In the Matter of:

Defense Nuclear Facilities Safety Board

June 20, 2019 Public Hearing

Condensed Transcript with Word Index



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Secretary for Field Operations; the EM Deputy Assistant of Secretary for Safety, Security and Quality Assurance; and the Principal Deputy Associate Administrator for Safety, Infrastructure and Operations in the National Nuclear Security Administration.

In addition, we will also hear from our Technical Director here at the Board. Finally, Mr. Paul Dabbar, the Under Secretary for Science, will provide us with a written statement for the hearing record following today's proceedings.

The purpose of our first session is to discuss the DOE's actions to strengthen the safety posture of solid nuclear waste operations. Two recent events have highlighted the need for the Department and the Board to examine safety aspects of the storage and processing of solid nuclear wastes. They are the February 2014 radiological release event at the Waste Isolation Pilot Plant near Carlsbad, New Mexico, and the April 2018 overpressurization and subsequent radiological release from four drums at the Idaho National Laboratory near Idaho Falls, Idaho.

These two events show that chemical reactions in the waste can lead to releases of radioactive material, both where the waste is generated and where it is disposed. Accordingly, today's discussion is going to

to ensure accurate and timely information for the public, this hearing is being recorded through verbatim transcript, video recording and live video streaming. The transcript, associated documents, public notice and video recording will be available for viewing at our public website. The video recording will be available through our website for at least 60 days.

Per the Board's practice, and as stated in the agenda, we will welcome comments from interested members of the public at approximately 3:30 this afternoon. A list of speakers who have contacted us is posted at the entrance to the room. We have generally listed the speakers in the order in which they contacted us, or if possible, when they wished to speak.

Ms. Blaine will call the speakers in this order and ask that the speakers state their name and organization, if any, at the beginning of the presentations. There's also a table at the entrance to the room with a sign-up sheet for members of the public who wish to provide comment, but who did not have the opportunity to notify us ahead of time. They will follow those who have already registered. We ask the speakers to limit their comments to five minutes in order to give everyone an opportunity to speak.

25 Information should be limited to comments,

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focus on the hazards posed by this undesired chemical reactions.

For context, in both the WIPP and Idaho events, the radiological consequences to human populations were inconsequential. The DOE investigation into the WIPP event described intakes of radiological materials by personnel as low level, with trace amounts of radiological contamination detected off site.

However, under other circumstances, exposures to personnel could have been more significant and there are lessons that can be learned from these two events. Today we are discussing solid nuclear waste, both those that are newly generated as part of the Department's ongoing national security activities, as well as those that were generated in the past and are commonly referred to as legacy wastes.

We will focus on solid transuranic wastes, those that contain greater than a statutorily defined concentration of certain radio nuclides; however, some of the discussions will also be applicable to low-level waste. High-level waste and used fuel are outside the scope of today's hearing.

Today's hearing was publicly announced on April 24th on the Board's public website and subsequently noticed in the Federal Register on June 17th. In order

technical information or data concerning the subjects of this hearing. Board members may question anyone who provides comments to the extent deemed appropriate.

The record of this hearing will remain open until July 20th, and until that date, members of the public, including those observing today's hearing live via video streaming, may submit written statements to the Board to be included in the record. Contact information for submitting that statement is available on our website.

We reserve the right to further reschedule and regulate the course of this hearing, to recess, reconvene, postpone or adjourn this proceeding and otherwise to exercise our authority under the Atomic Energy Act, as amended.

This concludes my opening remarks. I will now turn to my fellow Board members for their opening remarks.

Ms. Roberson?

BOARD MEMBER ROBERSON: I do not have an opening statement. Thank you, Mr. Chairman.

CHAIRMAN HAMILTON: Ms. Connery?

23 BOARD MEMBER CONNERY: Good afternoon. I would 24

like to start by thanking our witnesses from the

Department of Energy for joining us today to discuss the

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safety management of waste storage and processing. I appreciate you taking the time from your busy schedules to talk to us about our concerns, and to the public. From the public and anybody observing from Capitol Hill and the press, we do appreciate you taking interest in the safety of the complex and our work here at the Board. And finally, I would like to publicly acknowledge the work of our staff, our management staff, our legal staff and our technical staff who put in many hours of work in preparing for this hearing.

As is known from public correspondence with the Department, the Board was troubled by the events that took place on April 11th, 2018, in Idaho, with what we'll call an overpressurization event. Four drums energetically ejected their lids and spewed radiological waste throughout a facility. Luckily no one was in the facility at the time, sparing injury, or worse.

The fire department reacted, and while we aren't delving into those facts today, took some questionable actions, but again, were not harmed during the course of the event.

Since the event, the contractor at Idaho has been diligently, and appropriately, decontaminating the facility, investigating the event, and has even resumed waste processing of the material that was collocated to the event, and presumably precautions were taken to avoid a repeat event based on the information that was gleaned from that accident.

So this leads us to some very logical questions, and these are the questions we would like to explore during this hearing. What was not done post-WIPP that could have predicted, prevented or mitigated the events at Idaho, if anything. Why is it determined that a Federal investigation was needed at WIPP but not at Idaho?

In May of this year, over a year after the Idaho event, DOE's Environmental Management Office issued a safety alert to garner information from across the environmental management site, this is what we call an extent of condition, to determine how sites assess and control risks from radioactive drums with uncertain or unknown waste streams in their Documented Safety Analysis.

While this safety alert is consistent with the information that we, the Board, requested from the Department, why didn't the Department initiate this request for information itself and in a more timely manner?

The safety alert only pertained to environmental management sites. Why wasn't the Department Corporate

with the drums that erupted.

The Department declined a Federal investigation and opted for the contractor to conduct its own investigation. Root causes of the event were examined and a hypothesis was laid out by the contractor as to the cause of the event. The event itself was not incredible, yet it was also not predicted, analyzed or controlled for.

In February 2014, a drum within the Waste Isolation Pilot Program also erupted and ejected material and contaminated the single waste facility in the complex that was certified to permanently dispose of transuranic waste, closing that facility for nearly three years and costing hundreds of millions of dollars.

There is waste throughout the DOE complex, some of it newly generated, some of it dating back to before I was born. Some of that waste is well characterized, predictable and safely stored. A lot of that waste is being dug up because it was improperly disposed of, is not well characterized, and will need to be retreated and/or repackaged before it reaches its final disposition, whether that be at WIPP or some place.

Following the WIPP accident, there was a Federal investigation, lessons learned were promulgated and corrective actions taken. The whole complex was alerted

Operational Experience Program used in order to assess the risk across the whole enterprise? Are there other drums subject to chemical reaction events either through postulated mechanisms of the Idaho event, or through some other confluence of circumstances?

Are there other drums stored at waste generator sites that could undergo a chemical reaction with similar effects, and if so, are those drums in a safe storage configuration? Are they safe during processing? Are there sufficient controls to prevent, detect or mitigate future accidents?

Is the Department consistent in applying its standards across the complex to ensure that the workers and public are safe? And lastly, the standard itself, 5506, which the Department has been talking about updating since 2015, is that sufficient to protect the sites that are processing and storing waste?

It's important that the Department maintains consistency of approach, be predictive in its analysis of hazards, versus reactive to the last challenge it faced, and be transparent about the areas in which improvements can be made. I'm hoping that we can have a good dialog through this hearing to get a better understanding of how the Department sees these events, and perhaps even ask questions that you will find useful

3 (Pages 9 to 12)

as you develop your path forward on revising your standard, communicating your expectations for implementation, and engage in your mandatory regulatory and oversight role.

I would note that this hearing -- we had some timing difficulties, and I want to apologize to the folks in Idaho. I realize that there's a concurrent meeting of the Idaho Cleanup Project Citizens Advisory Board and they expressed concern about the timing of the hearing. So I apologize that we could not have done it at a more convenient time for them, but we look forward to any interaction that they would like to have with the Board.

That concludes my opening remarks.

CHAIRMAN HAMILTON: Thank you, Board Member Connery.

At this time, I would like to introduce the panel itself. Todd Shrader is the Principal Deputy Assistant Secretary in the Office of Environmental Management; Jeffrey Griffin is the Associate Principal Deputy Assistant Secretary for Field Operations in the Office of Environmental Management; Dae Chung is the Deputy Assistant Secretary for Safety, Security and Quality Assurance in the Office of Environmental Management; and Mr. Ted Wyka is the Principal Deputy

at WIPP and Idaho are spread around the areas surrounding the drums. In addition, the lids from the Idaho drums have been ejected. Both events had an impact on the Department's cleanup mission.

Although the actual radiological consequences to the people were limited in both events, this is only because of when the drums ruptured. Given other circumstances, exposures to personnel could have been more significant, and there are lessons that can be learned from these two events to help prevent future occurrences.

For example, the WIPP event occurred when normal work was not being performed due to the February 5th, 2014 salt haul truck fire. In addition, the Idaho event occurred at night, when no workers were present. If workers had been present during either of these release events, there would have been more potential for worker exposures.

In short, no one experienced significant exposures as a result of either the WIPP or the Idaho drum ruptures, but both events have affected the Department's cleanup mission.

CHAIRMAN HAMILTON: Am I correct that that photograph on the left, what looks like a big layer of detritus, is not from the container? What is that that

Associate Administrator for Safety, Infrastructure and Operations for the National Nuclear Security Administration. So welcome all for you of you thank you for appearing here today.

Also on the panel is our Technical Director, Mr. Christopher Roscetti. And we are pleased to have all of you here today.

I'm going to start the series of questions with Mr. Roscetti, our Technical Director. Mr. Roscetti, we understand that both the February 2014 radiological release at WIPP and the April 2018 overpressurization and subsequent radiological release at Idaho National Lab involved chemical reactions in solid wastes. Would you briefly describe the significance of those events for us.

(Exhibit Number 1 was entered into the record.)
MR. ROSCETTI: Yes, sir. I would like to enter
Exhibit 1 into the record. Exhibit 1 shows photographs
following the 2014 WIPP event, and the 2018 Idaho event.
Both events involve the rupture of waste drums and the
release of radiological material from those waste drums.
The picture on the left shows the ruptured drum at WIPP.
The pictures on the right shows two of the four drums
that ruptured at Idaho's Accelerated Retrieval Project.

Exhibit 1 shows that the contents of the drums

I'm looking at there?

MR. ROSCETTI: Yes, sir. This is one I will have to clarify through the record, but my recollection at WIPP is that they placed a large bag over the configuration of the drums and waste boxes stored at WIPP. The drums are stored in like a 6x6 or a 6x3 array, so there's about six drums and this bag fits on top of those six drums. And I forget what the contents of that bag is.

CHAIRMAN HAMILTON: Okay, I just wanted to make sure that nobody thought that that material was what was ejected from the drum.

MR. ROSCETTI: Right. Not all of that material in the picture on the left is from the drum. It's from the bag that's used on top of the drums throughout the mine to I believe suppress -- potentially suppress fires, but I will clarify that for the record.

CHAIRMAN HAMILTON: We can clarify that later. Will you describe the solid wastes that we're discussing today, please.

MR. ROSCETTI: Yes, sir. Both the WIPP and Idaho drum ruptures involved solid nuclear wastes. So these wastes exist in a wide variety of forms. They include sludges, surplus uranium and plutonium and other contaminated materials such as contaminated wipes, rags,

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filters, soils or equipment.

Some of the Department's sites store legacy wastes that were generated decades ago. Other sites continue to generate these same sort of waste materials as part of their ongoing missions. Both types of sites are commonly referred to as generator sites.

Some of the solid nuclear wastes will be categorized as transuranic, or TRU, wastes. Other solid nuclear wastes will be designated as low-level wastes. The plan is for generator sites to ultimately ship their TRU wastes to WIPP for permanent disposal in the geological repository.

(Exhibit Number 2 was entered into the record.) MR. ROSCETTI: I would like to enter Exhibit 2 into the record. Exhibit 2 provides an overview of the scale of the Department's solid waste mission. The first slide of Exhibit 2 describes the progress Idaho has made shipping waste to WIPP, processing waste, and certifying waste for WIPP. It also shows the amount of waste remaining to be exhumed and processed.

Of the legacy TRU waste and low-level waste, about 86 percent has already been shipped to disposal sites such as WIPP. About 11 percent needs further processing or analysis before it can be certified for shipment. To help visualize some of these numbers, the

and on behalf of the Department of Energy, I welcome and we all welcome the opportunity to provide opening remarks today for this session in today's public hearing on safety management of waste storage and processing in the Defense Nuclear Facilities Complex.

I want to thank the Board for the opportunity for open and transparent discussions, recognizing the topics we'll be discussing today are mutual importance to DOE, DNFSB and our stakeholders. I would like to introduce the others, and this will be for both panels.

Starting with Mr. Todd Shrader, and although while he was recently appointed Principal Deputy Assistant Secretary for Environmental Management, today he will be representing his former position as manager of the Carlsbad Field Office, which is responsible for the actual Transuranic Waste Program.

Also participating in the panel are Mr. Jack Zimmerman, deputy manager for the Idaho cleanup project; Mr. Dae Chung, Deputy Assistant Secretary for Safety Security, Quality Assurance; and Mr. Ted Wyka, Principal Deputy Associate Administrator for Safety Infrastructure and Operations for the National Nuclear Security Administration.

We look forward to a constructive dialogue with the Board that can provide a clear understanding of the

9,700 cubic meters of waste, which are the two center rows combined, currently above ground at Idaho is equivalent to about 40,000 mostly 55-gallon drums.

The second slide of Exhibit 2 shows the amount of current and future TRU waste at other DOE sites. While the Department is making progress, the solid waste mission will continue for years.

CHAIRMAN HAMILTON: Thank you, Mr. Roscetti. Ms. Roberson?

MR. GRIFFIN: Mr. Chairman, yes, I am sorry, I would like or we would like to make some opening remarks if that's possible before we enter the discussion.

CHAIRMAN HAMILTON: You know, it is, and I think I may have skipped over that. Let me see. Is that in here?

