Human Performance Improvement #214

Title MI40 Abort Lamberston Unauthorized Manifold Repair Work In High Rad Area

Event Date 07/25/2018

Close Out Date 10/19/2018

Performed On Accelerator Division, AD Deputy Org, Headquarters, Engineering

Led By Accelerator Division, AD Deputy Org, Headquarters, Engineering

Department Manager Michael Lindgren

Location MI40 Abort Lamberston

ORPS Yes

ORPS Reporting Level Informational

Incident Category Near Miss

Entered By Consolato Gattuso 07/26/2018 13:09

Updated By Dave Baird Jr. 07/14/2020 21:41

Incident Description On the morning of July 25, Technician A and B were with Engineer A assessing the MI40 Lamberston Magnet manifold leak job located in a high radiation area/contamination area. Technician A and Engineer A were looking at adjustments of piping to gain access to the manifold on Lambertson 3. Meanwhile, Technician B looked behind the magnet to see if he could gain access to the fittings. Technician B was wearing street clothes and nitrile gloves. Technician B stated that he could reach the fittings and thought that the removal would be easy and quick. Technician A gave the go-ahead to complete the task. The task was completed. Upon leaving the enclosure the technicians surveyed the equipment and found it to be class 1 radioactive, they labeled the equipment appropriately. Technician B left the building with the class 1 equipment and placed the equipment into his personal vehicle and drove the equipment to another building on site.

What Happened? Technician B emailed Supervisor A at 8am, July 24th asking are we going to attempt to fix this tomorrow. Supervisor A replied with, contact Supervisor B (Supervisor A's backup). The morning of July 25th, Technician B emailed Supervisor A again and stated that he had all the tools to complete the task and asked if they could start the repair. Supervisor A did not respond again to Technician B, but emailed Technician A to contact Engineer A to see if they could go into the enclosure to re-position the LCW pipes that are directly on top of the MI-40 Lambertson. Technician A then emailed Technician B to notify them that he was going into the tunnel - essentially inviting Technician B to join. Later that morning, July 25th, Technician A and B gathered at MI-60 Service Building to go into the tunnel. Supervisor B (Supervisor B was relieved of oversight duties as of July 25th when Supervisor A returned to the lab and completed training that day) overheard the conversation and conversed with the two personnel prior to going into the tunnel. Engineer A was called to also assess the situation. Technician A and B and Engineer A entered the tunnel at MI60 and drove the golf carts around to MI40 where the Lamberston resided. Technician A and Engineer A discussed moving water pipes to gain access in order to make the repair easier. Separately, Technician B attempted to reach the manifold connections to ensure they were reachable. Once Technician B felt confident that the manifold could be changed out and in short order, Tech B asked Tech A if he should proceed. Tech A replied to go for it. Technician B removed the water manifold and all 3 individuals moved to the MI-40 alcove to compare the removed part with the replacement part. At this time, Tech A transported Engineer A out of the enclosure, leaving Tech B alone in the MI-40 alcove. Engineer B was going down to check on another job and came upon Tech B inspecting the manifold in the alcove near the work area. There was approximately a 10 minute time frame where Tech B was alone, though there were electricians within 100-200 feet of Tech B, however Tech B did not have any communication with the electricians. Tech A returned to the area, Engineer B left the enclosure. Tech B completed the repair. Tech A and Tech B drove on a golf cart back to MI60 with the removed manifold. They exited the enclosure, surveyed the manifold and placed a class 1 sticker on it. Tech A went back to his office at MI-60 Service Building. Tech B placed the class 1 equipment into his personal vehicle, drove to the MCR and dropped off his enclosure Enter key, and then transported the manifold back to his shop at IB-2 and removed it from his vehicle. Tech B then took his personal vehicle home for lunch. After speaking with other personnel Engineer B realized that the work was not authorized and proceeded to notify management.

Immediate Actions Taken Work Pause for all enclosure work, HPI review commenced. Individual who handled the material away from the building (Tech B) was surveyed for contamination, the equipment and personal vehicle were also surveyed for contamination, none was found.

