTION LL 5-2	Develop and approve surveillance procedures for the five new RSS OSRs. Conduct training and perform these procedures. Ensure operability of all required OSR-related systems and components before the OSRs become effective.		23 MAY 95
LESSON LEARNED 6	CSA/OSR noncompliances must be reported immediately.		
ACTION LL 6-1	Conduct awareness and Lessons Learned training on importance of following procedures and management expectations for nuclear operations personnel.		22 MAY 95

ATTACHMENT C: CORRECTIVE ACTION TRACKING

TABLE I

N.1.2: CORRECTIVE ACTION PLAN FOR LMES EVALUATION OF CRITICALITY
SAFETY PROGRAM AND CSA/OSRs. (LMES Report Y/NO-00002)

REFERENCE NUMBER	CORRECTIVE ACTION PLAN (CAP) ITEM	PLANNED CLOSURE	ACTUAL DATE
ACTION LL 6-2	Organizations responsible for OSR compliance develop and approve specific procedures that provide guidance for completing LCO actions when equipment does not meet LCO requirements. (Required by RSS resumption POA)		JUN 95
LESSON LEARNED 7	Facilities and operations involving CSAs/OSRs must be controlled to meet the expectation that activities are performed within the approved safety basis.		
ACTION LL 7-1	Implement a rigorous conduct of operations program through the RSS resumption POA and the 94-4 Implementation Plan. A specific detailed schedule coordinating implementation and assessment is part of the RSS resumption.	RSS RESTART	
Y/NO-00002 SECTION 3	CONTINUED IMPLEMENTATION OF THE UPGRADE PROGRAM (Note: Continued implementation of the upgrade programs will be influenced by the assessments and CAPs resulting from the execution of Tasks 2-5 of the 94-4 Implementation Plan.)		
ACTION 3-1	LMES management apply the programmatic corrections described in Section 2 of Y/NO-00002 throughout the resumption process for Y-12 nuclear operations.	TBD	
ACTION 3-2	Upgrade the OSRs and CSAs for continuing nuclear operations to the new standards.	TBD TASKS 2/3 CAPs	

ATTACHMENT C: CORRECTIVE ACTION TRACKING

TABLE I

N.1.2: CORRECTIVE ACTION PLAN FOR LMES EVALUATION OF CRITICALITY SAFETY PROGRAM AND CSA/OSRs. (LMES Report Y/NO-00002)

REFERENCE NUMBER	CORRECTIVE ACTION PLAN (CAP) ITEM	PLANNED CLOSURE	ACTUAL DATE
ACTION 3-3	Upgrade the CSAs and OSRs for each subsequent mission area prior to resumption of normal operations.	PRIOR TO EACH MISSION AREA RESTART	
ACTION 3-4	Complete new operating procedures incorporating revised CSA requirements	TBD TASK 4 CAPs	
ACTION 3-5	Develop a configuration management system to supplement or replace the change control and document control processes in place for resumption.	TBD	
ACTION 3-6	Develop a standard describing the process for writing OSRs at Y-12.	JUN 95	
ACTION 3-7	Upgrade individual OSRs as required by Phase II of the Safety Analysis Report Update Program (SARUP) refinement of their technical basis.	PHASE II SARUP SCHEDULE	
ACTION 3-8	Develop and implement the Nuclear Criticality Safety Improvement Program (NCSIP) to support 94-4 Implementation Plan Tasks 2 and 3.	94-4 TASK 2 & 3 ASSESSMENT DATES	

ATTACHMENT C: CORRECTIVE ACTION TRACKING

TABLE II

N.2.2: CORRECTIVE ACTION PLAN FOR ORO ROLE IN Y-12 INCIDENT.
(ORO R.J. Spence Memorandum dated 28 April 95)

