DEFENSE NUCLEAR FACILITIES SAFETY BOARD

October 4, 2024

TO: Timothy J. Dwyer, Technical Director
FROM: A. Holloway and C. Stott, Resident Inspectors
SUBJECT: Pantex Plant Activity Report for Week Ending October 4, 2024

Special Tooling: C. Berg joined the resident inspectors for a meeting with CNS and PFO management to discuss several recent issues that have occurred within the Tooling & Machine Design and Special Tooling Program groups. CNS presented details concerning multiple tooling issues, including perceived common causes and the manner in which the responsible organization plans to address each associated root cause. For concerns related to releasing nonconforming tooling to the production line, CNS shared information from an ongoing analysis intended to identify programmatic gaps within the areas of work planning; tooling inspection; preventive maintenance; and fabrication, modification, and repair activities.

Conduct of Operations: Last week, CNS held an event investigation due to a nuclear explosive assembly that was removed from an enhanced transportation cart, which had a "do not use" tag attached. The CNS Special Tooling Program manager previously issued a stop work event for all operations utilizing these carts—including moving material into or out of the carts—due to a locking mechanism that detached from a cart during handling (see 9/13/2024 report). CNS included a written note on the tags indicating that the associated cart could not be used, except for continued staging activities, due to the stop work event. Unfortunately, notification of the stop work event was delayed due to technical difficulties with the communication system. Since the notification had not been sent by the beginning of grave shift, a CNS production manager authorized the technicians to move the assembly out of the cart to allow inspection for loose locking mechanisms. During the event investigation, CNS noted that the tag on the cart was applied by Special Tooling Program personnel; per sitewide procedures, the organization applying the tag must be notified before operations are performed with the equipment. CNS is planning to perform a causal analysis for the event.

Technical Safety Requirement (TSR) Violation: Earlier this year, CNS personnel worked closely with a subcontractor to plan maintenance activities on the roof of a defense nuclear facility within a material access area. During work planning discussions, the subcontractor explained that fall protection restraint carts would be utilized after being lifted into position on the roof by an all-terrain scissor lift. CNS agreed to the proposed plan as long as restrictions were in place such that the scissor lift could not be moved while the platform was raised and the extension deck would not be utilized. Last month, subcontractor personnel began to move the scissor lift toward the facility but had difficulty moving it close enough to perform the maintenance activities due to other ongoing maintenance in the area. From the ground, subcontractor personnel raised the lift and extended the extension deck to provide adequate access to the roof. During a walkdown of the work area, CNS safety analysis engineering personnel and a CNS facility manager paused the work after discovering the unanalyzed use of the extension deck on the scissor lift was a TSR violation. CNS then instructed the subcontractor to retract the extension deck, lower the lift, and reposition the scissor lift to an approved equipment staging area. During the event critique, CNS noted that they have conducted a stand down brief with the subcontractor and are planning a causal analysis for this event.