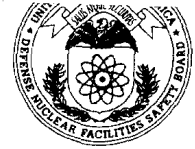


John T. Conway, Chairman  
A.J. Eggenberger, Vice Chairman  
John W. Crawford, Jr.  
Joseph J. DiNunno  
Herbert John Cecil Kouts

## DEFENSE NUCLEAR FACILITIES SAFETY BOARD

625 Indiana Avenue, NW, Suite 700, Washington, D.C. 20004  
(202) 208-6400

93-0002601



May 18, 1993

Mr. Everet H. Beckner  
Acting Assistant Secretary for  
Defense Programs  
U.S. Department of Energy  
Washington, D.C. 20585

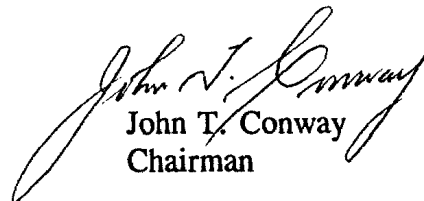
Dear Mr. Beckner:

The Board understands that DOE-Rocky Flats Office is in the process of conducting an in-depth evaluation of the ALARA (As Low As Reasonably Achievable) Program at the Rocky Flats Plant.

Enclosed are a number of observations concerning the ALARA program and review of occurrence reports related to radiological controls at the Rocky Flats Plant. These observations were developed by the Defense Nuclear Facilities Safety Board staff and an outside expert. These observations are based on reviews of available documents, and discussions with DOE-Rocky Flats Office staff and contractor personnel at Rocky Flats from March 29 to April 2, 1993. These observations may be of potential assistance in the ongoing reviews at the Rocky Flats Plant.

If you need further information, please let me know.

Sincerely,

  
John T. Conway  
Chairman

Enclosure:

(1) DNFSB Staff Memorandum "Rocky Flats Plant - Review of the ALARA Program and Radiological Occurrence Report" with attached reports, dated April 22, 1993

c:

V. Stello, DP-6  
M. Whitaker, Acting DR-1  
P. Grimm, Acting EM-1

**DEFENSE NUCLEAR FACILITIES SAFETY BOARD**

April 22, 1993

**MEMORANDUM FOR:** Technical Director

**COPY TO:** Board Members

**FROM:** R. E. Kasdorf

**SUBJECT:** Rocky Flats Plant - Review of the ALARA Program and Radiological Occurrence Reports

1. **Purpose:** This memorandum forwards two reports of reviews conducted by outside expert (T. Quale) during March 29, 1993 to April 2, 1993, at the Rocky Flats Plant (RFP). These reviews covered the ALARA (As Low As Reasonably Achievable) Program and recent radiological occurrence reports at the RFP.
2. **Summary:** The conclusions of the attached reports are:
  - a. The programmatic aspects of the RFP ALARA program are based on applicable industry standards. However, implementation of the program is not up to nuclear industry practices. ALARA design reviews generally do not appear to provide benefit either in the area of exposure reduction or cost savings. No effective training is provided to site management and supervision concerning how to effectively manage aspects of the ALARA program in their areas of responsibility.
  - b. Review of the radiological occurrence reports led to the following observations:
    - (1) The occurrence reporting system is not being utilized to its full potential, for example:
      - (a) Final reports are not being issued in a timely manner.
      - (b) Root causes and corrective actions are not always being documented in occurrence reports.
      - (c) There is apparently no effective tracking or trending of occurrences to identify areas where further corrective or preventive actions are necessary.

- (2) Many of the contamination problems are being attributed to "past practices and processes." There is apparently no effective program to characterize the contamination existing in work areas such as in Buildings 371 and 771 so they can be decontaminated. Contamination in the work areas is being found during routine or pre-job surveys.
- c. The DOE-RFO Radiological Protection Branch has started an in-depth evaluation of the RFP ALARA program. Initial findings indicate that DOE-RFO is discovering problems similar to those noted by the DNFSB outside expert's review.
3. Future Action: A staff review of the RFP radiation protection program, including a follow-up to this ALARA review and a review of the results of the DOE-RFO ALARA program review, has been tentatively scheduled for August, 1993.

