DEFENSE NUCLEAR FACILITIES SAFETY BOARD

September 3, 2021

TO: Christopher J. Roscetti, Technical Director
FROM: Alexander Velazquez-Lozada, Cognizant Engineer
SUBJECT: Waste Isolation Pilot Plant (WIPP) Report for August 2021

DNFSB Staff Activity. A. Velazquez-Lozada provided onsite oversight the week of August 9th.

Response during COVID-19. An increase in COVID cases required some WIPP staff to quarantine. Uneven floor conditions discovered in the underground resulted in a halt to disposal operations. Consequently, the Contact Handled (CH) Bay and the Parking Area Unit (PAU) reached maximum capacity and the Carlsbad Field Office (CBFO) was forced to limit the number of shipments the site could receive in this month.

Ventilation System. Nuclear Waste Partnership, LLC (NWP), identified a ventilation configuration in which the Waste Shaft Differential Pressure is more negative than the CH Bay. If a radiological release occurs in the CH Bay during this configuration, unfiltered contaminated air could travel from the CH Bay to the underground through the Waste Shaft and impact the underground facility worker. NWP determined that this was a Potential Inadequacy in the Safety Analysis (PISA). As part of its subsequent preventive actions, NWP implemented a Long-Term Timely Order requiring an attendant to monitor conditions and notify the Central Monitoring Room of any abnormal issues, fire, or fire risks in the CH Bay. NWP plans to complete an Evaluation of the Safety of the Situation.

Safety Basis. An independent team conducted a Contractor Readiness Assessment (CRA) of NWP's preparations for the restart of the 700C Fan to operate during non-waste handling activities. CBFO personnel and a Board's staff member shadowed the CRA. The independent team plans to complete the assessment and document its finding in a final report.

Waste Management. This month, NWP reported a noncompliance with the WIPP Hazardous Waste Facility Permit. Upon notification of a stop work for downloading activities, a waste handler was instructed to move a TRUPACT from the CH Bay to the PAU without being notified that it was un-processed and not empty. The waste handler, erroneously, placed an EMPTY label on the TRUPACT and placed it outside with other empty TRUPACTs. As part of shipments protocols, NWP staff reviewed the documentation and noticed that paperwork related to processing the TRUPACT was incomplete, then confirmed that the TRUPACT was not empty. NWP stopped work, informed management, and labeled the TRUPACT correctly. A fact finding identified failures of communication between waste handlers as the cause of mishandling and mislabeling the TRUPACT. NWP completed an event learning review the next day.

Fire Drill. The WIPP Fire Department completed a drill as part of the overall emergency management program. Although the Fire Department met the goals and objectives described in the Incident Action Plan, observers reported that firefighters failed to demonstrate adequate knowledge in the areas of respiratory protection and basic firefighter core skills.