BOARD MEMBER CONNERY: They said they weren't going to.

CHAIRMAN HAMILTON: Okay, go ahead and make your opening remarks. I didn't believe -- the information we got was that you didn't have any, but since you do, go ahead.

ahead.
 MR. GRIFFIN: Thank you very much.

So, good afternoon. I am Jeff Griffin,
 Associate Principal Deputy Assistant Secretary for Field
 Operations in the Office of Environmental Management,

actions and intent of the Department of Energy as they relate to waste storage and processing throughout the DOE enterprise. The safety of our workers, the public and environment is always our top priority. We recognize the work we do is hazardous and the implementation of the proper controls is critical to the safe operations and adequate protection of public health and safety.

A common theme for today's discussions is the potential for chemical reactions with some of our waste. We specifically discussed in the event last year at the Idaho Accelerated Retrieval Project, or ARP, and the 2014 event that led to a release at the Waste Isolation Pilot Plant, or WIPP.

We fully understand the root cause of both the WIPP and ARP issues, and the event leading to the 2014 release at the WIPP, the reactive nature of the waste was directly DUE to the use of incorrect materials and the processing of the well-known waste stream. The root cause corrective actions for the WIPP event are designed to prevent a similar adverse effect on WIPP, and from that standpoint have been highly effective.

The more recent ARP event is different in that it involved legacy waste that was processed without detailed knowledge of its contents. In fact, in this

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case, the waste was under audio/visual examination in an effort to aid in the characterization of the waste as one of the first steps leading to eventual certification for transport to WIPP.

The wastes in question processed at ARP had not yet been shown to meet the WIPP acceptance criteria, or WIPP WAC. It was far from certified for shipment and could not be accepted by WIPP without additional characterization and review. While lessons learned from the WIPP event are informing waste processing and packaging at the generator sites, the processes and controls developed to protect WIPP did not apply directly to the activities or issues involved in the ARP event.

The ARP event serves as a significant opportunity to apply lessons learned, particularly when dealing with legacy waste, and/or waste with uncertain characteristics. To that end, the Department values the sharing of lessons learned that will significantly minimize the risk of recurrence and maximize worker protection, not only at WIPP, but at other generator sites across the enterprise.

Following the completion of the extensive root cause analysis of the ARP event, a safety alert was generated and issued under my signature to all the EM

necessary on independent experts, such as the National Labs, to support our efforts. The implementation of the WIPP WAC has been successful in preventing unacceptable waste points from being sent to WIPP for processing of waste at local sites. The needs are often specific to the waste form and the required experts are engaged to ensure appropriate control sets. The lessons learned from the ARP event will be incorporated into our future operations.

I would also like to address the Board's previously documented concerns with DOE Standard 5506-2007, Preparation of Safety Bases Documents for Transuranic Waste Facilities. We did make significant changes to the hazards analysis at WIPP because of the 2014 incident. The hazards analysis was modified and Chapter 18 was added to the WIPP Documented Safety Analysis, or DSA, with the realization that accidents resulting from chemical incompatibility could exist at WIPP as a result of activities undertaken at a generator site.

Increased emphasis was placed on assurance that the WIPP WAC was met prior to receipt of waste at WIPP for the protection of public health and safety. Elements of this increased emphasis include: Enhanced chemical compatibility evaluations, added emphasis on

waste processing sites. It is important to note that we included all waste processors and not just TRU waste processors. The safety alert provides lessons learned to processing sites and requires responses to headquarters on actions taken and potential inventories of legacy waste to be processed.

The safety alert also considers potential deflagration hazards associated with the storage of processed waste, which was not the case at the DOE Idaho ARP V event, which was drum overpressurization. It is important to reiterate that the event at ARP did not involve a deflagration but rather an energetic pressurization that overwhelmed each installed event.

This safety alert was also informationally provided to other DOE program offices to alert them to the event. And as a followup, EM is working closely with the Associate Under Secretary for Environment, Health, Safety and Security to issue a formal operating experience report, or OE, incorporating the objectives of the safety alert to all DOE program offices that process waste. That OE is currently in the concurrence process for issue.

With respect to oversight, DOE maintains full control of its TRU Waste Program and the safety bases infrastructure that governs it. We also rely where

the basis of knowledge background of legacy waste, and enhanced reviews and oversight of the certification of waste prior to shipment to WIPP.

It is fair to say that these activities were not intended to protect waste generator sites for waste yet to be certified for shipment to WIPP. Where it protects such waste handling and processing activities at the generator sites are appropriate evaluation of activities and appropriate hazards evaluation, and establishment of controls to protect those activities.

DOE Standard 5506 is directed at analysis of postulated accidents from an appropriately thorough hazard assessment. DOE is currently in the process of revising Standard 5506 to incorporate lessons learned and feedback from the Board and the rest of the DOE complex.

In conclusion, the Board provides valuable insight and advice that the Department both appreciates and takes into consideration. Our work is critical to lowering environmental risks posed by the legacy of the Cold War. This requires us to take on hazardous waste streams and legacy waste streams that unavoidably lack complete information and documentation.

Especially for such waste with uncertain or unknown components, the potential for adverse chemical

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for certifying the waste for WIPP. We've made

Program and the generator sites.

structural program changes in terms of how we provide an

The result has been over 500 shipments since we

interface between headquarters and the sites, as well as

between the Carlsbad Field Office, the National TRU

have reopened at WIPP. We've even averaged, in the

month of May, 10 a week. So we really dramatically

25 27 1 reactions cannot be eliminated with 100 percent 1 increased, and this is from multiple sites, not just 2 confidence. There is no zero risk. We must recognize 2 Idaho. Of course, Idaho does tend to dominate and we 3 3 that there is risk in doing nothing. Our expectation is have new sites ready to come online. 4 this potential is minimized greatly by establishing 4 So I think we've taken those lessons to heart. 5 rigorous and appropriate control sets to protect the 5 We've made -- it's been, as I think in opening, the 6 workers, the public and environment. 6 Chairman's opening statement, made a comment about the 7 7 Thank you again for inviting us here today. recent years, but in just the couple of years we've made 8 8 CHAIRMAN HAMILTON: Thank you, Mr. Griffin, and tremendous progress in getting things back on the road. 9 that's a lot there. I think we may replow some of that 9 This is a critical program for the nation, 10 10 as we go through our questions, so keep that statement right? I mean, this waste cannot be left unattended. 11 handy, you may want to refer to it a little bit more. 11 We have to deal with it, and we are very serious about And you may also want to go back and look at the 12 12 take -- taking very seriously our responsibility to deal 13 reaction that I got from the Chairman of the House Armed 13 with it appropriately. 14 Services Committee Strategic Forces Committee when I 14 BOARD MEMBER ROBERSON: Thank you. So actually, 15 said that there is no such thing as zero risk. It 15 my next question is to tag on, as the manager kind of responsible for overseeing the EM world, the generator 16 wasn't a good day. 16 17 Okay. Ms. Roberson? 17 sites, what are the things that you're concerned about 18 BOARD MEMBER ROBERSON: Thank you, Mr. Chairman. 18 in this particular mission area as the mission is 19 And good morning and thank you to each of you, and thank 19 executed? 20 you, Mr. Griffin. You actually started to answer a 20 You talked in your opening statement about 21 question, my first question is actually to you. And I 21 sometimes not knowing what's in the waste. We 22 would say to you, the Board fully understands that there 22 understand that. In some cases, I mean, we're looking 23 is no such thing as zero risk. What we're focused on is 23 at specific activities at specific sites, in some cases 24 24 that there's I believe awareness of those known risks as the sites dealing with waste above ground still has 25 action is taken, and that there is a careful approach, 25 waste below ground. In some cases, you may generate 28 26 just like that EM applies to how it approaches D&D. 1 1 kind of unique waste as a result of treating other 2 So with that said, I mean, we're going to talk a 2 waste. What are the things that are on EM's leadership 3 lot about safety, but I want to offer you the 3 team's screen as it relates to this mission? 4 4 opportunity, since you didn't do it in your opening MR. GRIFFIN: Yes, thank you. My concerns, our 5 5 statement, to characterize, as we have noted, some of focus as an EM leadership team in that area are to make 6 sure that the sites have -- each site has to deal with 6 the considerable accomplishments EM has made in its 7 7 Solid Waste Management Program. their own particular set of issues. You know, Idaho 8 8 with the buried waste, in some other cases some newly MR. GRIFFIN: I'd be happy to do so. So I think 9 9 Mr. Roscetti pretty well described the progress that's generated waste, legacy waste with different histories, 10 been made in many areas. If I go back to 2014 and look 10 it's important that we help those sites have all the at the accomplishments, that's obviously a very 11 resources they need to deal with their waste, to 11 12 impactive event, and I think and what I'm sure we will 12 understand -- you know, to have the knowledge, the 13 13 discuss this more through today's session, but I think background and the information that's necessary to 14 there was a tremendous number of lessons learned and a 14 assess what needs to be done, what characterization is 15 tremendous impact across the entire program in terms 15 needed, what treatment may be needed, and we try very 16 of -- and I listed some in my opening remarks, but we 16 hard to help support those sites on their individual obviously have great improvements in the -- in processes 17 17 situations like that.

BOARD MEMBER ROBERSON: And I assume that applies even like at some sites, it only becomes TRU once it's characterized. So I assume that applies even

So that's why we have the National TRU Program

to help cut across the entire complex and deal with the

create this flow of waste that goes to WIPP and meets

individual challenges at each site in order to help

the requirements at WIPP.

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before something is deemed TRU Waste? Is that right? the Board transmitted Tech Report 43 noting deficiencies MR. GRIFFIN: So yeah, it's true of -- I'm in the standard, and as you noted, you're undergoing sorry, it applies to almost anything we deal with, review. And I was thrilled to hear that last week right? I mean, you have to deal with what you -- you coincidentally there was a workshop to discuss some of have to recognize where you have knowledge, what you these issues to maybe move this forward a little bit don't understand, and then you have to use information faster than it's been going. you have available, the expertise that we have in the So my question is to Mr. Chung. Can you just complex, that we have through the National Labs, that we describe the status and schedule for updating Standard have across headquarters and across the sites, to 5506, and the plan for incorporating lessons learned from both WIPP and Idaho? understand what you have. Whether we're talking about TRU waste or something else entirely. So yes. MR. CHUNG: Sure, thank you. Before I answer that question, since I was the lead for the original BOARD MEMBER ROBERSON: Thank you. effort that published 5506 standard 12 years ago, CHAIRMAN HAMILTON: Thank you, Ms. Roberson. roughly, I feel that as the former technical lead for Board Member Connery? BOARD MEMBER CONNERY: So I appreciate your that standard, that that standard has provided its intended purpose and objectives in terms of standardized opening comments, and we're trying to get some information out so the public has context. So I'm going the way we would analyze the hazards that are typically to ask Mr. Roscetti in the interest of time to provide a associated with TRU waste operations, which includes both processing, treatment, as well as storage. brief overview of the Department's processes for managing safety during waste storage and processing. In the context that it makes sense we're providing a control set, which goes beyond just the MR. ROSCETTI: The individual facilities at safety related controls that would provide reasonable generator sites and WIPP each have their own safety assurance for adequate protection for both public as bases. The safety bases is the tool that the Department well as workers. That went through a great deal of uses to systemically identify hazards related to a consensus building, including the Board at the time. As facility, estimate the consequences of potential accidents, and identify controls to prevent or mitigate I recall, that standard was supported by the Board, as the consequences to protect the public. well as the rest of the Department.

The Department's contractors typically use DOE Standard 5506-2007, Preparation of Safety Bases Documents for Transuranic Waste Facilities, to help determine which accident scenarios to analyze and how to analyze them. For events with potentially higher consequences, the Department implements controls that are more reliable. These are called safety controls. Different facilities may identify different control strategies based on their own analyses and circumstances.

The objectives of today's hearing focus on postulated accidents that may be initiated by undesired chemical reactions that occur in the waste.

Session 2 of today's hearing should cover specific controls for these scenarios.

BOARD MEMBER CONNERY: So Mr. Griffin described for us the fact that each site may have unique needs that the headquarters helps support, but that -- but as Chris just noted, and it was noted in both my opening and Mr. Griffin's opening, there is kind of an overarching standard, 5506, that kind of guides this.

Since 2015, the Department has been in the process of revising this standard, and in early 2018,

The other thing I'd like to mention is that 5506 standard does not stand alone as the set of controls or programs that provides adequate protection. 5506 is a supplemental guidance to the -- one of the safe harbors that are called out for in the section subpart B of 830, 10 C.F.R. 830.

The other thing that's important to all of us, I believe, is that we have many relevant safety management programs. Things like Radiation Protection Program, Hazardous Material Protection Program, Industrial Hygiene Program, maintenance, conduct of operations, Q/A. So there's all sorts of relevant programmatic elements that provide another strong basis for a safe operation.

So I'd like to point out that while 5506 standard provides important role in terms of providing upper tier set of controls from a nuclear safety standpoint, we do have a suite of directives and resulting controls that we apply during our day-to-day operations. Not so unique to waste processing operations, but throughout our nuclear operations in the complex.

With respect to your pointed question in terms

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of status of the Standard 5506, one of the reasons that we have waited until very recently to resume that effort is twofold. Is one, we wanted to make sure that we have a thorough understanding of the ARP V event in terms of the technical root causes, in terms of any other management or other types of root causes, or causal factors that may have contributed to that event. It took a while for our contractor folks and their corporate folks to be able to develop very definitive and root cause analysis and associated corrective action. So that was finalized back in February of this year.

The other thing that we were waiting for was some of the results that we were getting from the Sandia fire related test results, as well as any additional test -- needs that we may want to pursue. So we felt that this is the right time to resume in terms of having the right type of people, I think we assembled a pretty good group of experts last week to basically resume that effort, and my direction to them was to -- let's go through the entire 200-plus pages of the standard very carefully. Let's look at all of the feedback and comments that we have received from the complex, from our Federal colleagues, as well as from the contractors, plus the issues and concerns that were raised in the

that you put forward in 2015? Because it was already a justification.

