DEFENSE NUCLEAR FACILITIES SAFETY BOARD

September 21, 2007

MEMORANDUM FOR: J. Kent Fortenberry, Technical Director
FROM: M.T. Sautman, SRS Site Representative
SUBJECT: SRS Report for Week Ending September 21, 2007

Mr. Sharpless was at the SRS providing supplemental Site Rep coverage this week.

F Canyon: The Site Rep observed the third coached emergency drill for the transportation of high plutonium-equivalent curie drums between E and F areas. Traffic control during this drill was tighter than observed in an earlier drill (see 8/10/07 Site Rep weekly report) to the extent that Radiological Control Organization personnel were not allowed to pass through a security roadblock and had to drive around to a different one before being allowed to pass. Controllers and observers identified poor contamination control techniques that could have resulted in extensive cross-contamination and which may not have been detected by the improper contamination surveys that were performed. Controllers also noted that it took about 17 minutes before any protective actions were enacted in F Area.

Based on improved transuranic waste remediation performance, two first line managers were released by the SSW Review Board. Other compensatory actions remain in place for now.

Tritium: Last week, 7 unclassified alternate reclamation stems filled with less than accountable quantities of gas were mistakenly bagged out and placed in a waste disposal container. This week, it was discovered that they were missing and the parts were recovered.

L Area: An Area Radiation Monitor (ARM), which is used to detect a nuclear criticality, alarmed while a source check was being performed, prompting the evacuation of the facility. A subsequent investigation determined that the alarm was not due to an accident, but the fact that the ARM was in the incorrect mode during testing. The cause for this is unknown since a printout confirms the ARM was in the correct mode when it left the calibration shop and the only way it could have changed after that was if someone hooked up a laptap to the ARM. Another ARM was found to have the wrong alarm setpoint and to be in the wrong mode also. In the future, the facility will announce when alarm testing is in progress and not require evacuation.

Waste Solidification Building: The process vessel ventilation and high activity process area active confinement ventilation systems will now be credited as safety significant.

F/H Laboratory: An operator installed a locking device on a circuit breaker to isolate power and a second operator independently verified it was in the correct position. However, an electrical worker performing a required examination of the locking device noticed that it was installed upside-down and that power had not been isolated.

H-Canyon: A staff member observed a periodic inspection of nuclear safety blanks, but this work was suspended due to a discrepancy between the description of the blank on the label and that in the procedure.