Why Did It Make Sense At The Time At the time of accessing the enclosure, Tech A was under the impression that they were assessing the job with assistance from Engineer A to understand what needed to be done. Tech B was entering the enclosure with the intent to repair the manifold. Tech B realized that the fitting was accessible and assumed that the work wouldn't take much time to remove and the repair would save much time and accumulated dose. When Tech B asked Tech A if he should complete the repair, Tech A gave him the go-ahead understanding that the dose levels were not that high (assumed from previous survey, but did not have a survey meter to confirm at this moment) and the time to complete the repair was quick (less than 30 minutes). Tech A and Tech B made an assumption that due to previous approvals to do inspections for work planning in this area, they assumed this repair would fall under the previous inspection authorization. Engineer A and Engineer B made assumptions that the repair was authorized but did not ask for verification. No HA completed (verbal or written), no RWP and no RCT coverage for the job (which was required by area posting, the general Supervised Access RWP in the MCR, and the area RSO for this specific job which had been communicated to Engineer B) in the posted High Radiation, contamination area. Tech A left with Engineer A, leaving Tech B in the alcove under the assumption that because there were electricians in the area, and he was not "alone" that it was ok, though no communication between Tech B and the electricians indicating that they were now a team was made. Tech B surveyed the item and placed it in his personal vehicle due to bringing his personal vehicle to the job site, lack of government vehicles noted. During interviews Tech B indicated that he knew this was a violation of lab policy prior to placing the material in his personal vehicle. The MI 231 job was completed with this crew approximately one week earlier, the crew completed the job safely with the appropriate HA, RCT coverage and burn permit. The incident highlights a challenge with this group as they do not have a depth necessary to have proper oversight. Supervisor A concentrates on mechanical and has recently acquired Technician A who concentrates on water systems. Supervisor B (during the absence of Super A) concentrated on mechanical systems and is not well versed in water systems. He left the coordination of water systems to Tech A. Communication and expectations could be clarified in situations such as this and this group could benefit from further cross training (the intent of the recent movement of water system group members into the machine mechanical system groups) and more depth of personnel.

Topic(s) Communication | Documentation | General Management | Process | Project Management | Radiological Protection

Lead Reviewer McHugh, Eric 13747N (ES)

Review Team Gattuso, Consolato 08022N (AD)

Review Team Schoell, Maddie 16344N (ES)

Involved Person Anderson, Kris 15447N ()

Involved Person De Leon, Jesse, Jr. 14891N (AD)

Involved Person Hixson, David 15808N (AD)

Involved Person Juarez, Fernando 13251N (AD)

Involved Person Unold, Nicklas 32595N (APS-TD)

Organizational Weakness Communication: Emails were sent, but not fully understood, which caused Technician A to think they were going down for an inspection and Technician B to think they had the approval to do the full repair. Technician B did not communicate with the other group in the enclosure when Technician A and Engineer A left the enclosure, leaving Technician B alone.

Organizational Interfaces: Technician A and Technician B are from different divisions. Technician A is responsible for the machine/space, Technician B is not as familiar with the area. Technician B routinely fixes magnets, and had the mindset that his only goal/responsibility was to repair the magnet.

Procedure Development or Use: Procedure and plan had been developed for original scope of the job, but job scope changed while in the enclosure and was not properly reviewed or approved.

Supervisory Involvement: This group is very lean on resources and once the supervisor in on vacation, there are no viable supervisors to take over (next in line is PT phased retirement, next is a new person to the group experienced in water but not other areas, next is a contract tech, next is a new employee less than 4 months, and next is a vet tech leaving in less than 2 weeks)

Values, Priorities, Policies: Value placed on finishing the job instead of on appropriate safety evaluation and approval.

Work Practices: Technician A, who is responsible for the machine/area, was responsible for ensuring that the proper procedures and work control documents are in place before performing work. The planning for a larger-scope job had begun, but the job scope change did not have any review or updated plan/procedures.

Error Precursor Human Nature / Complacency / Overconfidence: Technician A thought that since Technician B could do the work in ~15min, and they've been able to do work in the area in the past without any safety issues, that they could go ahead and do the work. Technician B was complacent when transporting radioactive material in his personal vehicle - he knew it was activated (he put a Class 1 label on it) and didn't fully understand potential hazards.

Human Nature / Mental shortcuts (biases): Technician A and Technician B knew that dose rates in the area were less than anticipated, and made the assumption that this meant that other hazards were lessened as well. They did not check with anyone to ensure that their assumptions were true.

Human Nature / Mindset (tuned to see): Technician B had an understanding of the rules for transporting radioactive material onsite, and chose to move the material in his personal vehicle.

Individual Capabilities / Hazardous attitude of critical task: Technicians A & B had the "can do" attitude for a critical task that required, but did not receive, safety oversight.

Individual Capabilities / Imprecise communication habits: Emails were sent, but not fully understood, which caused Technician A to think they were going down for an inspection and Technician B to think they had the approval to do the full repair.

