DEFENSE NUCLEAR FACILITIES SAFETY BOARD

TO: Steven Stokes, Technical Director
FROM: William Linzau and Rory Rauch, Site Representatives
SUBJECT: Oak Ridge Activity Report for Week Ending May 8, 2015

Operational Excellence: This week, CNS senior staff (comprising the Chief Operating Officer and Vice Presidents) submitted to NPO the results of an assessment on their progress in establishing a culture of operational excellence (see 11/28/14 report). The performance assessment was honest and self-critical, acknowledging that the desired progress to date has not been achieved and attributing the lack of progress to the quantity and significance of change employees experienced after contract transition.

The assessment bins senior staff's evaluation of how CNS is performing against a list of six culture change enabling attributes (e.g., can CNS senior leadership articulate the difference between performance excellence and current operating practices?) and generally concludes that performance in these areas is improving, but remains inconsistent. The subsequent sections of the assessment identify planned actions intended to fully mature these attributes, breaking them into near-term "Targeted Improvement Initiatives," intermediate-term "Process and System Improvements," and long-term "Work and Leadership Models."

Based on the recent increase in operational events (see 4/17/15 report), the site reps agree with the assessment's conclusions regarding the lack of desired progress to date in achieving operational excellence. The site reps have met with senior CNS management to discuss the significance of recent events and are awaiting the issuance of the Production organization's performance improvement plan to evaluate how CNS is integrating these efforts to drive more immediate improvement.

Building 9212/Conduct of Operations: Last week, an operator made several errors while performing actions in the procedure for Oxide Conversion Facility (OCF) operations. The operator was not at work on the day the procedure was initiated and, the next day, the operator inadvertently started a section of the procedure that had previously been performed. The operator immediately identified the error, paused the operation, and notified the Shift Manager (SM). The SM conferred with the supervisor, reviewed the procedure, and then directed the operator to proceed with the correct section of the procedure. The operator resumed the operation and missed a step that required the SM to transition the status of the hydrofluorination bed (HFB) to operation mode. The SM caught the error when he called the operator to ask why the request to place the HFB in operation mode had not been made. The operation was again paused to allow the SM to confer with several other managers and the Shift Technical Advisor prior to directing work to resume again. This week, during the fact finding meeting, the SM acknowledged that he should have formally suspended the operation upon notification of the first error, as required in the site's conduct of operations (CONOPS) manual. In addition, supervisors noted that they relied on the pre-job briefing as the method to communicate to operators the section of the procedure they will be executing that day, but they do not formally document the stopping point on the procedure or in a logbook. The CONOPS manual directs that personnel should document the last step completed in a narrative logbook, in the procedure, or shift turnover in order to communicate to on-coming personnel the status of the activity.