DEFENSE NUCLEAR FACILITIES SAFETY BOARD

April 7, 2023

TO: Christopher J. Roscetti, Technical Director
FROM: Frank Harshman and Clinton Jones, Resident Inspectors
SUBJECT: Oak Ridge Activity Report for the Week Ending April 7, 2023

Conduct of Operations: While observing an assembly disassembly operations (ADO) worker insert a unit into the hood of a glovebox, a NPO Facility Representative (FR) noticed that the ADO worker was performing work while wearing gloves, but not sleeves or a labcoat, as the worker reached past the contamination boundary. Upon discussion with the Lead Radiological Control Technician and review of the radiological work permit (RWP), the FR confirmed that the worker was not wearing the anti-contamination personal protective equipment (PPE) specified by the RWP. Workers are required to read and sign a RWP prior to performing work in any contamination area. This is the second time in two months that a FR has identified improper PPE usage as it relates to anti-contamination clothing (see 2/3/2023 report).

During a recent x-ray evolution, the acting supervisor identified an issue with the procedure and brought it to the shift manager's (SM) attention. The SM suspended the use of the procedure until the issue could be corrected. The SM made a log entry of the suspension, but did not include specific details of the issue, only that it was inadequate. The following week, the x-ray system engineer arrived at the facility with a Computerized Tomography Technologist trainee to work on the trainee's x-ray operator qualification. They checked in with the SM to request work start for the training. The SM questioned whether the training involved fissile material but did not ask for any further details, such as what procedure was being worked. The system engineer was unaware of the suspended procedure and could not locate the record copy in the x-ray area. The system engineer referenced the procedure in the CNS digital document system, verified it was effective (not suspended), and printed a new copy. During this time, the supervisor that originally had the procedure suspended checked in with the SM prior to performing a walk down in the x-ray area. When the SM notified the supervisor of the training authorized in the area, the supervisor questioned how equipment was being operated under a suspended procedure. Subsequently, the SM went to the x-ray area and stopped the training. Lack of a questioning attitude by the SM resulted in work authorization being granted for an activity with a suspended procedure. The inconsistency of tracking suspended procedures was identified as a contributor to this issue. Due to the procedure being suspended locally and not having its status updated to suspended in the CNS digital document system, the procedure was left as effective in all facilities. This could have resulted in the SMs in the other facilities authorizing work for a procedure that was determined to be inadequate to use.

Oak Ridge Environmental Management (OREM): The resident inspector discussed current Transuranic Waste Processing Center status, performance since contractor transition, and upcoming projects for the facility with the OREM FR and UCOR management. The resident inspector questioned the group on several topics including the status of repairs required to exit a limiting condition for operation that is currently active. At Building 2026, the resident inspector observed U-233 processing operations and discussed current and future operations with the OREM FR and Isotek facility management. Overall, the resident inspector found the conversations productive and did not identify any issues with current operations.