**Attachments:**

1. Memorandum from T. Quale, "Review of ALARA Program at the Rocky Flats Plant," dated April 12, 1993.
2. Memorandum from T. Quale, "Review of Occurrence Reports Related to Radiological Controls," dated April 12, 1993 (without Attachment 1).

**Distribution:**

A.G. Stadnik  
J.P. Davis  
D.F. Owen

MEMORANDUM

April 12, 1993

**FROM:** T.J. Quale Jr. - Outside Expert  
**TO:** Roy Kasdorf - DNFSB Staff  
**SUBJECT:** Review of ALARA Program at the Rocky Flats Plant

1. As requested, during the period from 29 March to 2 April 1993, a review of the ALARA Program at the Rocky Flats Plant (RFP) was performed. The detailed observations of the review are contained in the attachment to this memorandum.
2. The review examined the programmatic aspects of the ALARA program and included an assessment of the extent of implementation of program requirements. In addition, the extent of ALARA program oversight performed by the Department of Energy's Rocky Flats Office (DOE-RFO) was assessed.
3. In general, the programmatic aspects (i.e. in-place programs and procedures) of the RFP ALARA program appear sound. Appropriate use has been made of applicable industry standards in the development of the program. The program standards at RFP are comparable in content to others in the industry. Implementation of the program, however, is not up to industry practices. Three of five site wide goals established for 1992 were exceeded. Goals exceeded included personnel radiation exposure and personnel contamination (internal and external). No appreciable progress was made in 1992 in reducing the amount of contaminated areas at RFP, another program goal. ALARA design reviews are generally not up to industry practices and do not appear to provide benefit either in the area of exposure reduction or cost savings. No effective training is provided to site management and supervision concerning how to effectively manage aspects of the ALARA program in the areas of responsibility.
4. The DOE-RFO Radiological Protection Branch is in the process of conducting an in-depth evaluation of the RFP ALARA program. The evaluation format is comprehensive and the initial results indicate DOE-RFO findings are similar to the findings of this review. The DOE-RFO evaluation is in the early stages. It is, therefore, difficult to predict the final outcome and how the results will be provided to the M&O Contractor, EG&G.

cc: John Drain - SPC  
J. DeLoach - COTR

## DETAILED COMMENTS ON THE ROCKY FLATS PLANT ALARA PROGRAM

1. A review of the ALARA Program Manual reveals that it is well-based in industry standards and includes the attributes necessary to manage a successful program. The site ALARA program Manual is based primarily on the Pacific Northwest Laboratory publication PNL-6577, "Health Physics Manual of Good Practices for Reducing Radiation Exposure to Levels that are As Low As Reasonably Achievable (ALARA)" 6/88. Use of other guidance such as INPO standards is also evident. The RFP Site Policy concerning the ALARA Program is sound and in place. Implementing procedures HSP-1.02, "Program Document for As Low As Reasonably Achievable (ALARA)" and various Radiological Engineering procedures provide an adequate foundation for conducting an ALARA program.
  
2. A review of 1992 ALARA goals found that many of the goals were not achieved. Goals for personnel radiation exposure, external personnel contamination and internal personnel contamination were exceeded.
  - a. The 1992 goal for personnel radiation exposure was 157 person-rem. The projected actual exposure total for 1992 is 189 person-rem or 20% over the goal. The personnel radiation exposure goal for 1993 has been set at 193 person-rem, an increase of 23% over the 1992 goal. No specific rationale can be cited by the EG&G Coordinator for this increase beyond a general statement that work load is increasing. Further, the estimates are developed on a "did cost" basis rather than a "should cost" basis. That is, the actual exposure for a given job is not adjusted to account for unnecessary exposure. Therefore, those unnecessary exposures become additive and inflate future estimates. This is due in part to the dose accounting methods in use at RFP. Specifically, dose received cannot be related to a particular activity or to activities within a specific building. According to the ALARA Engineering Manager, RFP is considering implementation of a secondary dosimetry system to allow for more specific dose accounting. Little if any progress has been made on this plan. In fact, the ALARA Coordinator was not aware of its existence until this review.
  
  - b. Skin and internal contaminations have also exceeded the 1992 ALARA goals but by smaller amounts. However, the rate of skin contaminations increased dramatically at the end of 1992. About half of the incidents occurred in the last 3-4 months. As in the case of personnel exposure, ALARA management at RFP was not able to identify specific reasons for this increase.
  