MR. CHUNG: It supersedes and supplements that --

BOARD MEMBER CONNERY: Okay.

MR. CHUNG: -- that document with a lot more detailed information that captures what we know today versus what we had known in 2015.

BOARD MEMBER CONNERY: Okay. I appreciate that. We look forward to seeing that. And I also appreciate the description of the fact that 5506 is nested into a number of other standards and directives. Obviously we follow those very closely, but I wish we had time to talk about revisions to 830, but we'll save that for another conversation.

But I'd like to turn, since we have been talking about Tech Report 43, to Mr. Roscetti to just describe the staff's assessment of the standard based on some of the information that we provided in Tech Report 43.

MR. ROSCETTI: As I said in my other testimony, the Department's contractors typically use DOE Standard 5506-2007 to guide the development of safety bases for facilities that process and store TRU waste, in addition to the other Department standards and safe harbors. In 2018, the Board issued Tech Report 2007, Preparation of

Defense Board's Tech Report 43.

So we believe we have a pretty thorough understanding of the overall needs going into this resumed effort to revise the standard. And as of this morning, we have issued a justification -- project justification statement to our corporate E, S and H, which means that there's a 15-day review process for that justification for revising that standard. And then we already have received some preliminary feedback from places like Hanford, in terms of their overall consolidated comments on the standard.

So our plan is to go through what was laid out in the justification statement for revising the standard, and roughly we think that by next year this time, that we would have that hopefully published.

So if you back off, in terms of drafting the revision to the standard in various sections, we're probably talking about six to eight months from now to have a final draft, and then that will allow adequate time for what is known as a RevCom process for complex-wide review and approval.

BOARD MEMBER CONNERY: Thanks, I appreciate that. Just a quick technical question. So the project justification document that was issued this morning, which we haven't seen yet, does that supercede the one

Safety Bases Documents for Transuranic (TRU) Waste Facilities. This technical report provided the Board's staff's assessment of weaknesses in the standard known in 2018.

(Exhibit Number 3 was entered into the record.) MR. ROSCETTI: I would like to enter Exhibit 3 into the record. Exhibit 3 quotes one of the deficiencies discussed in the technical report. The 2014 WIPP event highlighted the fact that undesired chemical reactions can lead to releases of radiological material. While Standard 5506 recognizes this fact, the standard provides relatively little guidance on how to analyze and how to control such hazards.

To the extent the standard does have guidance on chemical reaction hazards, the Board's staff is concerned that the standard underestimates the potential consequences of such events.

After the WIPP event, the Department determined that the amount of radioactive material released was significantly greater than currently considered by DOE Standard 5506. This is important for the entire complex because the amount of radioactive material estimated to be released during potential accidents is used to identify safety controls to prevent or mitigate such accidents.

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change in conditions of the waste. So it was just more

field, those that have generated waste and still are, to

And we've actually had some discussions with the

than dealing with a pure technical aspect.

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1	The Board's staff has performed a cursory review	1	look for their immediate input in terms of their
2	of the safety bases for TRU waste facilities and found	2	reaction to what they have read or heard. So which
3	that several facilities have not incorporated, updated	3	culminated in issuance of safety alert. So the safety
4	release parameters for an energetic chemical reaction	4	alert applies to all of the site waste generating
5	into their safety analyses. Including this information	5	activities, waste previously generated on site and now
6	in the safety bases could drive the Department and those	6	stored or being repackaged; retrieval and repackaging of
7	specific facilities to identify additional safety	7	legacy waste retrieved from other sites as well.
8	controls that could help prevent or mitigate an	8	If you look at the safety alert, we required
9	energetic release event.	9	certain actions, then we also have some recommended
10	Since the Board issued the technical report, the	10	actions. Let me just give you an example of required
11	April 2018 Idaho event occurred, which the Board staff	11	actions. So it is required for each site to complete a
12	believes provides additional information related to	12	site-specific extent of condition review for
13	release parameters. As with the WIPP event, the Board	13	radioactivity in mixed waste drums in storage that have
14	staff believes this information should be incorporated	14	not been certified.
15	into Standard 5506 and the facility safety bases.	15	And there are seven criteria or questions that
16	CHAIRMAN HAMILTON: Thank you, Board Member	16	they must encompass in terms of performing their
17	Connery.	17	site-wide or site-specific standard condition review:
18	Ms. Roberson?	18	Identification of flammable gas; testing protocols and
19	BOARD MEMBER ROBERSON: Thank you, Mr. Chairman.	19	frequency of testing; identify the circumstances in
20	So we're talking about 5506, and I wanted to say my	20	which flammable gas testing is not performed and the
21	question is actually I have several questions for	21	rationale for this approach; identify the number of
22	you, Mr. Chung, but I appreciate your comment, and as	22	waste drums containing flammable or near flammable gas
23	Ms. Connery said, we spent a lot of our time evaluating	23	concentrations; and the controls in place to mitigate
24	the execution of the safety management programs, as do	24	their hazard; identifying the inventory waste drums that
25	you and your staff, and we know the execution isn't	25	contain or could contain metal carbides, including waste
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1	always consistent and predictable across the sites and	1	streams yet to be discovered or recovered or excavated;
2	across the programs, which is the reason why it's so	2	identifying the inventory of waste drums which with
3	important to take a step like EM did in issuing the	3	uncertain process documentation to determine pyrophoric
4	safety alert.	4	and flammable gas generating potential; describe the
5	(Exhibit Number 13 was entered into the record.)	5	processes in place for monitoring and managing these
6	BOARD MEMBER ROBERSON: And so I want to enter	6	uncertainties in the waste management activities.
7	that safety alert on the record of the hearing as	7	And also, we asked them again to evaluate any
8	Exhibit 13, and a copy of it is on the resource table in	8	waste condition of concern that are identified in
9	the back, and it's also on our website. And I wanted to	9	accordance with DOE Standard 5506, including all of the
10	ask you, Mr. Chung, to summarize the environmental	10	lessons that were either already applied or should be
11	management safety alert.	11	applied from the WIPP event as well.
12	MR. CHUNG: Thank you. I'm just going to	12	Chris mentioned about the importance of
13	summarize what we have communicated in that written	13	predominantly the release fraction that resulted from
14	safety alert that Jeff mentioned. Not only that we have	14	the more energetic chemical event at WIPP, which was
15	considered the two main causes that were identified by	15	applied not only to the WIPP facility, but also for the
16	the contractor-led investigation, as well as their	16	remediated nitrate salt resumption operation at Los
17	corrective action, we also looked at the eight	17	Alamos. There was, I believe, an operating experience
18	contributing causes, which include some aspects of	18	report that was issued back in 2015 to highlight that
19	safety culture.	19	concern to the complex, and those two sites were the
20	Things like how to manage changes. How to	20	sites that responded in terms of the need to apply the
21	detect and also act properly when you see potential	21	higher release fraction, which would obviously give a

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higher consequence estimate.

So the site-specific extent of condition reviews

would be collected and compiled. We asked the sites to

submit their input by end of September, and then we will

put together a small, a very strong team at headquarters, which may include some other outside experts to look at all of the site-specific extend of condition reviews to come up with a complex-wide extent of condition review and lessons learned. That is the plan for addressing the required action.

There are also quite a few recommended actions, which include some of the nontechnical aspects, like -- let me just point out a couple of things. Promote continuance improvement in site safety culture, where workers can express an inquisitive attitude toward challenging assumptions, regardless of potential impact of cost and schedule.

A similar aspect of this was already identified by the Idaho Fluor contractor as part of their causal factors or contributing causes. So we think that that is an important factor into dealing with the uncertainties, recognizing that no matter how good your hazard identification or hazard analysis or reaction analysis are, you're going to have that element of uncertainties. And we believe that it's very important to have not only well trained and qualified operators, but we have to create -- we have to continue to provide positive safety culture so that they are able to pause or ask the right questions in terms of managing the

engaging up with the field folks in terms of what may be happening so that they don't have to wait until the so-called complex-wide extent of condition review is completed prior to making any necessary changes into or onto their safety base document.

BOARD MEMBER ROBERSON: Okay. Thank you, sir. So, Mr. Wyka, what actions or directions has NNSA provided to account for the known deficiency in the standards, since you guys generate waste, too?

MR. WYKA: Thank you, ma'am, for that question. And first of all, the safety management of waste and storage and processing is paramount to NNSA, you know, for our mission activities. You know, the timing of the inventory of the stored new gen waste from TA-55, transuranic waste facility, as well as Livermore, is critical to not only our current missions, but our future missions, which is the NNSA pit production initiative.

So it's critical that we get this done, and it's critical that we work as one team to get it done, because we can't do it all by ourselves.

It requires the Carlsbad Field Office, their contractor, the labs. We're required to assure continuous and efficient characterization and certification of the TRU waste before shipping it to

changes that I mentioned earlier.

BOARD MEMBER ROBERSON: Okay. Thank you. MR. CHUNG: And that's what the safety alert contains.

BOARD MEMBER ROBERSON: Thank you so much. One short question. You didn't require this, but you didn't preclude it either. If in doing that data gathering and analysis, is there an intent that the site make changes, for instance, to its facility safety bases if it identifies information?

MR. CHUNG: Yes.

BOARD MEMBER ROBERSON: You didn't require it, but that is your intent?

MR. CHUNG: Yes. You know, just if I may add, we do have a pretty good engagement in terms of what's going on in the field. Many of our headquarters staff are deeply engaged in either supporting or providing oversight/insight in terms of development or changes to the safety base documents.

In terms of revising fire hazard analysis, which is also a very important element of developing adequate safety bases, which should be provided to the hazard analyst in terms of identifying, hey, do we have a pyrophoric potential, do we have combustible materials, do we have any known prohibited items. So we're also

1 WIPP.

So with that in mind, you know, NNSA learned from both events, both from the WIPP event, as well as from this ongoing event, and it's critical that we take those lessons learned, and again, work as one team, recognizing that the events are distinctly different, but NNSA and I specifically reviewed the EM safety alert regarding the April 2018 event.

On May 31st, I issued a direction to the field office managers to review the safety alert. This was done via an email. The intent of this direction was to, you know, alert the NNSA sites to this issue, first of all, to gauge the potential for recurrence of this type of event, and to consider steps to prevent such occurrence.

Now, while the alert is sort of at EM sites, I think this allows the NNSA sites to pause and to think about it in terms of our respective operations. NNSA sites are not yet required to provide a written response on the specific actions such as required by EM, but they have been directed, requested, to complete these actions as soon as practicable, and that the results would be discussed with NNSA headquarters as part of our new gen TRU Waste Program Review in October of this year. The actions that I specified for them to take on was to

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first ensure and review the ARP causal analysis report, 1 2 and incorporate lessons learned into appropriate site 3 procedures, as well as review any DOE Standard 5506 4 accident scenarios against the waste repackaging 5 activities, as well as assessing training personnel, 6 training of personnel responsible for approving waste 7 for processing and treatment to ensure that they are 8 sufficiently qualified for such treatment operations. 9 Also ask them to review and update as necessary waste 10 operator training materials to ensure modules address the identification and change of waste conditions, i.e. 11 12 pyrophoric materials, oxidizing materials and other challenging waste type forms. To evaluate existing 13 processes for treating wastes of uncertain pedigree. To 14 15 ensure effective controls are in place to safely handle, package, treat and store waste pending that transport 16 17 and disposal.

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I also asked them to review procedures for current and future drums with packaged waste to ensure effective controls are in place to prevent or mitigate unexpected reactions, to review radiological procedures for appropriate entry requirements for areas with potential airborne transuranic hazards, and to continue promoting improvement of the safety culture to contributing causes specified in the alert.

statute calls for in the Atomic Energy Act is adequate protection. So I get that.

I also understand that any time any human endeavor involves some element of risk, there's also risk for not doing something. And so you have to have a schedule, and the question is how do you balance that.

(Exhibit Number 4 was entered into the record.)

CHAIRMAN HAMILTON: Could you put up Exhibit 4 and enter it in the record, please. And I'm just going to pause and let you read this for a minute.

My question to you is kind of general in nature, but I'd just like to understand how you and the Department balance production priorities and prevent greater pressure from schedules from eroding safety. How do you balance production priorities with your responsibilities as regulator of safety?

MR. GRIFFIN: Thank you, that is actually an excellent question. And actually I think one that the philosophy of that area is one that we actually have spent quite a bit of time talking about. And I guess I would start by saying, I don't think we see it as a balancing act, but more as a responsibility that we have the responsibility to execute work in the field, and we understand that that's our mission.

And so what we have to do is create the

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Recognizing that the Department will be operating -- will be issuing an operational alert, which will go Department-wide, but NNSA recognizing the importance, you know, of waste management to our mission, you know, taking a -- the actions as I specified.

BOARD MEMBER ROBERSON: Thank you. So that's formal guidance you provided to the generator sites?

MR. WYKA: Yes, ma'am. It was direction to the field office managers, outlined providing the alert, and providing the context and an application to us as well as some specific actions for them to take, and that we would be looking to discuss this as a team at the program review in August of this year.

BOARD MEMBER ROBERSON: So that guidance, is that something you could evaluate and provide into the record of this hearing?

MR. WYKA: Yes, ma'am.

BOARD MEMBER ROBERSON: Okay. Thank you. CHAIRMAN HAMILTON: Thank you, Ms. Roberson.

Mr. Griffin, I would like to shift gears a little bit

and talk about how scheduled pressure may erode safety. You and I are in violent agreement that there's no such

24 thing as perfection in safety, that our goal is to 25

achieve adequate protection. In fact, that's what our

processes and procedures that allow us to execute that work safely. I mean, it's a given that we have to go do this work, so how do we go about doing that? How do we create the processes and procedures and how do we bring in the lessons learned? Because things happen sometimes. How do you build that in and continually improve this?