REFERENCE NUMBER	CORRECTIVE ACTION PLAN (CAP) ITEM	PLANNED CLOSURE	ACTUAL DATE
ACTION 1-1	Performance Indicators and Analyses: Review existing monthly data to determine if new performance indicators should be added or old ones deleted. Review completed and recommended changes forwarded for processing as outlined in attachment 1 to Spence memo.	VARIOUS THRU NOV 95	
ACTION 1-2 / 1-3	Distribution of performance indicators is limited. Update and expand the distribution list. Distribute over LAN.		31 MAR 95
ACTION 2-1	ORO Oversight not Consistently Challenging Laxity: Develop a Conduct of Operations self-study course which would emphasize attention to detail and the standards based approach.	JUN 95	30 JUN 95
ACTION 2-2	Modify ORO appraisal training to include conduct of operations as the responsibility of everyone.	AUG 95	
ACTION 3-1	Inadequate staffing of the Facility Representative (FR) Program at YSO. Hire six more FRs.		3 APR 95
ACTION 4-1	Facility Representatives were unsure as to their shutdown authority. Issue ORO wide policy on shutdown authority.		6 OCT 94
ACTION 4-2	Facility Representatives were unsure as to their shutdown authority. Revise YSO procedure 1.6		13 DEC 94
ACTION 5-1	Incorporating Conduct of Operations into ORO internal value system requires upper management support. Brief Senior Management Board on Conduct of Operations.	JUN 95	
ACTION 6-1	ORO must improve its ability to anticipate problem areas and conduct subsequent mitigation planning. Develop issues management tracking system and program.	JUN 95	
ACTION 7-1	HQ funding and support to implement conduct of operations must be adequate. This will be evaluated as part of Task 4 to the 94-4 Implementation Plan.	94-4 TASK 4 ASSESSMENT DATES	

ATTACHMENT C: CORRECTIVE ACTION TRACKING

TABLE III

N.2.4 (b): CORRECTIVE ACTION PLAN FOR ADDRESSING DP-24 LINE MANAGEMENT ISSUES ASSOCIATED WITH ITS ROLE AT Y-12.
(D. Rhoades Memorandum dated 30 June 95)

REFERENCE NUMBER	CORRECTIVE ACTION PLAN (CAP) ITEM	PLANNED CLOSURE	ACTUAL DATE
SECTION A	FUNCTIONS, ASSIGNMENTS, AND RESPONSIBILITIES		
ACTION A.1	FAR compliance. DP-24 continue to monitor progress in addressing noncompliances with the FAR Manual as identified by the ongoing DP-31 assessment.	DEC 95	
ACTION A.2	Revise the Defense Programs Operations Manual (DPOM).	DEC 95	
ACTION A.3	Carry out management and oversight activities specified in Chapter 7 of the DP-24 Process Manual.		30 JUN 95
SECTION B	NUCLEAR SAFETY ISSUES		
ACTION B.1	DP-24 establish a Site Assistance Team to conduct assistance visits to Defense Programs sites including Y-12.		30 JUN 95
ACTION B-2	Develop an issue database for the DP-24 Action Tracking System that includes issues from assist visits, audits and assessments performed at Y-12, SRS Tritium Facility, and Pantex.	OCT 95	

ATTACHMENT C: CORRECTIVE ACTION TRACKING

TABLE III

N.2.4 (b): CORRECTIVE ACTION PLAN FOR ADDRESSING DP-24 LINE MANAGEMENT ISSUES ASSOCIATED WITH ITS ROLE AT Y-12.
(D. Rhoades Memorandum dated 30 June 95)

REFERENCE NUMBER	CORRECTIVE ACTION PLAN (CAP) ITEM	PLANNED CLOSURE	ACTUAL DATE
SECTION C	BUDGET PROCESS		
ACTION C-1	Develop office procedures which assure that ES&H measures are incorporated during the planning for activities involving stockpile support facility operations. (DP-24 Process Manual, Section 5.1)		MAR 95
ACTION C-2	Establish an Integrated Multi-Year Program Plan to implement guidance and direction for programmatic execution of the National Security Strategic Plan (NSSP).		30 JUN 95
ACTION C-3	Conduct program reviews on selected issues at each nuclear weapons facility on a quarterly basis.		30 JUN 95
SECTION D	DP-24 PROCESS MANUAL		
ACTION D-1	Complete development of the Process Manual.	NOV 95	
ACTION D-2 (a)	Develop and implement a training program on the Process Manual for DP-24 management and staff.	NOV 95	
ACTION D-2 (b)	Complete training for all DP-24 personnel on the Process Manual.	JAN 96	

ATTACHMENT C: CORRECTIVE ACTION TRACKING

TABLE IV

N.3.1: LMES ASSESSMENT OF THE CURRENT CONDUCT OF OPERATIONS POSTURE INCLUDING PROPOSED NEAR-TERM CORRECTIVE AND/OR COMPENSATORY ACTIONS. (LMES Report Y/NO-00003)

