

DEFENSE NUCLEAR FACILITIES SAFETY BOARD

March 6, 2026

TO: Technical Director
FROM: Savannah River Site Resident Inspectors
SUBJECT: Savannah River Site Activity Report for Week Ending March 6, 2026

DNFSB Staff Activity: Members of the DNFSB technical staff visited SRS, toured the Tank Farm, received briefings, and observed core operations. The cognizant engineer was also on site to renew their radworker qualification.

Savannah River National Laboratory (SRNL): The facility is in the process of performing renovation work in the SRNL glass shop. During a walkdown of the shop prompted by an employee request for access to work in the area, the shift operations manager and fire protection engineer discovered that several ceiling tiles had been removed, rendering the safety significant fire suppression system inoperable, and that the associated limiting condition of operation (LCO) had not been entered. The facility took immediate action and entered the LCO, completed all required actions, and a formal timeout was taken on the construction activities. During the issue investigation meeting, personnel noted that the work planner and subject matter experts did not identify any required impairments during planning activities, as they had assumed that there were no sprinkler heads installed above the ceiling tiles. However, they did not review drawings to confirm their assumption, nor was the fire protection engineer included in the work planning and approval process. DOE-SR facility representatives and the resident inspector (RI) noted that not all involved personnel attended the issue investigation meeting. The contractor has interviewed the absent personnel and plans to incorporate their statements into the apparent cause analysis (ACA) in lieu of holding a second meeting. The RI also noted that the ACA process and implementation of corrective actions can take several weeks and suggested considering compensatory measures to ensure that all approved work packages have had the proper engineering review and that all safety system impacts have been properly identified prior to authorizing the work to proceed.

The site's emergency preparedness organization and SRNL personnel conducted an exercise that simulated a radiological release with multiple injuries and contaminated personnel. The contractor and DOE will document their evaluation of the exercise in an after-action report.

H-Area New Manufacturing: While recycling a tank with tritium through the diffuser system, the operators noticed elevated activity in one of the gloveboxes. Once operators and the shift manager identified the leak location, the leaking valve and section of piping were isolated from the process. After the maintenance mechanics completed tightening the valve fittings, the alarms in the glovebox and the room alarmed on high tritium activity. Radiological protection personnel surveyed the room, and the individuals involved in the evolution submitted bioassays, which subsequently came back negative. After the room was downposted from an airborne radioactivity area, maintenance personnel retorqued the fittings and resolved the leak. At the issue investigation meeting, facility personnel identified that maintenance personnel had originally tightened the fitting under pressure, which was not allowed by procedures and likely led to a tritium release and high-activity alarm conditions. Operations personnel have implemented a shift order detailing the issue while corrective actions are being developed.