So I guess I'm trying to -- I'm trying to say that I'm not sure we would see that as necessarily having to choose one or the other, but recognizing that we have to go down this path of executing this mission, how do we build in the appropriate safeguards, processes and procedures that allow us to do that safely, or then constantly improve that.

So that's something that we're continually working at, and, you know, both at headquarters, with the sites, and I think it goes back to what Dae was talking about earlier, that, you know, the safety alert and trying to talk to the sites and get their feedback on this.

I'm not sure that completely answers the question, but I guess I wanted to try to get away of this view as the balance there.

CHAIRMAN HAMILTON: Well, Mr. Chung wants to provide some additional information. Go ahead.

12 (Pages 45 to 48)

MR. CHUNG: One of the I think significant lessons we have learned and we're continuing to learn from the whole ISMS, Integrated Safety Management System, related efforts over the last two decades, since the K-Reactor restart days, is that we need to factor in safety as part of our business model up front. Whether you're pursuing a major capital project, where safety becomes very important from a design perspective, whether safety plays into an important role from a day-to-day work planning and process activities.

So I think we fully recognize, by now, the importance of safety and even quality that those elements must be integrated into the work, while appreciating the fact that we do have cost and schedule. Without cost and schedule objectives, you know, why have contracts, right? So our work is being performed by very experienced contractor communities, and we have to establish contractor scope.

Within the contractor scope we have certain milestones. We have cost baseline, we have schedule baselines, and we are continuing to make sure that our workforce understands, not in terms of balancing, but they have to understand and appreciate the objectives of our mission and work scope at hand. At the same time realizing that the safety and the quality, security

look at that second bullet again. It talks about schedule pressure was felt by contractor personnel over the entire period evaluated. And that was a year and a couple of months ago. Just a short answer, what's one or two things that have been done in the last 14 months to address that?

MR. CHUNG: Me?

CHAIRMAN HAMILTON: Just very briefly.
MR. CHUNG: If I may, Idaho Fluor actually asked
EM headquarters to help them review their safety
culture. So we have provided our own expert from
headquarters as well as some of the well-known industry
experts in safety culture area to go up to Idaho and
looked at various facets of the safety culture, not at
just the program, but through a suite of interviews, all
the way down to the operating deck. They either
reinforced some of the weaknesses, they also found some
strengths. So that's one of the actions that both our
contractor and DOE have taken to strengthen that aspect.

CHAIRMAN HAMILTON: Thank you.
MR. CHUNG: And Jack may be able to provide a more detailed response.

CHAIRMAN HAMILTON: I think that's sufficient. Thank you.

Ms. Connery?

even, must be integrated into their work so that -- so that they make the right decisions.

Therefore, we actually enable getting our mission done more efficiently and effectively. I think that's our goal. And I think that's the goal of the Department for the past couple of decades, and I think EM is continuing to strive for that approach.

And also making sure that this business about safety bases isn't -- some folks think that if you have a very conservative, rock-solid safety bases, that you're good to go, but that is just a part of it. So we need to make sure that our workforce understands not only those upper tier set of nuclear safety related controls, but the importance of integrating hazard or safety into the work.

Everyone uses some sort of procedure to execute the work, right? So -- and there is a planning process. There is an execution phase. So that's where I think we need to continue to improve in terms of instilling that mindset as well as the activity level and process level controls so that the workers who are on the deck plate executing this important work carry those mission, work, safely.

CHAIRMAN HAMILTON: I appreciate that. Let me just in the interest of keeping us rolling here on time,

BOARD MEMBER CONNERY: So I appreciate that, and we would love to get a copy of the Safety Culture Report and the methodology by which it was provided, because I don't believe we have a copy of that yet.

But my question is for Mr. White, because he looks lonely and he looks like he is wanting to speak. As the lead for the Department's formal accident investigation for the WIPP radiological release and the previous deputy manager at the NNSA Los Alamos Field Office, you're uniquely qualified to understand the multiple factors that contributed to the release. And one of these factors, as we noted, was schedule pressure.

In your current role with the National Nuclear Security Administration, which is under schedule pressure to accomplish many of its national security missions, can you discuss NNSA's approach to avoiding the negative effects of the challenging schedule, particularly with respect to waste, which can receive a lot less attention compared to weapons components?

MR. WYKA: Thank you, ma'am, for that question, and as I previously mentioned, you know, the management of waste, from our perspective, is just as important, you know, as the mission, because we -- you know, for us to do our mission, we need to be able to remove waste,

13 (Pages 49 to 52)

you know, from our generator sites to make room in terms of tomorrow's world in terms of storage, but, you know, balancing the mission schedule and safety at generator sites is critical. And, you know, in response to the previous question of what new activities can we do, it's probably doing the old activities and implementing those effectively. And that's dating back from the Board's recommendation 95-2, Integrated Safety Management. And it's that balancing the schedule and the safety and making the safety as a critical part of the mission.

So the NNSA, NNSA generator sites constantly strive to balance that mission with safety through establishment of challenging and yet achievable goals in the TRU waste contracts, and that's our vehicle that we use. You know, there's a strong partnership to ensure that the mission goals and safety are intertwined, you know, as outlined in the Department's expectations for integrated safety management and for a strong safety culture.

And it's something that you have to continuously look at, because when you think you have a strong integrated safety management or safety culture in place, you know, you're looking for those weak signals, weak signals where it's degrading and where you're back sliding a little bit.

1 Ms. Roberson?

BOARD MEMBER ROBERSON: Thank you, Mr. Chairman.

So first of all, congratulations, Mr. Shrader, on your more recent assignment. But in light of your previous role as Carlsbad manager, and other roles in the complex, can you describe the division of responsibility in the Environmental Management Program

relating to ensuring safety of waste from generation to final disposal?

MR. SHRADER: Sure. I think Mr. Griffin alluded to this in his opening remarks. The programs and processes we've put in place after the WIPP event were specifically put in to protect WIPP, and these would be enhanced certification processes such as enhanced acceptable knowledge reviews, chemical compatibility evaluation reviews, basic knowledge reviews where we look at oxidizers, nitrates, et cetera.

All of that is intended to ensure the waste prior to putting into shipping container or TRUPACT, prior to the shipping at WIPP, is going to be safe there. That's been enshrined within our DSA. In fact, a new Chapter 18, and we were the first in the complex to have that specific waste management chapter within the DSA. That ensures that the work done at the sites as the waste is prepared ensures that WIPP is safe.

But these expectations are clearly defined in our prime contracts, and the workers at the generator sites are well versed on the hazards associated with the work, and are involved in the development of controls, but it's to maintain that pressure of continuing to strive for improvement with integrated safety management systems, safety culture, as a critical element of getting the work done and completing the mission.

And they prevent or mitigate consequences from the hazards and are comfortable with the controls established -- these are the workers -- to protect the workers, the public and the environment. So, you know, it's the actual and effective implementation, integrated safety management, continuing to build on that.

And we saw that in both the -- with this current event, the WIPP event, and some of the contributing causes were similar. The mechanisms may have been a little different, as well as any -- you know, most of the other, you know, events, if you dissect them and look at the contributing causes past the root causes, it's, again, effective implementation of, you know, those systems that we have been trying to and continue to put in place for the last, you know, 20 years.

BOARD MEMBER CONNERY: Thank you. CHAIRMAN HAMILTON: Thank you, Ms. Connery.

Moving up stream of that, the site itself is responsible for safety at the site. For instance, they have their own DSAs for, say, a TRU storage facility, they have their own permits, for instance, for RCRA compliance, that type thing. We define those through memoranda of agreement between the site and the Carlsbad Field Office, where we specifically call out what those divisions of responsibilities are.

We also have the site certification process where we send a team out to the site, look at the certified program, and ensure that it's meeting the requirements of our permit itself. When that team is satisfied that the permit requirement is being met, the Carlsbad Field Office manager certifies the site for shipment.

And then we have a third piece that we think helps in both sides of the equation, the Generator Site Technical Review. This was a new process put in place after the events where it's going to look at not the certified program and permit compliance, but general processes and work done at the site. It's built around giving assurance to the manager of the Carlsbad Field Office that the site has rigorous procedures and processes in place to ensure safety of the waste coming in, but at the same time, it also gives some lessons

14 (Pages 53 to 56)

learned and some issues that the site can use some improvement to safety at the site itself, also.

BOARD MEMBER ROBERSON: So I think we are going to have questions, we are going to talk about the technical reviews later, but based on your experience, can you describe some of the challenges that you have seen in making sure that waste is acceptable for risk? Is it really in the processes possible?

MR. SHRADER: Sure. You know, I think we've -it's been alluded to a couple of times here. Legacy
waste, of course, is our most challenging waste, and
that's because the paperwork or the acceptable knowledge
and the history of that waste is often not as detailed
as it is today. And it's because some of the waste was
generated 30, 40 years ago.

So our challenge there is to go in and expand how we look at the waste and look at the documentation. You don't look at just -- for instance, when you're looking at chemicals, potential chemicals of waste, you don't look at just what the process was. What are the chemicals used in the buildings, what were the other processes used in, say, a glovebox at Rocky Flats, for instance.

And so that's how we address those challenges. By far the biggest is just do we really understand what incorporate into how they do operations, also.

BOARD MEMBER ROBERSON: Okay. Thank you. CHAIRMAN HAMILTON: Thank you, Ms. Roberson.

Mr. Shrader, you're on a roll, so I'm going to stay with you for another minute here. I'd like to talk about how the learning at individual sites is translated across the complex. We understand that one of the Department's prominent corrective actions taken in response to the WIPP event was to establish a Generator Site Technical Review process to ensure the waste is acceptable at WIPP. This process uses experts to review whether processes and procedures are in place at generator sites to ensure that the transuranic waste meets the WIPP acceptance criteria.

(Exhibit Number 5 was entered into the record.) CHAIRMAN HAMILTON: I'd like to enter Exhibit 5 into the record, please, and I'll just pause and let you read that for a moment.

Our staff reviewed several of these reports, and we found that some common issues were -- some of the issues were common across multiple sites, and you can see them up there. Can you tell us how you identify and address deficiencies that are found at an individual site that turn out to be common over multiple sites? How do you translate that into policies and procedures

the waste is, and that's where we expand our reviews of the documentation and the history of the waste. And it gives us -- once we do that, we think we can build a much better, more comprehensive what we call acceptable knowledge package which is a combination of all the documentation to describe what the waste is.

BOARD MEMBER ROBERSON: And are there other potential actions that could be taken to ensure that the process from beginning to end is safer or more efficient? Or is that pretty much encompassed?

MR. SHRADER: No. If -- in certain cases, you may get to the point where the acceptable knowledge of paperwork simply is not sufficient, and you could go into a sampling analysis regime, if you needed to, for certain waste streams to build your higher level knowledge, for both safety and, frankly, RCRA compliance, also, compliance with our permit.

Further up stream of that, some of the things that certainly help with legacy, is I think we talked about the lessons learned process, both the formal process, the safety alert that was alluded to earlier, and even the informal processes the Carlsbad Field Office have that we communicate with all the sites on a biweekly basis, all the TRU generating sites of lessons learned and things we've seen and maybe they can

across the whole complex?

MR. SHRADER: Sure. So the -- I'll take the second one first. This issue of worker knowledge. Often times that may not translate into a -- necessarily a safety risk. It may translate into an efficiency risk. And by that I mean, there are a certain amount of knowledge we look for as we certify transuranic waste. What the process was, what the documentation, et cetera. By ensuring workers have a knowledge of where information is going to be used earlier, it can increase efficiency down the line.

How that's translated to the site specifically is, again, we have the -- our calls with the sites every couple of weeks where we have specific lessons learned we can apply. We also have -- about every nine months we have a generator site meeting where all the sites come together. The next one is in Chicago at the end of July.

We have very specific sessions on that about common areas -- common issues we've seen at GSTRs, lessons learned, and so that's a good chance to bring all the sites together and talk to them about here's what we've seen in multiple sites around the complex, and we can pass that knowledge on at that point.

The first one is similar. Some of that the

15 (Pages 57 to 60)

61 63 1 absorbents -- or some of the chemicals information we way to influence that? 1 2 2 knew, that will sometimes translate into the certified MR. SHRADER: Correct. The National TRU 3 program where we will have very specific questions we Program's boundary is at the certified program, not at 4 look for specific waste streams based on what we see 4 storage at the sites, et cetera. 5 there, also. So that goes into the certified program BOARD MEMBER CONNERY: Okay, thank you. 5 6 6 review of sites. CHAIRMAN HAMILTON: Thank you. 7 7 CHAIRMAN HAMILTON: I would hope certainly you Ms. Roberson? 8 wouldn't wait until you have a conference in Chicago if 8 BOARD MEMBER ROBERSON: So I just wanted to 9 you found something that was relevant to all the sites. 9 bound the Generator Site Technical Review process, which 10 MR. SHRADER: Certainly. And that's why I 10 is a tool that you use, and a good tool, but my 11 mentioned, we have a call every two weeks with the waste understanding is it's limited in scope. And so there 11 12 generator sites that's led by my assistant manager for 12 was a technical review done at Idaho before the event, 13 the National Transuranic Waste Program, all the sites on 13 and we had the exhibit up, you know, it pointed to 14 it, and that's a common place that we can talk about 14 certain things, but it didn't alert or preclude the 15 this. And if it were truly to rise to a high enough 15 event. 16 level, we can always use the more formal mechanisms the 16 So are there improvements planned to that 17 Department uses, such as the Safety Alert System or 17 process or other augmentation? For instance, is there 18 operating experience, et cetera. 18 any thought given to independent evaluation for the 19 CHAIRMAN HAMILTON: Okay, thank you. potential of chemical reaction events at generator 19 20 Mr. Griffin, would you like to add anything to 20 sites? 21 that? You don't have to, but I know this is in your 21 MR. SHRADER: The Generator Site Technical Review process is a programmatic review, and so it would 22 22 23 MR. GRIFFIN: No, I think I would have said 23 not necessarily detect individual waste stream problems 24 exactly what Todd said. 24 or problems in individual drums. But saying that, after 25 CHAIRMAN HAMILTON: Fine. I just wanted to give 25 that event, we are certainly always looking to expand or 62 64 1 you the opportunity. Thank you. 1 improve -- better word -- improve the Generator Site

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Ms. Roberson? Oh, I'm sorry.

