DEFENSE NUCLEAR FACILITIES SAFETY BOARD

May 23, 2001

TO: J. K. Fortenberry, Technical Director
FROM: D. F. Owen, RFETS Site Representative
SUBJECT: RFETS Activity Report for the Week Ending May 25, 2001

The site rep. was out of the office on Thursday and Friday this week.
Plutonium Stabilization and Packaging System (PuSPS). Kaiser-Hill continued with development of corrective action plans for the DOE Operational Readiness Review (ORR) findings (13 pre-start , 9 post-start). The site rep. noted to DOE-RFFO and Kaiser-Hill personnel that the DOE-approved corrective action plans provided to the site rep. to date did not appear to provide evaluation of "any overall programmatic deficiencies" as required by DOE Order 425.1, *Startup and Restart of Nuclear Facilities*. Additionally, the root cause evaluation provided for some of the findings is little more than a restatement of the finding. For example, the root cause identified for the pre-start finding regarding unintelligibility of the Life Safety/Disaster Warning System near the stabilization system gloveboxes cites only the noise of nearby air monitoring equipment. The root cause does not address whether this issue could or should have been identified and resolved by Building surveillances or any other means. DOE-RFFO and Kaiser-Hill personnel indicated that they would review and potentially revise the corrective action plans to address these issues.

As noted last week, the site rep. observed a drill simulating a PuSPS glovebox glove tear after an operator complained of chest pains and then collapsed from an apparent heart attack. The site rep. inquired on an approximate 2-3 minute delay due to security considerations of a Building 371 Emergency Support Team (BEST) member in entering the PuSPS room and attending to the victim. The security considerations involved protective force personnel delaying the BEST member's entry while attempting to get supervisory approval for the entry. The site rep. discussed this with DOE-RFFO management who indicated that they would look into the issue.

Building 771 Intakes Follow-up. As reported on March 23, 2001, Kaiser-Hill issued a report of a Price-Anderson "root cause analysis" concerning the factors surrounding the discovery of the intakes sustained by a work crew in the fall of 2000, chiefly failure to record and track air sampling data. The report identifies numerous root and contributing causes in radiological control program implementation and failure by Building 771 management to recognize and act on the staffing, performance and skill weaknesses in the RCTs and their supervision. Corrective actions addressing the causes have been developed.

The site rep. discussed with DOE-RFFO and Kaiser-Hill management the anecdotal failures described in the report that indicate lack of follow of basic functions and principles of Integrated Safety Management. Such failures include operations personnel changing activity work scope or safety controls without revisiting and revising the line management activity-level hazard analysis, sometimes without involvement of radiological control personnel as required. It did not appear that the report's recommendations nor the corrective actions responding to the report clearly addressed these failures. Kaiser-Hill management indicated that they would review the report and the corrective actions in light of this observation. (1-C)