  - c. Another specific goal of the ALARA program at RFP is to reduce the amount of contaminated areas on site. This goal is based on reducing contaminated areas that are not considered normal work areas. However, gloveboxes are not included in the process of developing the estimate. No appreciable progress has been made toward

reducing the contaminated gloveboxes. The EG&G Corporate ORR Team for Building 707 found that action was needed to reduce the amount of contaminated areas in the building. An action plan was developed to accomplish the reduction. However, when problems concerning decontamination methods developed, progress on the plan was stopped. No revised plan was developed to account for the problem until the DNFSB staff questioned the inactivity during a review of corporate ORR closure packages. Finally, the basis of the goal does not include a reduction in the amount of normal work space that is contaminated. Inclusion of this aspect for establishing the basis of the goal is not under consideration by RFP.

3. The RFP ALARA program cites trend analysis and lessons learned as key aspects of the program. While some trend analysis is performed by the ALARA Coordinator, little benefit is apparent. The results are provided to responsible management but beyond that little action appears to be taken. According to the ALARA Coordinator, the general site lessons learned program is the vehicle used for the ALARA Program. The ALARA Coordinator could provide no details concerning what tangible benefits were received while also stating that was not his program. This aspect of the ALARA program appears to be nothing more than an inefficient accounting process which produces no program benefit.
4. The Site ALARA Program Manual states in section 3.1.4.6 that "Management training shall be provided with emphasis on demonstrating the importance of each groups activities in establishing and managing ALARA program goals. A thorough understanding of the Rocky Flats ALARA commitment and each employee's specific responsibilities is required of all management employees." This training consists of an eleven minute video tape that has been shown to all management personnel at RFP. This video is only an overview of the ALARA program that is introduced by the EG&G General Manager who states a strong commitment to the program. The EG&G ALARA Coordinator characterized the video as a "pep talk" and conceded that it provides no specific training to management personnel. It does not describe the management tools available or inform personnel of methods to effectively use these tools to achieve ALARA goals.
5. ALARA design and procedure reviews are well characterized in site procedures. Two Radiological Engineering procedures, RE-1001 - ALARA Design Review and RE-1002 - ALARA Job Review, provide adequate direction for performance of these functions. The results do not reflect proper utilization of these procedures to achieve a reduction in personnel radiation exposure. For example, an ALARA review of the SARF Operation previously reviewed by the DNFSB Staff was based on a two year old dose estimate that over estimated the current work scope by an order of magnitude and was conservative in predicting the doses to which personnel would be exposed. The result was a review that did not accurately characterize the expected personnel exposure and in fact predicted personnel exposures that were high by a factor of at least four. This fact was brought to the attention of EG&G and DOE-RFO management by the DNFSB staff in February 1993. EG&G concluded that the review should be revised. At the time of this review, EG&G had just submitted the revised report to DOE-RFO. DOE-RFO was still completing their review

of the report, and it was not assessed during this review.

6. The minutes of several of the ALARA Action Committee Meetings were reviewed. The minutes were not in the format recommended in the ALARA Program Manual and contained little, if any, specific information relative to actions under way to reduce exposure. The minutes do not reflect detailed actions to follow-up on previous activities. Given their current form and content, it does not appear that these committees are resulting in any "value added."
7. The ALARA Coordinator stated that ALARA criteria have recently been added to management performance evaluations. Specifically, the evaluation is tied to the managers' performance against ALARA goals in their area of responsibility. This is a positive step, however, it is not clear how such an evaluation can be made given the lack of detailed tracking and trending information discussed above.
8. The site ALARA Program Manual requires in section 3.1.5 that internal audits of the ALARA program be conducted at least every three years by personnel outside of ALARA Engineering. The ALARA Coordinator stated that some reviews had been conducted by the EG&G Audit and Appraisal Group, but he was not able to discuss the specifics of their findings.
9. The DOE-RFO Radiological Protection Branch has initiated a review of the EG&G ALARA Program. The review consists of a series of detailed surveillances of the specific aspects of the ALARA Program. According to the DOE-RFO Radiological Protection Branch Chief, the initial results indicated that the program was sound programmatically but very weak in implementation. He also stated that two of the initial surveillances had been judged to be unsatisfactory.