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BOARD MEMBER CONNERY: Excuse me, can I ask a question? So I just want to clarify, though, because the TRU Waste Program is not a reporting chain from the generator sites. So they're both -- it's more of a customer service relationship.

So I understand that that is a good way to send information informally that good generator sites will adopt because it's in their best interest to do so, but there's really no mechanism, as I understand it, for the National TRU Program to require anything from the generator sites, except for as it applies to the Waste Acceptance Criteria. Is that a true statement?

MR. SHRADER: Yes, but the waste -- the -- as a general statement, I agree with that, but the Waste Acceptance Criteria can have fairly expansive requirements in it. If we truly found an issue that was multiple -- was being an issue of multiple sites, we can revise the Waste Acceptance Criteria. That is now -- becomes a requirement for all shipping sites to send to us.

BOARD MEMBER CONNERY: But those requirements would only take place prior to shipment, so while that waste is at the generator sites, you wouldn't have any

improve -- better word -- improve the Generator Sit Technical Review process.

I don't have the specifics now to talk about it, but if there are areas we can find particularly to address common issues around the complex, we would certainly bring that into the GSTR process.

Again, I would also mention, you know, if there's common lessons or common issues, we do have the more formal processes within the Department that we could also engage in, and Mr. Griffin has spoken of those, also.

BOARD MEMBER ROBERSON: Thank you. MR. GRIFFIN: If I may add, if I go back to the

MR. GRIFFIN: If I may add, if I go back to the safety alert that they discussed earlier, you know, I think it's -- as he outlined, the idea would be that we go collect this information, and then go sit down, or maybe not sit down, but get with all the sites and figure out how this translates into impacts across the whole program, including the site technical reviews at Generator Site Technical Reviews.

BOARD MEMBER ROBERSON: So don't turn it off yet. So I just want to clarify. You're expecting some form of that data in around September. The executive leadership is going to look at that, and there may be additional processes or requirements as a result of

16 (Pages 61 to 64)

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65 that. Is that what I understand? 1 1 2 2 MR. GRIFFIN: Absolutely. 3 BOARD MEMBER ROBERSON: Okay. Thank you. 3 4 MR. GRIFFIN: Did you want to add anything? 4 5 5 MR. CHUNG: Just the only thing that I did mention about not only the required actions, but 6 6 7 7 recommended actions. We do have an established process 8 8 for communicating issues. We do have a -- either 9 monthly or quarterly site briefings that we have been 9 10 10 conducting for several years, and we have identified that as an example for communicating any issues from 11 11 12 12 even this safety alert related information gathering 13 13 effort. 14 14 So that there are multiple mechanisms I believe 15 15 that where the field can let us know what's -- what 16 16 they're finding, as well as the ability for us to be 17 17 able to ask questions. So I just wanted to add that. 18 BOARD MEMBER ROBERSON: Thank you. 18 MR. WYKA: If I could add as well, at least it 19 19 20 was mentioned that as the deputy manager for a generator 20 21 21 site, I found the GSTR reviews very helpful, especially 22 22 looking at the lessons learned from the other reviews 23 23 and improving your programs, because GSTR actually looks 24 24 at, you know, wide area things, such as the Q/A Program,

but there wasn't one at Idaho, and the contractor's formal causal analysis report does not, and I quote, "include an evaluation of DOE's actions or contributions to the event. In fact, after our analysis, we believe that deficiencies in Standard 5506 could have been a contributing factor to the event as well."

So I'd like to know, now that you've issued the safety alert, and I understand we're going to get a lot of information that we will find relevant to our questions of about a month ago, how are you identifying corrective actions for the Department itself, or for Idaho ops based on the event, given the fact that you didn't do a Federal investigation?

MR. CHUNG: If I may answer that question. Idaho Field Office, along with the EM headquarters, have discussed the options at -- that we had in terms of whether or not this event, based on the knowledge that we had at the time, would trigger an AIB type of investigation, or could we do something else.

So we examined the criteria that are given in the governing order, 225.1(b), so we considered those factors pretty carefully. It did not trigger any of those criteria, including the financial or monetary aspect at the time, but both contractors and DOE recognized that finding the technical root cause is

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Management Program, which is problematic across the enterprise, you know, our conduct of operations, as well as our Federal oversight. And the Waste Management Program itself, including the generation piece, the treatment, packaging processes, the permitting aspects, and then the hazardous waste determination, all critical elements. As well as the deferred maintenance.

a Generator Site Assessment Program, an Issues

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So I found that as a deputy manager useful, not only for the TRU Waste Program, but, you know, across the site in terms of programmatic pieces that it looked

BOARD MEMBER ROBERSON: I appreciate that, and I thank you for that, and as I'm sure the rest of the Board does, look forward to see what comes of the effort you're taking. I guess the only thing I'd say is, yes, there has been two events. There's a history of events, but I think through this effort, it looks like the recognition is, it isn't the event that's the anomaly, sometimes it's the waste that's the anomaly, and try and figure out how you equip yourself to handle that is very important. Thank you. CHAIRMAN HAMILTON: Thank you, Ms. Roberson.

BOARD MEMBER CONNERY: After the WIPP event,

there was an extensive Federal accident investigation,

Board Member Connery?

going to be an essential part of this -- whether you want to call it investigation or review.

So we decided to have Fluor Idaho to lead the investigation, but with a very strong oversight from both DOE Idaho and EM headquarters. So that was our collective decision at the time.

And then by working with our contractor, Idaho Fluor, we have broken investigation into three different groups, if you will. There was a group that focused on causes. Also there was a group that evaluated the responses from firefighters and whatnot. We also wanted to make sure that the corrective action plan, development process, was sound and rigorous.

So, and then Idaho Field Office, under the leadership of Jack and Mark Brown, put together very strong team on the order of about a dozen SMEs to provide individual attention to each one of those functional areas I mentioned, the three of them, as well as the several important functional areas, including root cause analysis, fire protection, work planning and control, accident investigation, occupational safety and industrial hygiene area, operations, waste management, environmental compliance, radiological protection and nuclear safety.

I would say that was pretty thorough coverage in

17 (Pages 65 to 68)

terms of their oversight. In addition to Idaho's oversight, EM headquarters provided a significant oversight. We had had a chief engineer at the time to very deeply engage in the discussions of the chemical reactions and the chemistry surrounding the event. We also provided expertise in nuclear safety, conduct of operations, and radiation protection.

As I mentioned earlier, we also provided, at the request of the field, and the contractor, very strong team including industrial experts to look at the Safety Culture Program. And also, during the development of the corrective action phase, which took a while, I seem to recall seeing a draft coming out back in December of last year, three or four of our headquarters staff working with Idaho Federal colleagues, we have extensively reviewed that.

I don't know whether the Board has seen the record of our comments, but it's a very extensive set of comments which we believe help the contractor to come up with a pretty good set of corrective actions.

The other thing that Idaho and we decided to do, in terms of looking at Idaho's Federal oversight, two experts from ORP, Office of River Protection, and one senior person from EM headquarters, were put together to look at the Federal Oversight Program at Idaho. They

directing these events is really can we learn anything, and can we learn anything that's going to, you know, help the enterprise, not only in NNSA, but the Department. And there's really no -- there's different mechanisms to do that.

In fact, I've used three different mechanisms in chartering accident investigations. I've had two where there were complete Federal teams. I've had one where it was a combined effort with combined Federal as well as contractor team, and I had one in which I had the contractor lead the investigation and I assigned a Federal monitor, you know, to look at the deliberations of the investigation, as well as a team to do the Federal oversight piece from both the contractor as well as the Federal component. And all four of them have been just as successful in terms of their rigor and in terms of the depth, in terms of the conclusions of the root causes and contributing causes, and all four have been briefed to the administrator.

So there's different mechanisms for doing accident investigations. The key is management attention, you know, on these investigations and making sure that they have the tools to successfully do what they need to do, without any interference, and that you're looking at all aspects of it. You know, as well

provided a 30-page report. They basically concluded that the oversight was adequate; however, they pointed out certain recommendations which Idaho either have completed most of them or are in the process of completing most of those recommended actions.

So if you look at the rigor and the depth that the contractor have done in terms of their technical root cause and the also resumption effort related investigative work, I think that was pretty comprehensive investigation. Along with the DOE oversight provided by Idaho and EM headquarters, I think that we have done a pretty good job of not only identifying root causes, but also all the relevant contributing causes, as well as pretty responsive corrective action.

MR. WYKA: I'd like to add onto that, if I can, especially with the experience as the investigation board chairman for the salt truck fire as well as the drum event, but probably more importantly with my current hat as the cognizant secretarial officer for NNSA, I'm the one that directs the accident investigations for NNSA.

I've had the -- I've had the chance of directing four actually within the last year, using the DOE Standard 225.1, and my main trigger for issuing -- to

as all the oversight aspects, both from the contractor, the parent organizations, as well as Federal organizations.

BOARD MEMBER CONNERY: Thank you. Actually, I appreciate that explanation. I would just note that the field office at Idaho, that Federal oversight review actually took place months before the contractor event investigation was concluded. So I'm not sure that it was as helpful because it was completed before the causes of the Idaho event were thoroughly understood.

But when I asked this question originally, and I asked it back in May of last year to somebody who is no longer working at EM, I was told that the reason that they weren't wanting to do that, in addition to the fact that it didn't reach the financial threshold, was the fact that they didn't have the Federal resources to conduct such an event.

And so I'm curious as to whether in the event that there was something else that happened in the future, would you have the resources? And by that I mean the talent was I think what that individual was getting at, in-house, to perform a Federal accident investigation on the EM side.

I understand the capabilities on the NNSA side, because I came from that, but I don't know whether or

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not EM, from what I've heard, would have that capability. And if that was really one of the causes of not doing a Federal accident investigation, that's troublesome and we would want to make sure that you do have the resources to be able to do that in the future.

MR. CHUNG: My position at the time of this particular incident was that I was acting EM-3, as well as special projects office director, so I was aware of the incident, and I was engaged with Idaho DOE leadership in terms of deciding whether or not federally led AIB would be needed. It wasn't. The lack of resource was not -- was not a factor at all, as I recall.

So we have -- we have -- we still have enough talent at headquarters, as well as our field offices, to be able to conduct very high quality and reliable investigations. We thought that the method that we chose would result in a satisfactory investigation, and more importantly, as Ted said, that we would learn from it. And then we wanted to make sure that Idaho's Oversight Program was okay by bringing in ORP colleagues to look into that. Because that gives them an opportunity to learn about various processes and whatnot.

And so I have to go back and echo what Mr. Chung was talking about. My sense, and I have -- you know, this is one of those areas in my current responsibilities that I have -- would have great concerns over. My sense is that we do have a very strong technically capable organization that has the capabilities to do the kind of work we're asking them to do at these sites relative to at the sites and the complex as a whole relative to the National TRU Program, the generator sites and the Carlsbad Field Office. It's a well trained staff, it's -- they're generally very familiar with the issues. They are qualified.

So, and we have technical resources, great technical resources within -- not independent, but within the contractors as well as the National Labs, and we don't hesitate to draw those resources in.

So I don't have a great many concerns in that particular area. I mean, you're always concerned about an organization and managing it for the future, and so, of course, that's something that we continue to talk about. Relative to this specific question, I am not sure that I can speak very knowledgeably about it. I'd ask Dae or Todd if they want to.

CHAIRMAN HAMILTON: Before you do, and I'll let them do that, but before you do, and I understand eight

that.

CHAIRMAN HAMILTON: Thank you, Board Member Connery.

BOARD MEMBER CONNERY: Thank you. I appreciate

I would like to address this to you, Mr. Griffin, and maybe a followup to Mr. Wyka. Let's talk about current Federal oversight at the generator sites.

(Exhibit Number 7 was entered into the record.) CHAIRMAN HAMILTON: I'd like to enter Exhibit 7 into the record, and I'll pause so you can read it.

This exhibit notes continued heavy reliance on your facilities representatives to conduct Federal oversight to protect the Waste Isolation Pilot Plant, including oversight of chemical reaction hazards. So could you please discuss whether you think the facilities representatives are the appropriate personnel to provide oversight of the chemical reaction hazards, and maybe expand that to talk about whether you need other Federal subject matter experts to perform this oversight.

MR. GRIFFIN: Yeah, I'll do what I can. So I have to say that I've been within the Department for eight months, so some of this precedes me, but then also that does provide a perspective, right, from coming from outside a National Lab background.

months on the job, but also understand that sometimes a new broom sweeps cleaner, so again, one of those balancing things. Have you ever considered updating the qualification requirements for any of these Federal positions? Is that -- and a yes/no could be the answer.

MR. GRIFFIN: I think those kind of discussions are on the table, and so we'll be looking at that.

CHAIRMAN HAMILTON: And I'll go ahead and open it up to Mr. Chung and Mr. Wyka. Go ahead.

MR. WYKA: Let me address it from the NNSA perspective.

CHAIRMAN HAMILTON: Sure, go ahead.

MR. WYKA: Because this is a very important question, and it's a question that deals with everything that happens right and everything that happens wrong, whether it's waste management or whether it's a shipping container that shuts things down for a prolonged period of time, and, of course, all of that sort of affects mission.

You know, so let me sort of discuss in terms of the quote up there, the facility representatives, great individuals, very well qualified, they are the trip wires of our Oversight Program to identify, you know, issues, and they're there because they have that questioning attitude, and very, very valuable. Very

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well as as the CSO.

valuable to me as a deputy manager at Los Alamos, as

But for this -- for oversight was a really basis for your question, and you have to really look at it at all levels. And I'll try to talk philosophically from an NNSA perspective and the Technical Qualification Program, is a big key with that as well, so focusing on the waste management activities.

