DEFENSE NUCLEAR FACILITIES SAFETY BOARD

March 4, 2022

TO: Christopher J. Roscetti, Technical Director
FROM: L. Lin, Z. C. McCabe, E. P. Richardson Resident Inspectors
SUBJECT: Savannah River Site Activity Report for Week Ending March 4, 2022

Staff Activity: The Nuclear Regulatory Commission Office of the Inspector General staff was on site this week for familiarization and interview with the resident inspector.

H-Canyon: A fact finding was held to discuss an issue where two portable generators used to support work activities did not have the correct arc flash labels installed. One was missing the arc flash label and the other had an arc flash label, but the hazard category was blank/faded. Due to the less than adequate labeling, the correct Personal Protective Equipment (PPE) was not in use while equipment was operated. Upon discovery, a Time-Out was called and notifications were made. Portable generators across the site are being inspected as an extent of condition. This event was classified as a ORPS 2D(2).

Savannah River Tritium Enterprise (SRTE): SRNS has finalized the determination that a potential inadequacy of the safety analysis (PISA) does not exist for the tritium release event that occurred on January 30, 2022 (see 2/25/2022 report). While the safety basis considers an inadvertent tritium release from the stack, it does not consider the potential reintroduction of tritium into a facility. However, SRNS believes their safety basis remains valid.

A fact finding was held on exposed electrical wiring (uncontrolled hazardous energy) found inside a cabinet. Maintenance personnel had unplugged a thermocouple vacuum gauge (TCVG) display for calibration. Previously, the entire TCVG assembly, including the cord, would be removed, resulting in no leads being exposed. About a year ago, the practice changed to remove the TCVG display only, leaving the plugs and exposed wiring in the cabinet. A lockout was prepared for the overall job. Maintenance personnel held a pre-job brief but had not included operations since they were only moving the TCVG display to the calibration lab and were not going to be involved in the linebreak portion of the work. After the TCVG readout was removed, the maintenance personnel notified the Shift Operations Manager (SOM) that their work was completed. The SOM, believing the entire work order was completed, authorized the lockout to be removed. Later, the shift manager asked about the lockout and both walked down the glovebox where the TCVG would be, but not the cabinet where the TCVG display would normally be, and confirmed that the linebreak work had not been completed. The SOM generated a duplicate lockout to complete that work. During the next shift, the operator installing the new lockout noticed the exposed wires from the removed TCVG display and notified management. Personnel will hold another meeting to develop corrective actions.

Oral Boards: The resident inspectors observed two DOE Facility Representative (FR) final oral boards and one SRTE Shift Technical Engineer (STE) recertification oral boards.

Area Walkthroughs: The resident inspectors conducted walkthroughs of F-Area/H-Area Laboratory, Solid Waste Management Facility and F-Tank Farms with DOE FRs. All comments and observations were adequately dispositioned by the FRs following the walkthroughs.