REFERENCE NUMBER	CORRECTIVE ACTION PLAN (CAP) ITEM	PLANNED CLOSURE	ACTUAL DATE
Y/NO-00003 SECTION 3	NEAR TERM ACTIONS THAT ADDRESS THE ROOT CAUSE		
ACTION 3-1	All OSRs, CSAs, and implementing primary procedures supporting the RSS Mission Area are in the final phase of approval. Complete the approval process. (para. 3.2.2)	RSS RESTART	
ACTION 3-2	Employee training on all revised procedures will be completed shortly after approval. Train employees. (para. 3.2.2)	RSS RESTART	
ACTION 3-3	Issue revised OSRs, CSAs, and implementing primary procedures. (para. 3.2.2)	RSS RESTART	
ACTION 3-4	Upgrade surveillance procedures supporting the initial resumption Mission Area. (para. 3.3.1)		25 MAY 95
ACTION 3-5	Revise the procedure use categorization process. (para. 3.4.1)		25 MAY 95
ACTION 3-6	Properly categorize existing operating and surveillance procedures in resumption mission area and train personnel to the new definitions-of-use. (para. 3.4.2)	PRIOR TO EACH MISSION AREA RESTART	
ACTION 3-7	Upgrade the procedure verification and validation process. (para. 3.4.3)		25 MAY 95

ATTACHMENT C: CORRECTIVE ACTION TRACKING

TABLE IV

N.3.1: LMES ASSESSMENT OF THE CURRENT CONDUCT OF OPERATIONS POSTURE INCLUDING PROPOSED NEAR-TERM CORRECTIVE AND/OR COMPENSATORY ACTIONS. (LMES Report Y/NO-00003)

REFERENCE NUMBER	CORRECTIVE ACTION PLAN (CAP) ITEM	PLANNED CLOSURE	ACTUAL DATE
ACTION 3-8	Develop a Conduct of Operations Manual with sections of the manual to be issued in accordance with an implementation plan schedule to support RSS. (para. 3.5)	RSS RESTART	
ACTION 3-9	Operations Areas will be defined to manage operations and maintain safety envelope integrity. The Operations Area for Bldg 9212 has been established and described in Chapter 1 of the Conduct of Operations Manual. Identify remaining Operations Areas. (para. 3.6.1)	PRIOR TO EACH MISSION AREA RESTART	
ACTION 3-10	Four new positions are being established that will directly impact conduct of operations practices: Operations Manager, Shift Manager, Shift Administrative Assistant, and Shift Technical Advisor. Fill these positions. (para. 3.6.2)	PRIOR TO EACH MISSION AREA RESTART	
ACTION 3-11	Develop and implement a training program for Shift Technical Advisors (STA). (para. 3.6.2)	MAR 96	
ACTION 3-12	Develop a detailed and formalized self-assessment program to promote management identification of weaknesses in conduct of operations performance. (para. 3.7.1)	JAN 96	
ACTION 3-13	Develop and implement conduct of operations performance measures which will provide management with clear trends and a basis for corrective actions. (para. 3.7.1)	PRIOR TO EACH MISSION AREA RESTART	

ATTACHMENT C: CORRECTIVE ACTION TRACKING

TABLE IV

N.3.1: LMES ASSESSMENT OF THE CURRENT CONDUCT OF OPERATIONS POSTURE INCLUDING PROPOSED NEAR-TERM CORRECTIVE AND/OR COMPENSATORY ACTIONS. (LMES Report Y/NO-00003)