Task Demands / Time Pressure: Self-imposed: Technician A wanted to get as many jobs done as his crew could before being on non-work related medical leave. No other external or internal time pressures were mentioned over the course of the investigation.

Task Demands / Unclear goals, roles and responsibilities: May have been unclear on who was running the task. Technician A and Technician B had different goals - Tech A thought it was just an inspection while Tech B planned on doing the full repair.

Work Environment / Changes / Departures from routine: Technician B was in an area that they were unfamiliar with, and Technician A did not adequately relay all of the hazards and necessary safety information/requirements that Technician B needed for the repair.

Work Environment / Confusing displays or controls: The work list functions differently for different parts of the organization. The functionality has evolved over time. Certain views may not adequately convey some pertinent information (safety reviews). Also the job status review does not have clear language detailing exactly what is required for the job with regards to safety review and documentation. The work list entry screen has options that do not map one for one into the work list registry screen.

Work Environment / Lack of alternative indication: There was a lack of TD government vehicles that led Tech B to choose to use his personal vehicle to go to the job site.

Causal Codes

Item ID	Causal Code	Narrative
99350	A3.B2.C01 Strong rule incorrectly chosen over other rules	The excitement over the speed at which they could complete the job and save time and dose led them to move forward with the job.
99350	A3.B3.C01 Attention was given to wrong issues	Technician B was called upon during the shutdown to fix magnets such as this one. He found that he could reach the fittings and thought that the repair would be relatively easy compared to the plan. Asked the task leader to complete the repair who gave the go ahead. Technician A was focused on completing work before going on medical leave. Both were focused on getting the job done and didn't think about the safety requirements.
99350	A3.B3.C03 Individual justified action by focusing on biased evidence	Technician A and Technician B knew that dose rates in the area were less than anticipated, and made the assumption that this meant that other hazards were lessened as well. They did not check with anyone to ensure that their assumptions were true.
99350	A4.B2.C02 Insufficient supervisory resources to provide necessary supervision	See latent org weakness, supervisory involvement.
99350	A5.B1.C01 Format deficiencies	Layout of work list does not show necessary information, approval check marks may give false approval of entire task, Required safety form column may have differing information for the same task/inconsistencies. User may or may not understand the safety form requirements which will leave a blank in the work list in that section potentially leading them to believe no safety forms are required.
99350	A6.B1.C02 Training requirements not identified	The two person policy is a division policy, but it is unclear when or where it is communicated to the workers.
99351	A3.B2.C01 Strong rule incorrectly chosen over other rules	The excitement over the speed at which they could complete the job and save time and dose led them to move forward with the job.
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	was given to wrong issues	that the repair would be relatively easy compared to the plan. Asked the task leader to complete the repair who gave the go ahead. Technician A was focused on completing work before going on medical leave. Both were focused on getting the job done and didn't think about the safety requirements.
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99390	A3.B3.C01 Attention was given to wrong	Technician B was called upon during the shutdown to fix magnets such as this one. He found that he could reach the fittings and thought that the repair would be relatively easy compared to the plan. Asked the task leader to complete the repair who gave the go ahead.

	issues	Technician A was focused on completing work before going on medical leave. Both were focused on getting the job done and didn't think about the safety requirements.
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iTrack Items

