DEFENSE NUCLEAR FACILITIES SAFETY BOARD

October 8, 2021

TO: Christopher J. Roscetti, Technical Director
FROM: L. Lin and Z. C. McCabe, Resident Inspectors
SUBJECT: Savannah River Site Activity Report for Week Ending October 8, 2021

Savannah River National Laboratory (SRNL): Last week the resident inspector noted several issues regarding the preparation and execution of a Criticality Control Overpack (CCO) and provided feedback to BSRA management (see 10/1/21 report). This week, BSRA personnel held a post-job review to discuss the evolution. In the discussion, BSRA personnel touched on several of the issues and identified that the lack of a task preview likely contributed. In addition, the DOE-SR Facility Representative identified several more issues with the planning and preparation of the work. For instance, the checklist they used to load and close the CCO was not an approved checklist included in the SRNL procedure. Further, the personnel that did the work did not have the facility qualifications to perform the task. BSRA personnel are planning to hold a fact-finding meeting to discuss this issue further.

Saltstone: As part of an ongoing effort at Vault 4, personnel removed a High Radiation Area (HRA) boundary without implementing (intentionally) the proper controls and subsequently left the area incorrectly posted and uncontrolled for 6 days. When construction personnel removed the chicken wire fencing serving as the HRA boundary, they failed to realize that they were required to use the procedure for accessing HRAs. They then constructed a wall to serve as the new boundary and installed two doors. Both doors were left unlocked, and one was posted as an HRA with information dated 10/2016. The other door was unmarked. This week, a radiological protection department (RPD) inspector noted the out of date posting and lack of posting on the other door. They discussed this with their management and then entered the area to dose rate. They stopped when they measured a dose rate of 150 mrem/hr. The inspector informed the appropriate personnel and the proper controls were implemented. SRR personnel held an issue investigation. Corrective actions identified during the issue investigation include issuing a lessons learned, revising and improving the HRA procedure (that was not actually used at the time), and ensuring that all current HRAs are secure. As such, the only action they are pursuing directly related to the issue that resulted in personnel removing an HRA barrier and leaving it unsecured is the lessons learned. These types of actions are typically used as a one-time measure to ensure all personnel are aware of the issues until training can be revised or the lessons learned can be incorporated. The resident inspector discussed these observations with DOE-SR personnel.

Oral Board: A resident inspector and DNFSB staff member observed a reboard for a Defense Waste Processing Facility (DWPF) shift operations manager (SOM) candidate. The resident inspector believed the conduct of the board and the action identified for supplemental on-the-job training following the board were appropriate. An observation was made that the process could be improved to encourage candidates to answer the question to the best of their knowledge before looking at documents when appropriate.