MEMORANDUM

April 12, 1993

**FROM:** T. J. Quale Jr. - Outside Expert  
**TO:** Roy Kasdorf - DNFSB Staff  
**SUBJECT:** Review of Occurrence Reports Related to Radiological Controls

1. As requested, during the period from March 29 to April 2, 1993, a review of Rocky Flats Plant (RFP) occurrence reports related to radiological controls was performed.
2. Using a search of the ORPS System (attachment one), a sample of 63 occurrence reports related to radiological controls that occurred from October 1, 1992 to March 29, 1993 was selected. A summary of these reports is included as attachment two. Occurrence reports related to selective alpha air monitors (SAAMs) were excluded from the sample based on DNFSB staff guidance. Attachment three is a table summarizing the occurrence reports by type and related facility.
3. The occurrence reports analyzed primarily involve radiological contamination (Attachment 3). The following observations were drawn from this analysis:
  - a. Final reports are not being issued in a timely fashion. Only one of the reports has been issued as a final report as defined by DOE Order 5000.3A, "Occurrence Reporting and Processing of Operations Information." As a result, much of the information necessary to thoroughly understand the causes and develop corrective actions is not available. DOE-RFO (Hicks for Ruscitto) indicated that they intend to require EG&G to finalize outstanding reports within a six month period and maintain subsequent reports current within the guidelines of the recent revision to the DOE Order (5000.3B) which contains requirements for issuance of a final report.
  - b. The review of the individual reports indicates that many of the contamination problems are being attributed to "past work practices and processes." It is not apparent from the reports that RFP personnel are developing a process to characterize the contamination existing in work areas such as Buildings 371 and 771 where a majority of the problems have occurred. Such efforts have been undertaken in Buildings 559 and 707 and have been effective in identifying problem areas so they can be decontaminated.
  - c. DOE-RFO (Hicks) indicated that he does not currently conduct tracking and trending reviews of occurrence reports nor is he aware of such reviews being conducted by EG&G. Industry practice has identified such tracking and trending as valuable management tools for identifying areas where corrective and or preventive actions are necessary.



- d. In several cases, the root cause of the occurrence has not been determined. This not only prevents management from taking corrective action but also can lead to recurring problems due to failure to correct the underlying problem.
  - e. Two reports from Building 771 imply that the design of some criticality drains may be contributing to the spread of contamination outside of gloveboxes. There is no indication of actions to resolve this potential design problem.
  - f. Twelve reports indicate that an evaluation of the occurrence is ongoing. In seven of the reports an expected completion date was established. None of these seven dates appear to have been met.
  - g. At least ten of the reports specifically state that contamination was found during routine or pre-job surveys. This shows that these surveys are improving but implies that work areas are not fully characterized as to extent of contamination.
4. DOE-RFO (Hicks) stated that RFO will be utilizing a new contractor to further analyze these reports in the near future. Industry practice has shown that this type of effort, if made an ongoing practice by DOE-RFO and EG&G, can benefit the overall ALARA effort at Rocky Flats.

cc: John Drain - SPC  
J. DeLoach - COTR

SUMMARY OF RFP OCCURRENCE REPORTS  
 RELATED TO RADIOLOGICAL CONTROLS  
 (EXCLUDING SAAM PROBLEMS)  
 FROM 10-1-92 TO 3-29-93

<u>NUMBER</u>	<u>CATEGORY</u>	<u>DESCRIPTION</u>	<u>CAUSE</u>
<u>3710PS</u>			
1992-0079	1-T/10-92/O	Contamination under G/B 37, routine survey	Leaking G/B gasket
1992-0085	1-T/10-92/O	Contamination under G/B 36, pre-job survey	Leaking G/B seal
1992-0086	1-F/10-92/U	Contamination under G/B 37, routine survey	Leeching from paint
1992-0096	5-T/11-92/O	RWP violation, orange vs white coveralls	Knew rqmts, wore orange to expedite job, no lockers available
1993-0004	1-T/1-93/U	Contamination under G/B 47, routine survey	not addressed beyond stating that there was contamination on the vent line. no action to determine where it came from.
1993-0006	1-T/1-93/O	Contamination on G/B glove from hole	Hole in glove determined to be due to normal use, glove in service about six years.
1993-0007	5-T/2-93/O	Person in RCA w/o resp card, no fit test	Personnel error
1993-0015	2-T/2-93/O	<u>C</u> wound due to nail puncture	Personnel error in getting the wound. No action to find the source of the <u>C</u> . Decon in progress.
1993-0016	5-T/2-93/U	Two w/o resp prot as reqd by posting	Personnel error.

