DEFENSE NUCLEAR FACILITIES SAFETY BOARD

September 12, 2025

TO: Technical Director
FROM: Savannah River Site Resident Inspectors
SUBJECT: Savannah River Site Activity Report for Week Ending September 12, 2025

Savannah River National Laboratory (SRNL): The drill team conducted an emergency preparedness exercise at SRNL. The scenario involved a projectile impacting a ventilation system, causing a radiological release, and multiple injuries from the shrapnel. The resident inspector observed the drill from the incident scene, incident command post, and control room. The contractor and DOE-SR will develop an after-action report to document any findings and opportunities for improvement from the exercise.

Solid Waste Management Facility (SWMF): SWMF operations performed a mock-up demonstration of loading 55-gallon remote-handled Transuranic (TRU) waste drums into shielded container assemblies (SCA) for shipment to the Waste Isolation Pilot Plant (WIPP). The SCAs are designed to meet the waste acceptance criteria of the WIPP and provide the necessary radiological shielding to reduce dose rates for personnel involved in the handling, shipping, and long-term storage of the material. The use of the SCAs supports the SWMF mission to de-inventory the site of over 130 legacy remote-handled TRU waste drums.

Defense Waste Processing Facility (DWPF): A construction worker was injured while performing modification field activities for canister double stacking at one of the Glass Waste Storage Buildings. The worker was struck in the back when a drill assembly, consisting of a 10-foot extension tool, fell from its location on a transport cart. The facility responded to the injury and the worker was transported to the hospital. DWPF facility operations called for a timeout on all field activities pending the completion of an issue investigation. During the issue investigation, construction management noted that this was a routine task and that it required one worker to reposition a magnet and a second worker to physically secure and transport the drill assembly to the next location. The second worker stated that while repositioning themselves to avoid a tripping hazard, they temporarily released hold of the extension tool, causing the entire assembly to fall off the cart, resulting in the injury. The issue investigation team considered potential impacts of what could have happened if the worker had been struck in the head. The resident inspector noted that the field activities were performed in a contamination area, and potential impacts of contamination spread were not discussed during the issue investigation. DWPF personnel have implemented corrective actions to update work instructions, to remove the extension tool prior to loading the drill assembly onto the transport cart, and to secure the drill assembly onto the cart with a tether. Facility management required implementation of immediate corrective actions to be completed prior to resuming field work. This is a good practice following an incident that results in an injury.