As you know, I think you were briefed on it, NNSA has developed a safety roadmap. There's nothing really new in that roadmap, it's really a collection of things that we have developed, you know, sort of as a department, and we are working on oversight process improvements employed with our management and operating contractors, you know, through this roadmap. So it's something that we're building together.

Recognizing the limited resources that we have, and, you know, also resource challenges on the M&O contractor's side, especially with our increased mission growth. You know, the key to most initiatives of this roadmap, and again, this is a higher tier before getting down to the Waste Management Program, but it applies. You know, standardizing the Process and Technical Qualification Program, which as well as the safety management -- the safety bases review processes and the

valuable. It's very valuable in our infrastructure program, where we built that trust where we share information. The same thing on the safety side, which, again, gets into the oversight of activities.

And then employing correct visual management tools, the metrics, you know, and working collaboratively, not only with the field office, as well as the M&Os, to develop what are those critical metrics that tells you something about performance, the confidence in the information, risk and consequences. And something that we're using as a team to leverage the resources across the enterprise to swarm those issues where we need to swarm them.

TQP, as I mentioned, we're working towards an enterprise accreditation, and this is, again, to ensure consistency of the technical capabilities for employees in their technical disciplines, as well as enhance the passdown of acquired knowledge from senior staff. You know, especially with our retirements, of losing folks, it's very important, you know, to have a strong base program like that.

This accreditation program is going to include an independent review of the NNSA programs, confirming that we've established a qualified training program, qualified trainers, that we have a strong oversight in a

specific way we do those things.

We're working towards a, first of all, NNSA enterprise-wide TQP Accreditation Program, rather than accrediting individual sites, we're trying to accredit an entire NNSA program, program offices as well as site offices, to maintain and ensure we had the base technical qualifications to do our respective jobs.

And also, using the safety bases review teams to leverage the Federal resources across the enterprise for consistency. And that's really valuable, especially for me as a deputy manager, looking back, because you have the opportunity to use resources across the enterprise to look at your safety bases issues so that you don't have the same eyes looking at the same issue over and over again. So it's even if you had unlimited resources, I would still want the use of, you know, resources from other sites to help us in that area.

Roadmap also uses modern tools and data science and integration to organize information for accessibility and transparency, and that's going to be the key is the data analytics piece, recognizing, you know, with our resource limitations, to be able to add transparency to that flow of information, you know, from the M&O contractor to the field office to the headquarters, and across the enterprise is very

program and formal feedback evaluating M&O performance within our Technical Qualification Program. And that will be done by an independent office by AU.

We did a self assessment already, we're doing pretty good in terms of field offices. Headquarters we're making significant improvements. We'll be ready for accreditation by about the August time frame.

Now, implementing NNSA governance, which is the next piece of that, you know, after the roadmap, is, you know, is the governance, which we have been implementing since 2017. I know the Board has been briefed on that. And NNSA continues to implement and mature its Site Governance Program in accordance with 226.1(d).

The governance is to set expectations for M&Os, field offices, program offices, functional offices that govern our nuclear sites and to leverage the M&O assurance systems, contractor assurance systems, enabling Federal oversight so that we can focus on the high-risk activities, including the waste management and the National TRU Program. And this is, I think, resulting in more effective M&O performance and Federal oversight. You know, so that's the higher type layers.

Looking at the TRU Program itself for TRU waste activities taking place at the generator sites, increased emphasis is placed on assurance, that the WIPP

WAC would be met prior to receipt of waste at WIPP. And parts of this assurance is enhanced by the chemical capabilities, evaluations that was previously mentioned, the added emphasis on basis of knowledge, which is a key piece of our collective enhanced AK Program, and enhanced reviews and oversight of the certification of WIPP prior to shipment to WIPP.

And at the generator sites. This also includes appropriate preparation of activities at the generator sites, appropriate hazard evaluations, establishment of controls to protect the activities at the generator sites. And we have a team at, you know, not only at headquarters, but our field offices, and we use our TQP Program to make sure they have the required base knowledge for doing the jobs that they're doing, as well as transferring a lot of experience, you know, from those that we have in place now to, you know, the staff as they come in.

CHAIRMAN HAMILTON: Okay, thank you. MR. WYKA: So it's a -- it's not just facility representatives, it has to be the entire program, and the facility representatives are a key piece of that program.

CHAIRMAN HAMILTON: Thank you. Very briefly, and I want to put up the second slide here, and just let

them doing their normal job. It's creating that

environment from the top down, and if I went through all

the layers of oversight to allow them to make those

4 calls on a -- you know, on the field, to be able to make 5 those questions; to, you know, look at changes in

procedures that haven't been reviewed by appropriatesources.

CHAIRMAN HAMILTON: Thank you. I think that's sufficient to address my question.

Did you want to add, Ms. Roberson?

BOARD MEMBER ROBERSON: Well, I wanted to push back just a little bit. I understand what you just said, Mr. Wyka, but I would say, even a change in procedure, I mean, to some degree, these events do require a certain degree of sophistication and understanding chemical interactions, and I would say you are a very talented and very smart facility rep, but it isn't just them being on the front lines, it's who's to back them up. Who are they to call? Who are those people and where are they?

MR. WYKA: You're absolutely right, and I'm glad you made that clarification, because it's the team. You know, again, the facility representatives are those that, you know, sort of see, smell, hear different things that they may call into question, and they need

you have an opportunity to look at it.

And I don't present this as some type of a 'gotcha,' my point is that 2015, this was shown to be a problem -- challenge, and then here in March of this past year, we see the same sort of thing. So three years later, you still have these continued weaknesses, and I recognize what you just said about the process and practice that you've got going on. Is there anything else that you specifically want to address this three-year lack of a positive trend?

MR. WYKA: Thank you for the question, good question. This is where you need the system, and you need a questioning attitude. Because the facility representatives don't have to be chemical experts to stop these incidences, because if you look at the contributing causes, most of them were, you know, decisions being made, you know, that weren't well thought out. Changes in procedures without appropriate reviews, changing constituents, you know, and pieces going into the drum without the appropriate reviews. And these are all the questioning attitude.

So by establishing that environment of the facility representative, again, stop, pause, question, maybe without being the -- you know, the technical expert on the chemical compatibility issues, but it's

to have somebody to go to. You know, subject matter experts in those areas, whether it's an electrical safety event, whether it's a chemical compatibility event or whatever to go to, you know, have -- to allow the team to drill down on, you know, these issues identified by the facility representative.

But the facility representatives themselves is what I was trying to -- you know, sort of it doesn't necessarily need to be an expert in every area, they just need to have a mature questioning attitude to take it to, you know, an expert that, you know, they have available to them. And it doesn't necessarily need to be at the site. It could be, you know, at another site where we leveraged resources, where appropriate, or as well as at headquarters to, you know, drill down on a specific area or issue that was identified.

CHAIRMAN HAMILTON: Do any Board members have any last questions for the panel before we take a break?

(No response.

CHAIRMAN HAMILTON: Seeing none, thank you very much for this first session. We're going to take a 15-minute break and restart at 2:05. I'll point out that the clocks in this room appear to be a couple of minutes slow. So just look at your phone. We will recess now for 15 minutes. Thank you.

21 (Pages 81 to 84)

1 (Whereupon, there was a recess in the 2 proceedings.)

CHAIRMAN HAMILTON: At this time I would like to reconvene our hearing for session 2. In session 1, we failed to enter into one exhibit into the record, it was Exhibit Number 6, so I'm entering that exhibit into the record now. Did we already show it?

BOARD MEMBER CONNERY: We did show it. (Exhibit Number 6 was entered into the record.)

CHAIRMAN HAMILTON: Thank you. So Exhibit 6 is formally entered into the record.

Our goal for this panel is to gather information on safety controls to address the vulnerabilities associated with handling and processing solid nuclear wastes at Defense Nuclear Facilities. Our panel is the same as it was for session 1, except that instead of Mr. Todd Shrader, we have Mr. Jack Zimmerman. Welcome. Mr. Zimmerman is the Deputy Manager for the Idaho Cleanup Project at the Office of Environmental Management. Thank you. Thank you for being here.

I am going to start out again with our technical director, Mr. Roscetti. During the first session of the public hearing, we discussed the programmatic requirements and the Federal oversight responsibilities for solid nuclear waste. So this second session will

1 being shipped to WIPP.

The Department now uses this information to perform an enhanced chemical compatibility evaluation. The Waste Acceptance Criteria must be met before waste can be certified for shipment to WIPP. However, this means the generator sites may handle and store waste containers for extended periods of time prior to demonstrating that the waste contents meet the new requirements.

During this period of time, the generator sites rely on their own processes to ensure chemically compatible waste. Finally, as we discussed in the first session, the Department also initiated the Generator Site Technical Reviews, or GSTRs, following the WIPP event.

CHAIRMAN HAMILTON: Thank you, Mr. Roscetti.

17 Board Member Connery?

BOARD MEMBER CONNERY: Thank you. Mr. Roscetti

just described that the environmental management
 generator sites are required to the Waste Acceptance

21 Criteria -- the WIPP WAC, before shipping waste to the

Waste Isolation Pilot Plant. Mr. Griffin, we've heard

both in the first session and in Chris' description

24 about the WIPP WAC and those criteria. Can you describe

any other significant measures that were taken by the

focus on operational execution and safety controls for processing solid nuclear wastes at individual sites. Would you please provide an overview of the Department's response to the February 14th, 2014 Waste Isolation Pilot Plant accident?

MR. ROSCETTI: Yes, sir. Mr. Griffin provided some of that information in his opening statement, but I will try and summarize more here.

In response to the WIPP radiological release, the Department conducted a comprehensive accident investigation that identified multiple judgments of need. Several judgments of need were related to strengthening confidence that waste is adequately characterized and compatible from a chemistry perspective. The Department's primary corrective actions in this regard are more rigorous activities and processes to ensure that the waste being shipped to WIPP is acceptable to WIPP.

Even before the February 2014 event, WIPP had a document called the Waste Acceptance Criteria, or WAC, WIPP WAC, which defined the requirements for sending waste to WIPP. Following the February 2014 radiological release event, the Department made some improvements to the Waste Acceptance Criteria. These improvements included measures to collect better data about the waste

Department of Environmental Management generator sites in response to the WIPP accident for the purposes of preventing accidents at those sites? So not at WIPP, but at those sites.

MR. GRIFFIN: Well, yeah, I think actually, some of this was covered when Mr. -- in the earlier session when Mr. Shrader talked about kind of the -- and I mentioned also the comprehensive set of activities that we put in place.

So, you know, we have the -- as you discussed -- was just outlined by Mr. Roscetti, the WIPP WAC, and then we have the Generator Site Technical Reviews that we put into place, and the certifications, the Strength and Certification Program with enhanced chemical compatibility evaluations, the acceptable knowledge -- enhanced acceptable knowledge, enhanced basis of knowledge for this.

So I believe that we pretty well covered all that. I don't know whether Mr. Zimmerman would like to add more to that based on his experience of being at a generator site.

MR. ZIMMERMAN: I can speak to some of the actions taken at the Idaho site, in particular, and I imagine many of the other sites did something similar, because as I recall, there was some guidance from

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headquarters at the time to take the Accident Investigation Board Report from the WIPP accident and basically evaluate that for your site and look at what the appropriate actions are.

So primarily, you know, for Idaho, we directed the contractor to review the report and conduct an extent of condition review as it applied to their activities, and take the appropriate actions to prevent recurrence of, you know, similar type events.

In Idaho, the response from at the time we had two contractors, because the mission was kind of split. So it went to Idaho Treatment Group, who was primarily dealing with the stored above-ground transuranic waste, and also CWI, who was the contractor responsible for the buried waste.

Both of them largely came up with some of the same set of actions, but for Idaho, it was really focused on strengthening the procedures that would prevent the inadvertent addition of incompatible materials, similar to the root cause of the WIPP event. And additionally, they continued efforts to ensure that they had strong employee safety effort through the Voluntary Protection Program, as well as periodic evaluations of their safety culture.

Also, as part of that, you know, initiative,

whether or not additional controls or Defense-in-Depth were put into place because of the potential for that type of release?

MR. ZIMMERMAN: Yeah, we were already using conservative release fraction values that were consistent with the larger numbers that were recommended, so there were ultimately no changes in the consequences of the evaluated events in Idaho.

BOARD MEMBER CONNERY: Mr. Griffin, can you address it for other sites across the Environmental Management Program?

MR. GRIFFIN: I think as I said earlier, that some of this precedes, I do not have good insight into the thinking that occurred at that time, so -- back to 2014. So rather than trying to speak out of school on that, I'd really rather to defer to Dae on that.

MR. CHUNG: I was also absent from those days when folks were busy working on the --

(Laughter.)

MR. CHUNG: Anyways, but having read most of the lessons learned documents, including the operating experience, the letter of recommendations and various responses from the sites that were asked to evaluate potential impact, particularly with, you know, nitrate salt being commingled with organic absorbance and

they made sure that they communicated the results of the WIPP event, so they basically educated the workforce on what happened and what the consequences were so that there was a general employee awareness associated with that.

And with Fluor Idaho, I mean, they continued to maintain VPP STAR status site, and they also conducted a safety culture assist visit that really found a strong safety culture at the site. But what that really did is prove that really just one weak link in your safety culture can have very significant impacts.

BOARD MEMBER CONNERY: So just to follow on, in the first session we talked about the WIPP event basically showed the magnitude of the release could be greater than postulated and greater than previously expected. So logic tells us that if DOE sites analyzed the larger releases for postulated events, then the estimated consequences could have driven them to implement greater controls.

And specifically, I'm talking about the release fraction that wasn't necessarily adopted in the safety bases across the sites, they were at least adopted at WIPP and maybe one or two other EM sites.