<u>NUMBER</u>	<u>CATEGORY</u>	<u>DESCRIPTION</u>	<u>CAUSE</u>
1993-0020	4-T/3/93/O	<u>C</u> on respirator filter	<u>C</u> due to radon buildup in the area.
<u>7710PS (771)</u>			
1992-0090	3-T/10-92/O	<u>C</u> boots due to loose <u>C</u> on floor	Loose <u>C</u> on floor of 3 rooms, 750-4200 dpm, no source found, investigation ongoing.
1992-0091	1-T/10-92/O	<u>C</u> on crit drains G/B's 3(rm149) & 42(rm 114)	OR says cause either design of drain or evaporation of liquid in drain to an unacceptable level.
1992-0092	4-T/10-92/O	Low level <u>C</u> H corridor (150-100, f1-2000)	Attributed to residual fixed but one section says loose due to paint chipping off the floor, another says floor tiles will be replaced. Floor tiles are not normally painted.
1992-0094	1-T/10-92/O	<u>C</u> on crit drains 4 & 8 G/B 53 Rm 153	OR says cause either design of drain or evaporation of liquid in drain to an unacceptable level. Has a specific cause been identified?
1992-0095	1-T/10-92/O	<u>C</u> on flange under G/B 2, rm 180D	Reported to be residual contamination on the gasket from "...past work practice and processes...".
1992-0096	3-T/10-92/U	Clothing <u>C</u> due to <u>LC</u> in work area	Report cited loose <u>C</u> in area due to past

<u>NUMBER</u>	<u>CATEGORY</u>	<u>DESCRIPTION</u>	<u>CAUSE</u>
			practices. How did pre-job survey miss 10Kdpm loose.
1992-0105	4-T/11-92/O	<u>C</u> on floor rm 180F; .8DAC on fixed head	Report attributes floor <u>C</u> to past practices but does not address the cause of the 0.8 DAC except to say they are unrelated.
1992-0107	4-T/11-92/O	<u>C</u> on floor Rm 180F, pre-job survey	residual <u>C</u> in paint on floor. Paint chipped by activity in area including moving 55 gallon drums. Was area marked or mapped as being contaminated?
1993-0002	4-T/1-93/O	<u>C</u> on drum, pre-job survey, up to 19.6kdpm L	Report attributes to residual <u>C</u> from prior incident. Drum on dolly for ten years, rusty but not cause of <u>C</u> . Drum to be discarded, contents repackaged.
1993-0005	5-T/1-93/O	Persons in RCA w/o qualitative fit-test	Personnel error - they "knew" fit tests were required but forgot to have them done.
1993-0006	1-T/1-93/O	<u>C</u> glove 2, G/B 49, Rm 154, 7.5Kdpm	Glove scheduled to be changed on the mid shift. No indication of why it was being changed or of how the <u>C</u> got out.
1993-0007	3-T/1-93/U	10 <sup>6</sup> dpm on clothing during glove change	High dP (vacuum) due to obstructed inlet filter

