## DEFENSE NUCLEAR FACILITIES SAFETY BOARD

November 4, 2022

**TO:** Christopher J. Roscetti, Technical Director

**FROM:** A. Z. Kline, L. Lin, Z. C. McCabe, and E. P. Richardson, Resident Inspectors **SUBJECT:** Savannah River Site Activity Report for Week Ending November 4, 2022

**Savannah River Tritium Enterprise (SRTE):** SRTE personnel conducted an issue investigation regarding a fire patrol that was not started within the required time limit. The issue investigation exhibited several weaknesses, ultimately leading to operations management deciding to suspend the meeting. Operations personnel involved in the event were not in attendance and the personnel statements did not provide sufficient clarity on the contributing events. Additionally, the responsible manager for the event was not clearly identified, as required, which is one of several recurring issues regarding event investigations across the site (see 9/9/2022 and 9/23/2022 reports).

The RIs met with NNSA-SRFO, DOE-SR, and SRTE management to discuss the deficiencies (see 10/28/22 report) and the current state and path forward for the SRTE Emergency Preparedness (EP) program. SRTE management explained that an EP Coordinator (EPC) had been named and that they are working closely with site personnel to ensure all EP requirements are being met via implementation of a drill improvement plan. The RIs are concerned with the lack of attention that was given to EP program prior to this meeting, including the integration between SRTE and site EP.

H-Area: The RIs observed an EP drill that involved a simulated radioactive spill of solvent and subsequent fire in H-Area Outside Facilities. This was the third time in the past few months that this specific drill scenario was performed. Previous drills displayed significant weaknesses (see 9/2/2022 and 9/16/2022 reports). Operations management attempted to improve drill performance by including training, tabletop drills, and simplifying the scenario. Overall drill performance improved, though additional areas for improvement were identified, particularly in the area of controller communications. Specifically, the team responding to the scene travelled through an area the smoke plume had traveled, which prompted a radiological protection controller to direct the response team that approximately half of the personnel were contaminated. However, the radiological protection controller did not immediately communicate the contamination details to the lead controller, resulting in confusion amongst the other drill controllers. The lead controller appropriately paused the drill to clarify who was contaminated and to discuss the deviation from the approved scenario.

**Oral Boards:** The RIs have observed a series of oral boards at a liquid waste facility where facility management advanced candidates for operations management positions on to the final verification of competence prior to the candidates demonstrating the requisite knowledge throughout the qualification process. This included numerous failed evaluations and practice boards leading up to final boards after months of dedicated remediation.