Item	Responsible Person	Categroy	Item Title	Item Description	Item Due Date	Item Status	CAP	CAP Scheduled Date	CAP Close Date	CAP Title	CAP Description	CAP Resolution	C St
99350	McHugh, Eric	Recommendation	Is ESH for supervisors training adequate for the intended audience	It is unclear that the ESH for supervisor training gives supervisors what they need to effectively guide employees.	17-DEC-18	Closed	81753	16-DEC-18	17-DEC-18	Is ESH for supervisors training adequate for the intended audience.	ESH for supervisors has been updated with input from an HA training update team and EPG team member.	ESH for supers has been updated with information from recent lessons learned.	Cl
99351	McHugh, Eric	Management Concern	Incident occurred with unauthorized repair and rad material transport in personal vehicle	The incident and corrective action communication via an all hands meeting.	03-AUG-18	Closed	80928	03-AUG-18	03-AUG-18	Hold all hands for AD discussing incident and errors and path forward.	AD Division office conducted AD all hands in response to the incident, attendance was taken.	AD division office held the all hands and discussed failures and path forward out of shutdown, DOE was in attendance.	Cl
99352	McHugh, Eric	Recommendation	2-person policy in AD not fully understood	Understand 2-policy in AD, then investigate if it fits into FESHM.	13-SEP-18	Closed	81112	13-SEP-18	13-SEP-18	Update and communicate Two person policy	Review, update and communicate AD two person policy	The AD Two-person policy has been reviewed, updated with clarifying language and communicated via the dept head listserv and the September 13th AD Dept head meeting.	Cl
99354	McHugh, Eric	Opportunity for Improvement	Rad material transported in personal vehicle	Make rad material transport challenge question in Rad worker mandatory for all trainnees.	09-AUG-18	Closed	80930	09-AUG-18	09-AUG-18	quiz question on rad material transport not on all rad worker quizes	Make quiz question mandatory	Quiz question now mandatory.	Cl
99359	Schoell, Maddie	Opportunity for Improvement	rad signage process and procedures can be evaluated for improvement of communication	Review tunnel rad signage process in order to understand current process and any near term or future improvements.	30-SEP-19	Closed	83128	29-MAR-19	30-SEP-18	Update language on static signage	Short term - Update language on static signage to be more accurate (exchange "keep out" with "pass through quickly".	Signage updated to be more precise on requirements.	Cl
99359	Schoell, Maddie	Opportunity for Improvement	rad signage process and procedures can be evaluated for improvement of communication	Review tunnel rad signage process in order to understand current process and any near term or future improvements.	30-SEP-19	Closed	83129	30-SEP-19	09-JAN-20	Investigate long-term solution	Long term - investigate possibility of using lights/sirens active devices. Active lights/sirens not fesable in primary beamline areas	No fesable options found, other than static postings and communications.	Cl

											(prompt beam will be an issue with the electronics). Looking into other potential options.		
99360	Gattuso, Consolato	Opportunity for Improvement	Opportunities for improvements in work planning and control for AD shutdowns	Review AD shutdown communication tools for shutdown, is the correct info sent, timely fashion, clear and understandable? Do personnel know when a job is approved, released?	01-FEB-19	Closed	81611	10-JAN-19	01-FEB-19	AD Summer shutdown Work plan imporovments	A multi-prong Approach to resolving the issue has already been taken and will be expanded upon starting during our planning period which will span from Jan 2019 until Jul 2019. 1). Crew involvement will be moved up earlier in the planning process. 2). Clear verbal and written authorization will be provided the week prior to work starting. 3). Clear verbal and Written authorization will occur the week that work is scheduled.	We have several items in place to address this issue. 1) We will be following up with additional clearer email communications to authorize work 2) the future work plan tool will address this by better-defined dates for work 3	Cl
99361	Wong-Squires, Mayling	Opportunity for Improvement	AD MSD MI technical group resources are stretched thin	Evaluate the MSD organizational resources and ensure adequate resources allotted, ensure proper training, proper equipment and oversight of tasks.	22-JAN-19	Closed	82488	22-JAN-19	22-JAN-19	Evaluate MSD MI technical group and ensure adequate resources to be successful	Evaluate MSD MI technical group and ensure adequate resources to be successful. Make adjustments as necessary.	The MSD has reorganized the MSD/MI group and had a changing of leadership. The MSD will continue to evaluate the group to ensure resources are allocated to be successful.	Cl
99370	Schoell, Maddie	Opportunity for Improvement	RCT task approval procedures can be evaluated for improvement of communication	ESH&Q Rad safety to standardize information request for task permissions, to include location, general job summary and time allotted, after which a new permission must be requested.	13-JUL-18	Closed	81432	31-MAR-19	13-JUL-18	Rad Job Approvals	Rad work authorization and communication only subset of overall shutdown work communication and approvals. This item should be worked on in conjunction with Item 99360. An overall understanding of work authorization and approvals and communications is needed, in addition to looking into potential scope/location/time changes associated with some jobs.	clarification of information request has been communicated to RCT crew. this will standardize the information requested to understand the job and to understand what controls are necessary.	Cl
99390	Sood, Romesh	Opportunity for Improvement	Vehicle usage noted as a contributing factor to why a personal vehicle was used to transport rad materials - evaluate vehicle usage	Review TD vehicle usage and evaluate opportunities for increased efficiencies. Also communicate the requirement of only transporting rad materials in government vehicles.	29-MAR-19	Closed	82869	15-DEC-18	15-DEC-18	Finding Closed		The three written procedure (TD-6010, TD-6060, and TD-4160)have been updated with the Help of ESH&Q staff. The APS-TD Division Head has communicated with all APS-TD employees to	Cl

												adhere with Division policies and procedures regarding the personal use of vehicle; i.e., when and not to transport materials in personal vehicles.

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