DEFENSE NUCLEAR FACILITIES SAFETY BOARD

August 16, 2024

TO: Timothy J. Dwyer, Technical Director
FROM: L. Lin, Z.C. McCabe, and E.P. Richardson, Resident Inspectors
SUBJECT: Savannah River Site Activity Report for Week Ending August 16, 2024

Staff Activity: Board's staff members A. Hutain, M. Randby, and F. Ruz-Nuglo were onsite to observe the Savannah River Tritium Enterprise (SRTE) annual emergency preparedness (EP) exercise and meet with federal EP program management. M. Randby and a resident inspector (RI) also observed the SRTE readiness activities, including demonstrations and interviews, for the Combined Tritium Facilities safety basis (see 8/9/24 report).

Defense Waste Processing Facility (DWPF): An independent assessment of safety system management at DWPF by DOE Enterprise Assessments found that "SRMC issues management processes do not ensure appropriate classification, analysis, and resolution of issues." The RIs identified a similar concern earlier this year, specifically regarding DPWF management's decision to not formally investigate certain issues (see 3/8/24 report). This concern persists, as evident by DWPF management's decision to not conduct a formal issue investigation regarding the near technical surveillance requirement (TSR) violation from last week (see 8/9/24 report).

DWPF operations has also experienced two conduct of operations events this week even with senior supervisory watches stationed. In the first event, a crane operator inadvertently manipulated the joystick for the 13-ton hoist for a few minutes while attempting to lower the three-ton hoist. This de-spooled much of the cable and took the 13-ton hoist out of service, impacting the facility's ability to process waste. The operators involved did not call a timeout or notify management until after attempting to correct the error. This event is similar to another event that was not subject to an issue investigation meeting from April 2024. In that instance, operators inadvertently lowered the three-ton hoist for 15 seconds while attempting to lower the 117-ton hoist which caused a lifting device to fall off the three-ton hoist hook after impacting the yoke attached to the 117-ton hoist hook. All of these devices are operated from the same station. The second issue consisted of operators entering a posted confined space to install a lockout without meeting the fall protection or confined space entry requirements. A DOE facility representative questioned the operators and stopped the activity. The investigation process identified that similar confined spaces are not labeled and were routinely accessed without the proper controls for years.

H-Canyon: H-Canyon personnel failed to meet the minimum required staffing during Operations mode, which resulted in a TSR violation. An oncoming operator informed the outside facilities first line manager (FLM) that they would be late. The FLM incorrectly assumed that the TSR allowance for operating with less than minimum staffing for up to two hours applied during turnover. The shift operations manager (SOM) was aware of the late oncoming operator and the requirement, but failed to verbalize it believing the FLM was also aware that the off-going operator would need to remain in position until relieved. The SOM recognized the problem while completing the watchbill when they asked the FLM for the name of the individual staying and was told that they had already left.