REFERENCE NUMBER	CORRECTIVE ACTION PLAN (CAP) ITEM	PLANNED CLOSURE	ACTUAL DATE
ACTION 3-14	For the RSS Mission Area, resumption supporting activities have been incorporated into a detailed logic driven integrated schedule. Remaining Mission Area Managers develop their integrated schedules. (para. 3.7.4)	PRIOR TO EACH MISSION AREA RESTART	
Y/NO-00003 SECTION 4	LONG TERM ACTIONS THAT ADDRESS THE ROOT CAUSE		
ACTION 4-1	Expand the staff to the Manager, Nuclear Operations to provide him direct staff support in matters impacting on conduct of operations practices. (para. 4.1)	DEC 95	
ACTION 4-2	Assign an Assistant Manager to each Operations Manager (Depleted Uranium, Disassembly and Storage, and Enriched Uranium). (para. 4.1.1)	DEC 95	
ACTION 4-3	Hire for a newly approved position titled Qualification and Procedures Manager, who will ensure all department procedures are current and all affected employees are current in their respective qualification. (para. 4.1.2)		JUN 95
ACTION 4-4	Establish and fill a new position called Program Support Manager to coordinate key activities that influence implementation of a conduct of operations program. (para. 4.1.3)		25 MAY 95
ACTION 4-5	Establish a continuing training program that will ensure that proficiency and requalification are performed in accordance with DOE Order 5480.20A. (para. 4.2.2)	TBD 94-4 TASK 5 CAP & 5480.20 TIM	

ATTACHMENT C: CORRECTIVE ACTION TRACKING

TABLE IV

N.3.1: LMES ASSESSMENT OF THE CURRENT CONDUCT OF OPERATIONS POSTURE INCLUDING PROPOSED NEAR-TERM CORRECTIVE AND/OR COMPENSATORY ACTIONS. (LMES Report Y/NO-00003)

REFERENCE NUMBER	CORRECTIVE ACTION PLAN (CAP) ITEM	PLANNED CLOSURE	ACTUAL DATE
ACTION 4-6	Implement and integrate administrative processes for configuration control, work control, document control, and other site-wide processes. (para. 4.3.3)	TBD	
ACTION 4-7	Train line managers to assess conduct of operations performance by observations/evaluations at the working level. (para. 4.4.1)	JAN 96	

**CHANGE 2 to Rev. 0 of the Department of Energy Implementation Plan
for Defense Nuclear Facilities Safety Board Recommendation 94-4**

Purpose of Change: The original due dates for the Task 4 Conduct of Operations assessment were based upon a January 1995 resumption schedule, which depicted several areas of resumption being completed by the August 1995 timeframe. Since the Task 4 assessments require the observation of plant operators performing actual conduct of operations functions, August was thought to be the appropriate timeframe to begin this Task.

In light of changes in the resumption schedule, the Task 4 assessments must be deferred so that the assessment teams have the opportunity to observe actual plant evolutions. This change to the Plan will adjust due dates for Commitments 4.1 and 4.2 by approximately four months.

Instructions: Replace page 20 with page 20, Ch. 2

Distribution: Senior Steering Committee
Senior Working Group
Task Leaders
Defense Nuclear Facilities Safety Board

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Commitment 4.1 Assessment Plan

Each Assessment Team will create an Assessment Program that identifies successful, current COOP elements. The Assessment Programs will address appropriate past COOP improvement items and reasons for lack of success in COOP implementation.

Deliverable: Assessment Programs
Action: Team Leaders
Due Date: 30 days following second resumption or
November 1995, whichever is earlier

Commitment 4.2 Assessments

During the assessments, management positions associated with COOP activities will be identified at MMES/Y-12. The desired qualifications will be examined for these positions. The COOP experience that is available to support MMES/Y-12 will be analyzed. The approved MMES/Y-12 DOE Order 5480.19 Implementation Plan will be examined for commitments. These commitments will be compared to the actual COOP status. The DOE Order 5480.19 Implementation Plan effectiveness will be evaluated. These evaluations will consider results of the readiness assessments performed to date. Successful methods used at other DOE sites will be evaluated for application at Y-12/MMES to enhance implementation of COOP at the floor level. Both the DOE COOP program and the contractor COOP program will be independently assessed against successful DOE benchmarks (Rocky Flats/Savannah River/Pantex/LANL).

Deliverable: Assessment Reports
Responsibility: Assessment Teams
Due Date: 60 days following second resumption or
December 1995 whichever is earlier

Commitment 4.3 COOP AP

The integrated COOP AP tasks will be based upon the recommendations of the Assessment Teams. The COOP AP provides long-term programs necessary to upgrade COOP activities, as well as near-term projects necessary to resolve immediate COOP issues. Each of the COOP AP tasks will have a due date and an estimated completion date. Responsible organizations will be identified for each task.

Deliverable: COOP AP
Responsibility: Y-12/MMES
Due Date: 60 days after Assessment Report