So can you talk about why or whether it was considered to update those release parameters and

whatnot. The two, as I mentioned earlier, there were two sites that responded positively, WIPP obviously, but also Los Alamos. So those two sites are where they have applied the value for both airborne release fraction times, respirable fraction of 0.205, which is greater than what had been typically used in the complex. So that was corrected at those two sites.

The rest of sites responded negatively in terms of the need to apply higher release fractions. Having said that, having said that, if you look at -- I'm sure we're going to get into more details on ARP V event, but not only are the potential consequences important, but, you know, what is estimated frequency or likeliness of chemical reactions or deflagrations or overpressurization events could occur.

So that comes into play in terms of selecting your safety significant controls. Because typically, typically, when you go through hazard analysis process, and you're looking for those bounding/representative scenarios, you go through what is known as a risk meaning process. So where they look at the likelihood of certain event happening as well as the potential consequences.

So in the case of ARP, the ARP event, the consequence was evaluated to be still bounding; however,

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if they through their PISA and USBD process, and associated safety evaluation process, they identified that that type of event could occur more frequently. So they changed from unlikely, to anticipated, however, because of the fact that they already screened in from the previous analysis, they didn't have to change the safety bases level controls based on the risk meaning.

However, as Jack may want to talk about in more detail, but they did add, as part of TSR, a couple of programmatic or specific admin controls to restrict the operations so that they can deal with a potential pyrophoric and other types of chemical reactions in a much more reliable manner.

So that's how I think we had learned lessons from both WIPP event as well as the ARP V event, in terms of release fractions, as well as, you know, how do we make sure that we end up setting the right set of controls through the hazard identification and analysis process.

BOARD MEMBER CONNERY: I understand, I understand what you just said because I've been studying this for a while, but just as we go through this, it would be helpful if you note when those changes were introduced, because the changes that you spoke of were introduced after the -- some of them were introduced

pressurization events. They were told to analyze those, regardless of likelihoodness from a consequence determination standpoint. That was the philosophy that was built into that standard.

And then basically applying the release fraction data that had been used for a long time, you know, 3010 handbook, was basically brought into that 5506 standard as a standard means of selecting or using a release fraction related data.

So it was the fact that we have learned from the very chemical -- the very chemical reaction phenomenon from the WIPP, I think the Department did the right thing by telling the complex that you've got to be careful in terms of the nitrate salt and other organics.

So that was dealt properly in terms of using the higher release fraction, but that does not necessarily mean that the standard had to be revised.

BOARD MEMBER CONNERY: You're in the middle of revising the handbook right now, aren't you?

MR. CHUNG: Yes, but not just because of that. BOARD MEMBER CONNERY: Mr. Roscetti?

MR. ROSCETTI: So I would just like to make a point from the Board's staff perspective, because we're talking about WIPP and nitrate salts and we're talking about Idaho and overpressurization, potentially

after the Idaho incident, so they were not preventative of the Idaho incident because they didn't exist until after the Idaho incident.

So I would just be very careful of the timeline of this, because that's what we're trying to get at is why after the WIPP event some of these precautions weren't put into place, some of these release fractions weren't taken into consideration that could have prevented and mitigated the accident.

So if you're speaking in generalizations of things that are put in place after, that doesn't really help the conversation.

MR. CHUNG: My point being that the operating experience document specifically identified nitrate salt issue, okay? So that that was distributed throughout the complex. I do believe that the generator sites have adequately responded to the OE concerns.

Having said that, if you look at the 5506 standard, it does -- it does say that you need to evaluate certain accident types. They were selected deterministically, not based on -- not necessarily based on significant level of hazard investigations or analysis. We decided that these are the typical types of accident types that you must re-analyze. Container deflagration, multiple container deflagration,

deflagration, and we're talking about the release fraction.

So for people who may not understand, when we're talking about a drum, there's a certain amount of material that's in a drum. The release fraction is a value that is used to calculate how much material potentially could come out of that drum given an accident.

So whether it's nitrate salts or whether it's an overpressurization event, if you're using a smaller release fraction, you're estimating that the amount of material coming out of that drum in an accident is going to be less than if you're using a larger release fraction.

So from the Board's staff perspective, we're looking at across the complex, regardless of the cause, whether the Department is using an appropriate release fraction to estimate the amount -- appropriate amount of material potentially coming out of a drum in an accident.

BOARD MEMBER CONNERY: Thanks, Mr. Roscetti for that clarification.

I'm going to yield my time back to you all since I'm not seeming to make any progress right now.

CHAIRMAN HAMILTON: Ms. Roberson?

24 (Pages 93 to 96)

BOARD MEMBER ROBERSON: So I'll just add one comment, and Mr. Roscetti can certainly jump in. You know, the airborne release fraction we're talking about 0.205 is not our number now, that's the Department's number. So we're still, as Mr. Roscetti said, we're still looking, but we don't know if that's the right number or not. And it is very limited.

But taking the same question and going to NNSA, you talked to us earlier about something you've done since the Idaho event. What did NNSA do or what kind of direction did it provide to its generator sites in response to the Waste Isolation Pilot Plant accident for the purpose of preventing or mitigating accidents at those sites?

MR. WYKA: Thank you, ma'am.

We did, you know, extensive training, obviously, on the root causes, all the contributing causes, all the programmatic breakdowns and process and procedure oversight, but specifically, like for Los Alamos, you know, the safety bases documents, all the safety bases documents were evaluated and revised for the remediated nitrate salt containers. We went through and RNS drum campaign for about, you know, six to eight months and was able to remediate successfully without incident all of those drums.

correct. In fact, we're in the process now of beginning shipment of some of those POCS containers which, again, will have a significant mission impact for NNSA.

BOARD MEMBER ROBERSON: So how many NNSA facilities have revised their safety bases to account for the increased magnitude of release from an energetic chemical reaction?

MR. WYKA: The only one that had to was Los Alamos. The others looked at their processes, they looked at their procedures, safety bases in place, and, you know, there weren't any changes needed. It was only Los Alamos that needed to change theirs.

BOARD MEMBER ROBERSON: So you guys have confirmed no other site needed to make any adjustment?

MR. WYKA: Yes, ma'am.

BOARD MEMBER ROBERSON: Okay. Thank you. CHAIRMAN HAMILTON: Thank you, Ms. Roberson.

Mr. Roscetti, you mentioned earlier that after the WIPP event, the Department began to rely on enhanced chemical compatibility evaluations to understand the potential reactions in the waste drums. Could you summarize these evaluations and the staff's views on the challenges involving the execution of them?

MR. ROSCETTI: Yes, sir. Before waste can be shipped to WIPP, the Department now requires an enhanced

The WCRRF facility implemented restrictions on the use of organic kitty litter to prevent an exothermic reaction. Significant operational control improvements were made, including renewed attention to procedures, ensuring compliance with the WIPP WAC during drum filling, as well as validation of contents through records, verification prior to shipping at the LANL, a lot of significant safety bases changes in retrieval, transportation, processing of RNS drums, containers and the use of a suite of safety controls that were used to prevent a similar type reaction.

The other type of thing we learned from the -- and what was changed as you go to Phase 2 review, was the uncertainty of the AFR with the values with respect to POCS. I think that was a collaborative success story over the last couple of years where we did significant or subsequent fire tests completed at Sandia on tested filters, which ultimately determined where the DR was ultimately determined to be zero. The new filters were manufactured and made available at Los Alamos. I think we replaced 740. We have about 124 to go. We've completed all 50 -- 150 changeouts at Livermore, 150.

So with the new filters in place, all the parameters used in the five-factor formula for calculating those consequences in the Standard 5506 are

chemical compatibility evaluation. This type of evaluation is important because it helps the Department identify hazards which would then allow the Department to devise strategies to prevent undesired chemical reactions.

(Exhibit Number 8 was entered into the record.)
MR. ROSCETTI: I would like to enter Exhibit 8
into the record. The Department's enhanced chemical
compatibility evaluation is based on a method published
by the Environmental Protection Agency in 1980 as
described in Exhibit 8. The EPA document describes a
method for determining whether the waste could be
involved in undesired chemical reactions.

CHAIRMAN HAMILTON: Take a breath and let's -- so we can read this here.

MR. ROSCETTI: Okay, sir.

CHAIRMAN HAMILTON: Okay, go ahead.

MR. ROSCETTI: So the authors of the EPA document performed a survey of accidents involving undesired chemical reactions in hazardous wastes. They found that one of the primary causes of these accidents was insufficient or inaccurate information about the waste contents. Accordingly, the EPA's method starts with collecting as much information as possible about the waste and listing which chemicals are included.

25 (Pages 97 to 100)

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The EPA document then provides methodology to determine if combinations of any two chemical types could lead to undesired consequences such as a fire, explosion or the generation of flammable gases. The purpose of the Department's evaluation is to provide some confidence that inappropriate waste is not sent to WIPP. The evaluation requirement is not designed to ensure safety at the generator sites where the waste is generated, processed, and/or temporarily stored.

The Board's staff has identified challenges with performing chemical compatibility evaluations in wastes. Some are of these are listed on the second slide of Exhibit 8.

One challenge with performing chemical compatibility evaluations is the uncertainty regarding the chemical composition of legacy wastes, which we heard either Mr. Shrader, I believe it was Mr. Shrader talk about in the first session.

Consider the waste buried at Idaho. Some of these wastes were buried in the 1950s and 1960s, and the documentation about them is not complete or does not exist. The wastes are also from a wide variety of sources and generating processes. While the Department and its contractors have worked very hard to collect as much historical information and records as they can,

hazards associated with this waste?

MR. CHUNG: Sure. Dealing with uncertainties with respect to how we perform hazards or accident analysis is not unique to solid waste mission elements. We have wrestled with this issue for a long time, even with tank waste in terms of chemicals and whatnot.

So at the onset of the formation of our safety bases methodology, which goes back to early '90s, we recognize that we have to develop a set of what I would consider deterministically driven accident types as a starting point. In other words, we would -- we would so designate certain types of accidents to be analyzed, realizing that we are dealing with certain degree of uncertainties in terms of having -- in terms of being able to correctly and accurately identify hazards. Because you will only know as much as you would know based on the knowledge.

So with that methodology, we also felt that it is still important to do a bottoms-up type of hazard analysis. So you do walkdowns. You look at the circle data. You interview. So you try to gather as much information as possible in terms of being able to perform the hazard identification accurately.

And then you start to roll up in terms of -- so of all these hazards, you know, how can we -- how can we

gaps still remain.

As an example, the Department's contractor found that a chemical, beryllium carbide, could have played a role in the 2018 Idaho drum event. Before the event, beryllium carbide did not appear on the Department's list of chemicals that could be in the Idaho waste.

Another challenge is determining whether to analyze so-called trace chemicals. The WIPP Waste Acceptance Criteria, or WIPP WAC, allows for trace chemicals to be excluded from the chemical compatibility evaluation with documented justification. However, if any chemicals are inappropriately excluded, important chemical interactions could go unidentified.

Finally, chemical compatibility evaluations are not an end in themselves. If the evaluation identifies potential hazards, it requires the Department to take further actions to address those hazards by implementing controls and/or treating the waste.

CHAIRMAN HAMILTON: Thank you, Mr. Roscetti. Ms. Roberson?

BOARD MEMBER ROBERSON: Thank you, Mr. Chairman.

So, Mr. Chung, Mr. Roscetti just highlighted the uncertainty associated with composition of legacy wastes. Can you describe the Department's -- how the

Department accounts for limited knowledge when analyzing

group them or categorize them into a certain set of potential hazard events or accident scenarios so that we can come up with a reasonable set of controls, both preventive, mitigative, including Defense-in-Depth, including safety management programs, to be able to come up with that set of controls that we can rely on for provision of adequate protection.

So in terms of the solid waste or TRU waste, we have come up with what we thought was very reasonably bounding material risk formulation, 10, 12 years ago, in terms of providing that additional margin of safety right up front in terms of estimating that material risk.

We have historically proven that the things like release fractions and respirable fraction values contained in DOE Handbook 3010 were conservative. We also have demonstrated over the years that not only the five-factor formulation, which also includes damage ratios, but dispersion modeling, whether it's for public boundary type of air dispersion calculation or enclosed for collocated worker, we have chosen a very conservative set of dispersion parameters.

So when you look at the totality of our accident analysis, from a consequence determination standpoint, that we felt that our methodology is very conservative,

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right? So the uncertainty aspect in terms of the waste

characterization, we have assumed that our overall accident analysis methodology would be still conservative enough to be able to develop adequate set of controls.

BOARD MEMBER ROBERSON: Okay. So let me -- and if this isn't -- if you're not the right person to answer this, I'm happy for anybody on the panel. So some of the things we're paying attention to, for instance, I'm not going to say I'm not implying that it caused the event at Idaho, but the commingling of waste would be one of those phenomena. Things that are done in the process of handling the waste, you know, additive at Los Alamos.

At the end of the day, because I agree with you, and I love modeling, but at the end of the day, it's the waste. So something that Mr. Shrader said earlier when I asked him, you know, how does WIPP handle accepting questionable or difficult waste, and he said at the end of the day, there's sampling and analysis, which the Department used to do a lot, but stopped doing because of the cost benefit.

What's the trip wire for just analyzing the

MR. CHUNG: As Mr. Shrader pointed out that

processing processes, as known at the time, that we do not warrant to use that higher release fraction. That was a decision based on their evaluation.

Now, when we -- when we go through the revision process for 5506, we will look at whether or not we need to adjust not only the release fractions, but do we need to make that -- it's going to be another judgment call in terms of, hey, do we think that should be analyzed as a likely event versus unlikely, or should we look at it as anticipated versus likely? Because that will also reinforce in terms of the potential need to develop any additional controls at a safety significant level through that safety analysis process.

So those are the kind of things that I think we're going to go through in order to continue to bound, at the same time -- at the same time that we can make a certain progress because we still believe that WIPP is the safest place where we can finally dispose our waste.