<u>NUMBER</u>	<u>CATEGORY</u>	<u>DESCRIPTION</u>	<u>CAUSE</u>
			known before glove change started. That combined with glove change techniques resulted in the occurrence. Why the glove change given the filter problem.
1993-0012	1-T/1-93/O	L <u>C</u> on G/B 5, Rm 114, up to 15K dpm loose	Report attributed <u>C</u> to past activities since there is fixed <u>C</u> in the paint on the G/B, paint is chipped.
1993-0013	4-T/1-93/O	L <u>C</u> under cabinet, 10K dpm, pre-job survey	Attributed to residual <u>C</u> from past practices.
1993-0014	4-T/1-93/U	L <u>C</u> on conduit & pipe, G/B K-20, Rm 180K	30Kdpm loose & 400Kdpm fixed. Attributed to Past practices. Found during routine survey, deconned. (including fixed?)
1993-0017	4-T/2-93/O	<u>C</u> under exhaust duct, Rm 114, prior to paint	Report attributed cause to residual <u>C</u> from past practices. Area deconned.
1993-0020	4-T/2-93/U	<u>C</u> on & under tank 529, Rm 114, 16Kdpm	Attributed to past practices. Found during routine survey. Area deconned.
1993-0022	1-T/2-93/U	<u>C</u> on gloves 32 & 39, G/B 1, Rm 114, 80Kdpm	Cause listed as contamination of the gloves. No indication of where the <u>C</u> came from. Report indicated that the gloves should be changed

<u>NUMBER</u>	<u>CATEGORY</u>	<u>DESCRIPTION</u>	<u>CAUSE</u>
1993-0026	4-T/3-93/U	<u>C</u> Tk 451, Rm149, up to 21Kdpm L, 300Kdpm F	on the next shift. Sight glass on tank leaked. Leak was contained. Area deconned. Was leak ever repaired?
1993-0029	3-T/3-93/U	<u>C</u> on clothing after bagout, 12Kdpm direct	No cause known at time of report. Seem to suspect laundry, investigation of laundry being done. Results?
1993-0031	1-N/3-93/U	<u>C</u> on G/B gasket, 30Kdpm L, routine survey	Notification report, no cause provided.

ANALYTOPS (559)

1992-0102	4-T/10-92/O	Fixed <u>C</u> on step stool, 6Kdpm	Cause of the <u>C</u> step stool has not been determined.
1992-0114	4-T/11-92/O	Fixed <u>C</u> on poly bottle, 4.8Kdpm	Bottle marked and contained, no <u>C</u> found in cabinet where bottle stored. No cause provided for why the <u>C</u> is on the bottle.
1992-0115	3-T/11-92/O	<u>C</u> on glove after work in glovebox	Appears to be degradation of G/B glove due to use of tin snips. Status of evaluation, expected completion 12-11-92?

<u>NUMBER</u>	<u>CATEGORY</u>	<u>DESCRIPTION</u>	<u>CAUSE</u>
1992-0126	3-T/12-92/U	Glove <u>C</u> due to hole in G/B glove	Results of evaluation of cause of hole in glove bag glove due 12-14-92. What were the results?
1992-0128	4-T/12-93/O	4Kdpm on furnace handle, Rm 101	Evaluation of probable source for ORs 0128,0129 and 0130 due 1-22-93. What were the results?
1992-0129	1-T/12-92/O	8Kdpm on face G/B C-30, Rm 102	Evaluation of probable source for ORs 0128,0129 and 0130 due 1-22-93. What were the results?
1992-0130	4-T/12-92/O	4.8Kdpm on floor of Decon Rm, Rm 110	Evaluation of probable source for ORs 0128,0129 and 0130 due 1-22-93. What were the results?
1993-0002	1-T/1-93/O	3Kdpm L, G/B 055, Rm 133, Bldg. 779	Although further analysis is required, there is no indication as to cause of the <u>C</u> on top of the glove box
1993-0005	4-T/1-93/O	4Kdpm F top of battery, found at C.P.	Although further analysis is required, there is no indication as to cause of the <u>C</u> on top of the battery.
1993-0012	4-T/2-93/O	<u>C</u> in wound received in uncontrolled area	Further evaluation due by 4-2-93 but the report speculates <u>C</u> due to residue from thoriated weld rods.

<u>NUMBER</u>	<u>CATEGORY</u>	<u>DESCRIPTION</u>	<u>CAUSE</u>
1993-0017	5-T/2-93/U	Escorted Visitor in RCA w/o resp quals	Personnel error, escorts failed to ensure visitor followed requirements.
1993-0023	3-T/2-93/U	Clothing <u>C</u> , 5Kdpm, Bldg 779, Rm 137	<u>C</u> on floor near crit drain. No cause provide for <u>C</u> on floor.
1993-0028	1-T/2-93/U	<u>C</u> crit drain, G/B 954, Rm 133, Bldg 779	Evaluations of cause(from corrective actions) due NLT 3-19-93. Results?
1993-0035	3-T/3-93/U	<u>C</u> bootie, suspect the laundry.	Status of investigation of the laundry. See 7710PS-1993-0029 also laundry problem.

