DEFENSE NUCLEAR FACILITIES SAFETY BOARD

March 4, 2011

MEMORANDUM FOR: T. J. Dwyer, Technical Director
FROM: B.P. Broderick and R.T. Davis
SUBJECT: Los Alamos Report for Week Ending March 4, 2011

Pasko was onsite this week to attend a workshop on the conceptual design for potential seismic upgrades to portions of the Plutonium Facility ventilation system.

Transuranic Waste Operations - Readiness: This week, the contractor readiness assessment (CRA) team completed their review of drum venting operations at Area G and concluded that line management has not successfully demonstrated readiness to commence operations, meaning the CRA will need to be re-performed in the future. The team identified nine pre-start findings, one post-start finding and seven observations. Pre-start findings included inadequate technical bases to demonstrate compliance with functional requirements for two credited design features, an incorrectly written procedure, failure to follow procedures, inadequate operator training and failure to demonstrate adequate emergency response capability. LANL management intends to develop lessons learned based the results of this review. In addition, these issues will be factored into the response to the NNSA site office request on improving the startup process, which included several examples of startup problems at Area G (site rep weekly 2/25/11).

WCRR Repackaging Facility – Conduct of Operations: There have been a series of events over the past several weeks at the WCRR repackaging facility where personnel failed to initiate or properly execute procedures.

Two weeks ago, an operator was using a drum dolly to transfer transuranic waste drums out of the WCRR facility and onto a truck to prepare for onsite shipment. During the transfer evolution, the operator lost control of a waste drum which tipped over and fell on the ground. WCRR personnel did not initiate execution of an abnormal operating procedure as required in the event of a dropped or tipped drum. Last week, a glovebox glove was breached during WCRR operations. Upon detection of the breach, WCRR personnel did not use an abnormal operating procedure, as required.

This week, WCRR operations center personnel completed and filed the wrong checklist to effect a TSR mode change to allow waste processing operations. At the beginning of a shift, one operations center operator completed the appropriate checklist to transition from Warm Standby mode to Operations mode and pre-filled the checklist to change from Operations mode to Warm Standby mode that would be needed at the end of the day's operations. The operator inadvertently handed the wrong checklist to another operator who signed and filed it and the facility began waste processing operations. Later the same day, the error was discovered by an individual performing Senior Supervisory Watch when he was reviewing operations center documentation.

In response to the first two events, facility management conducted refresher briefings for operators on abnormal operating procedures and instituted a Senior Supervisory Watch for WCRR operations. After the latest event, management paused work to discuss conduct of operations issues with facility personnel. This negative conduct of operations trending has coincided with a significant increase in operational tempo at WCRR, which has moved to 12 hour a day, 7 day a week operations.