DEFENSE NUCLEAR FACILITIES SAFETY BOARD

February 15, 2019

TO: Christopher J. Roscetti, Technical Director
FROM: M. T. Sautman and Z. C. McCabe, Resident Inspectors
SUBJECT: Savannah River Site Activity Report for Week Ending February 15, 2019

Training: When a qualified/certified person is absent for greater than 12 months, the SRS training and qualification manual requires the individual to retake comprehensive written and oral exams, performance demonstrations, and operational evaluations. The watchbill software used at SRS tracks qualification card requirements and watch-stander proficiency hours, but does not disqualify a person if they do not stand watch for more than 12 months. This allowed a control room operator at H-Canyon to stand watch for a certified position for which they were not currently certified. In this case, the person had been reassigned to a non-control room operator position for more than 12 months. Once they had stood watch (under direct supervision of a qualified/proficient watch-stander) in the control room for enough hours to satisfy the proficiency requirement, their status was incorrectly changed to "qualified." While they were within their two-year routine requalification period, they were still officially disqualified because they had not completed the exams, demonstrations, and evaluations required after an extended absence. Once they were "qualified," they were listed inappropriately on the watchbill 13 times over an 8-week period. SRNS does not know if the person conducted any activities that require certification (e.g., fissionable materials handler) while they were standing watch. SRNS is investigating the extent of condition and pursuing corrective actions to address this loophole.

Solid Waste Management Facility (SWMF): Rigging personnel were relocating several B-25 containers holding low-level waste into Engineered Trench 3. After placing one of the boxes with a fork truck, the operator inadvertently contacted another B-25 while simultaneously backing up, turning, and raising the fork tines. By the time the operator recognized the issue, the B-25 had already began to rock such that it would fall over completely if the operator raised the fork tines. The operator then used the fork tines to slowly roll the B-25 onto its side. Meanwhile, the spotter had recognized that the operator's actions would cause the fork tines to impact the B-25; however, the fork truck operator was looking in another direction and was unable to hear the spotter. The rigging personnel involved informed the appropriate personnel of the incident. Shortly after the event, an operator provided the wrong container number (the one just placed instead of the one that was impacted) to the control room, which slightly delayed the recovery actions. Before long, SWMF personnel corrected the information and were able to safely upright the B-25. The B-25 did not breach or open during this event. SRNS personnel identified several areas for improvement following this event. Notably, they discussed the need for improvement in communications between the spotter and fork truck operator and ensuring those involved have the correct information prior to passing it on.

Savannah River National Laboratory (SRNL): SRNL personnel held a facility radiological action team (FRAT) meeting to discuss an upcoming evolution to remove legacy sections of the Off-Gas Exhaust system piping in E-Wing. As part of the FRAT meeting SRNL discussed the construction work order, hazards analysis, and the radiological work permit.