NONPUOPS1

1992-0005	4-T/12-93/O	L <u>C</u> in uncontrolled tool crib, Bldg 444	Due to past practice, not found earlier due to inadequate surveys.
1993-0005	3-N/3-93/U	U <u>C</u> found on footwear at laundry, 20Kcpm B	Notification report, no cause available.

NONPUOPS3

1992-0013	2-T/10-92/O	Skin <u>C</u> , Bldg 883, 500cpm beta-gamma	Personnel error. SOE failed to use "hand protection", as required by the RWP, when wiping water up from the floor.
1992-0014	3-T/11-92/O	20Kdpm alpha on gloves after maint. B-887	Ten day report provides no results of follow-up



<u>NUMBER</u>	<u>CATEGORY</u>	<u>DESCRIPTION</u>	<u>CAUSE</u>
			surveys or any other information that could identify the cause.
1993-0001	4-T/1-93/O	489dpm alpha in uncontrolled rooms B-881	Area posted & controlled. Decon methods being investigated. Cause TBD at a later date.
1993-0004	4-N/3-93/U	<u>C</u> found in uncontrolled area in B-865	Notification report, no cause available.
<u>PUFAB (707)</u>			
1992-0336	8-T/11-92/O	<u>C</u> above plenum 102, pre-job survey	Residual contamination from past problem.
1992-0340	2-T/11-92/O	Skin <u>C</u> while removing ALARA paint	Personnel error, failure to use protective gloves over surgeons gloves.
1992-0378	5-T/12-92/O	Failure to wear protective gloves reqd by RWP	Personnel error
1993-0001	2-T/12-92/O	<u>C</u> on two people necks, exit plenum 104	Failure to adequately secure hood to anti-c overall. Corrective action?
1993-0014	2-T/1-93/O	Skin <u>C</u> on left palm, Bldg 707	No cause could be determined
1993-0035	9-T/2-93/O	Routine nasal smears ID pot. int after SBAG	No Cause could be determined,
1993-0057	4-N/3-93/O	<u>C</u> on floor corridor L, Mod C, Bldg 707	Notification Report, no cause available.

<u>NUMBER</u>	<u>CATEGORY</u>	<u>DESCRIPTION</u>	<u>CAUSE</u>
1993-0064	1-T/3-93/U	<u>C</u> chainveyor S3B, Mod A, Bldg 707	Report lists cause as blank not properly secured, but does not state why the blank was loose.
<u>SOLIDWST (SOLID WASTE)</u>			
1992-0081	2-T/12-93/O	Skin <u>C</u> , Bldg 776, Rm 134, 2.5Kcpm on hand	Although this is a ten day report, no details of the occurrence are provided.
<u>SUPPORT</u>			
1993-0005	4-T/1-93/O	3 <u>C</u> drums found in uncontrolled area	Past practice
<u>UTILITIES</u>			
1993-0007	3-T/3-93/O	<u>C</u> Bootie (84 dpm loose), found in laundry	Cause not yet determined
1993-0008	3-T/3-93/U	<u>C</u> White Coverall, 3.75Kdpm, found in laundry	Not yet determined. Suspected from the 800 area. Stopped shipments from 800 until review completed.

DRAFT

ANALYSIS OF RFP OCCURRENCE REPORTS  
RELATED TO RADIOLOGICAL CONTROLS  
(EXCLUDING SAAM PROBLEMS)  
FROM 10-1-92 TO 3-29-93

Subject	371OPS	771OPS	ANALYTOPS	NONPUOPS 1&3	PUFAB	SOLIDWST	SUP/UTIL	TOTAL
Contamination on/under GB (1)	5	7	3		1			16
Skin (2) Contamination	1			1	3	1		6
Clothing (3) Contamination		4	4	2			2	12
Other (4) Contamination	1	9	6	3	1		1	21
Other Personnel Issues (5)	3	1	1		1			6
Contamination on Plenum (8)					1			1
Potential Uptake (9)					1			1
Totals	10	21	14	6	8	1	3	63