So I think that's going to be a -- you know, a disciplined process where we look at all the options again in terms of not only the particular parameter within the five-factor source term formulation, but also in terms of the overall methodology and keeping in mind that we are dealing with certain level of uncertainties, no matter what.

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sampling could be done, as a last resort, but if we make that as a standard method for so-called every unknown waste stream, that even sampling activities themselves bring about certain level of risk for our workers.

So I think we have to carefully examine when we really need to do a sampling. At the same time, as part of our revision efforts or any other mechanisms that we have in the Department to make necessary correction from a safety analysis standpoint, I think we have to make that judgment very carefully.

BOARD MEMBER ROBERSON: And I guess, and maybe there is no answer, I'm struggling with, you know, an example of when that judgment would be made.

MR. CHUNG: So the other thing that -- I mentioned about the likelihoodness of some of these events. Certainly that what we have experienced at WIPP wasn't something that we anticipated, right? So if you were to have nitrate salt with organics and commingled, you know, incompatible, you know, reactive chemicals, you need to use higher release fraction.

BOARD MEMBER ROBERSON: Okay.

MR. CHUNG: We do believe, however, that because of the OE that was issued, that this complex responded appropriately in terms of, hey, we have looked at our waste streams, we looked at our treatment, and the

MR. ZIMMERMAN: If I could, I'd like to maybe share some insight to where we are in Idaho with regard to this question, because certainly sampling is possible, but sampling has its own set of hazards. Now, what we've got historically is most of the waste has reasonably good paperwork, acceptable knowledge, process knowledge, associated with it. And right now, you know, we're down to really the very tail end of the Idaho mission as far as TRU waste goes, as Mr. Roscetti's slides in the opening indicate.

And what we're dealing with now is really a lot of the cats and dogs and some of the other stuff that the previous contractors have set aside, either because it was difficult or primarily because in some cases there's a lack of that proper documentation from the generator site, which for our waste primarily came from Rocky Flats, but there were also other generators.

So right now the contractor, and this is partly in response to the ARP V event that occurred, they are doing computer modeling on basically interactions from all the chemicals that are in the waste streams that we have information about and coming up with a set of controls that we can apply to that situation.

But what we have, and this is exactly what -- to a sense what was in ARP V, is there's probably about 150

cubic meters remaining that we don't have adequate acceptable knowledge and documentation associated with. And so we are evaluating whether for the unknowns that sampling may be the appropriate piece, but the computer modeling has shown that the controls that we've developed after ARP V are adequate for all the chemicals

The other very important control that's in place is the waste streams are essentially segregated, and we've -- you know, we've directed the contractor, and their analysis accounts for this, as well as their procedures, but we don't commingle waste streams.

that we know that are in the existing waste streams.

So, in general, you know, it's when there is mixing, it's usually waste stream to waste stream. In the ARP V event, as it turns out, commingling, you know, probably was not a potential issue, but it -- it will come out later that -- and through the investigation, that it was essentially a collection of unknown waste streams. So there was the potential for commingling inadvertently, which wasn't really apparent at the time.

However, you know, in this case, you know, that ARP V drum was -- and because of the lack of data, this was really some part of the characterization process that it was undergoing, as well as the initial treatment for removal of any prohibited items, in accordance with

1 improperly remediated nitrate salt. Is that correct?

2 MR. CHUNG: And the only other very energetic 3 chemical runaway reaction that could be formed with 4 other types of chemicals and organics --

BOARD MEMBER CONNERY: So it shouldn't only be at sites which had potential nitrate salts, it should be at any site that could have that kind of energetic reaction? That's different from what I understood you to say earlier.

MR. CHUNG: Yes.

BOARD MEMBER CONNERY: And my second question is the decision to determine whether or not to use that release fraction, that was done at the site level, because you put the OE out and it was up to the site to determine whether or not they were going to use that release fraction or a different release fraction?

MR. CHUNG: My understanding is the site responded and then headquarters had also reviewed the responses.

BOARD MEMBER CONNERY: In any cases did headquarters overturn the site's determination?

22 MR. CHUNG: I would not know that. Maybe Ted 23 can shed some light.

MR. WYKA: No. No. Post-WIPP, you know, all DOE sites, including NNSA sites, evaluated their waste

the WIPP WAC. And the chemicals that actually reacted and led to the overpressurization had co-existed within that drum pushing 60 years at this point. You know, that drum I think got on site in the early 1960s.

And so it was actually this activity of initial characterization and treatment that ended up basically exposing the uranium to air that subsequently led to the methane generation from the beryllium carbide.

BOARD MEMBER ROBERSON: Thank you.

MR ZIMMERMAN: Louiss if Louid Louiss

MR. ZIMMERMAN: I guess if I could, I guess I would conclude, just to make sure it's clear, I believe that the sampling is currently under evaluation, but it is for those waste streams and individual drums that there's not sufficient characterization already existing. Because the majority of the paperwork that could be -- that can trace a drum back to the generator has been fairly accurate.

BOARD MEMBER ROBERSON: Thank you. CHAIRMAN HAMILTON: Board Member Connery? BOARD MEMBER CONNERY: I have a line of questioning on Idaho from Mr. Zimmerman, but before I do that, I have two quick questions for Mr. Chung with hopefully quick answers. One, based on what you said, my understanding is the Department considers that release fraction of 0.205 only in the circumstances of

streams per the OE that was put out. We noticed -- that was in June, I think, of 2015.

BOARD MEMBER CONNERY: Yes.

MR. WYKA: And all the sites applied DOE -OE -- DOE evaluation criteria and they concluded that
they did not have, you know, any such waste streams, or
very limited quantities. The only one from our side was
Los Alamos, in that they needed to continue to evaluate
for energetic chemical reactions. So headquarters
agreed with it and it's what the site field office had.

BOARD MEMBER CONNERY: I appreciate that, I just wanted to clarify, because I was getting lost in the long answer, so I just wanted a quick answer to that.

I want to turn to Mr. Zimmerman now, because we were talking about the WIPP event, and based on your last bit of testimony, obviously we're switching over to talk about the Idaho incident in 2018 and the overpressurization event and subsequent radiological release.

So I want to focus on that for a few minutes and I would like to enter Exhibit Number 9 into the record.

(Exhibit Number 9 was entered into the record.)

BOARD MEMBER CONNERY: So this exhibit shows the progression and causes, in simplistic form, of the April 2018 events as described by your contractor. We're

28 (Pages 109 to 112)

still evaluating, but this is what the contractor postulates as the progression. So I just want to put that up there so everybody can see it. And because I like the pictorial description of it.

So I'm not trying to beat a dead horse here, but Idaho has had previous experience with uranium fires, as well as methane generating waste. Were the hazards considered -- these hazards considered in this facility safety bases, and if so, why didn't the facility have controls in place to prevent or mitigate the accident?

MR. ZIMMERMAN: I guess one perhaps comment on the record about the drawing, but the uranium and the beryllium carbide were in the same drum, they didn't come from separate drums and then placed in the trailer.

BOARD MEMBER CONNERY: I think that's your contractor's drawing, but we'll make a note of it. Same batch.

MR. ZIMMERMAN: But I mean, the bottom line is, the previous assumptions that we had in place wasn't the reaction -- any reaction that would occur quickly and violently. You know, for example, consistent with the pyrophoric reactions that had been observed previously and throughout the history at Idaho. And we had not seen this type of event, which was basically a slow reaction and heating that led to secondary reactions.

that occurred in the advanced mixed waste treatment facility because that was a pyrophoric reaction that occurred when they opened up a sealed container inside of the box line, and in this case, it was just -- it had become kind of an ingrained cultural issue that uranium and sludge was not reactive. And in this case, from the radiography, all indications were this was a homogenous solid sludge that contained some uranium.

Then in addition to that, you know, as identified in the investigation report, the workers that were conducting this, when they opened up the drum and saw the materials, did notice that it was somewhat different than they had seen in previous sludges. In this case it was -- you know, they saw a silvery type powder substance, which was most like the uranium in the drum, and it wasn't like -- it wasn't exactly like other sludges. And so at that point, you know, that issue, again, was failed to be raised at that point.

So there were multiple barriers that were in place or expected to be in place that were not effective. For this event.

BOARD MEMBER CONNERY: So in general, what you're saying is you were relying on the operators to recognize that this was a waste stream that was poorly characterized and notice any differences in the waste

In this case it was the beryllium carbide, and essentially moisture from the air reacting to generate methane once the temperature exceeded 200 Celsius in the drum that overwhelmed the vent that was in place so that ultimately the lid came off the drum and released some of the contents into the room inside the ARP facility.

Additionally, the control strategy that was in place at the time of the ARP event was not successful, again, because we were not aware of rapid hydrolysis of the beryllium carbide would generate large quantities of the methane gas. In fact, you know, we were not aware of the beryllium carbide content within the waste drum, because all of this drum was lacking a lot of characterization data.

What data was available at the time was that there was less than 1 percent beryllium in the drum. Sampling post-event identified 30 percent beryllium. So that really challenges -- obviously was challenging even the ability for the contractor or DOE to have identified the potential for this event.

Also, throughout the process, I mean, there was basically some nonconservative decisions and a lack of questioning attitude that was conducted. For example, the folks that are really responsible for the facility probably didn't look broadly enough at the 2017 event

stream as they were processing it, rather than any other kind of physical controls within the facility for monitoring?

MR. ZIMMERMAN: No, that is not the primary control that we were relying on, it is one of the administrative controls that is relied on, and it is part of -- and it wasn't necessarily the operators. Maybe I misspoke. We were also doing, you know, visual observation with trained and qualified individuals who can identify visually the specific waste stream back to processes, primarily at Rocky Flats. And so we were relying on that aspect, also, to identify, you know, unexpected type conditions, and just have a questioning attitude.

But the location where, you know, this waste at the time was being processed does have engineered controls in place, but those are the barriers that I mentioned that failed that allowed the drum to then, you know, be filled and essentially put the lid on, which basically containerized the event. And again, that control set was really focused previously on the reactions that are going to occur quickly, and they occur in the place where the engineered controls exist.

BOARD MEMBER CONNERY: Thank you. CHAIRMAN HAMILTON: Ms. Roberson?

29 (Pages 113 to 116)

BOARD MEMBER ROBERSON: So, Mr. Zimmerman, wing onto Ms. Connery's question. So we understand

following onto Ms. Connery's question. So we understand that Idaho has implemented a thermal monitoring control after the event. Can you describe this control?

MR. ZIMMERMAN: Yes. Yep. Since the event, we

MR. ZIMMERMAN: Yes. Yep. Since the event, w have implemented additional TSR level controls through, you know, the evaluation, the safety of the situation, that was conducted, as well as a significant amount of analysis that the contractors conducted dealing with basically all the possible adverse chemical reactions that could occur.

So based on that modeling, it has concluded that for the known chemicals that we could put into the facilities, that those reactions would all occur within 16 hours, based on the technical analysis, and result in temperature rises that within that time frame should be within 3.6 degrees or less.

So the control is basically we empty the drum into the tray, inside of the facility where the engineer controls exist, and we essentially use a mechanical raking action to disturb the material, mix it with oxygen, and try to force any reactions that are -- you know, could potentially occur, to occur in that location where it is protected. And then hold that material in the area with the protected measures in place for 24

developed for our application and the waste that we have. But also, as I understand it, you know, this control is a form of actually -- like I said, reacting the waste, treating the waste to be less reactive.

BOARD MEMBER ROBERSON: So in the worst case, it would be less reactive. Is there any monitoring after the waste is packaged and set aside for whatever is next, disposal? Is there any temperature monitoring, any thermal monitoring or any other?

MR. ZIMMERMAN: There are some additional controls. So after it is basically packaged, I'm not -- I shouldn't say it's packaged. So this occurs in a place where it's -- the personnel don't have access. Once it meets the first checkmark where it's less than the 3.6 degrees from ambient, it's been held for 24 hours. It comes into a drum packaging station, and in that drum packaging station, there are additional thermal monitoring that's in place, which is immediately prior to placing the material inside the drum, and after that point, it would be placed in a drum. And there are some additional monitoring after it's placed in storage, just in a general area for potential flammable gases and things like that.

BOARD MEMBER ROBERSON: So after it's placed in storage, there's monitoring for flammable gases. Is

hours, and conduct the thermal monitoring throughout the process.

And again, as I said, if basically the temperature in the tray is below -- within 3.6 degrees of the ambient room temperature, then the modeling shows that no further adverse reactions could occur once it's placed inside of the drum that could cause basically an overpressurization event like we had seen with the ARP V event.

I do want to just make sure it's clear, it doesn't mean that there's no chemical reactions that are ongoing, just that the chemical reactions that may continue on and decline off would not have adverse consequences.

BOARD MEMBER ROBERSON: Thank you. I think that was going to be my next question. That's very important. So now my next question is, obviously DOE has a lot of information available to it both from Rocky Flats, and at one time DOE had its own standard for stabilizing uranium to create the oxide. Was that body of knowledge relied on for validating this control? Do you know?

MR. ZIMMERMAN: I mean, I don't know that that body of knowledge was used for this particular control. I know the technical basis for how this control was

1 there -- go ahead. I don't want to interrupt you.

MR. ZIMMERMAN: I was going to say, that's in the general area, yes.

BOARD MEMBER ROBERSON: So it's monitoring in the general area?

MR. ZIMMERMAN: Right. The contractor is considering whether there's any value to conducting flamm gas sampling on every drum after it's treated. However, when we evaluate it, I mean, we've got to look at what is the value of that kind of sampling and what will we do with that data. And right now, the analysis looks like the control set would be exactly the same as what we have, except if we did the flamm gas data and it tested high, we would put the drum into basically a single plainer array, mark it with a nonconformance report. It's just an added layer of control to make sure that it doesn't get shipped to WIPP in any inadvertent manner. And then ultimately flamm gas sampling is required prior to shipping to WIPP.

BOARD MEMBER ROBERSON: How long does the stuff stay in storage once it's packaged?

MR. ZIMMERMAN: Well, for us, we're projecting at the current shipping rates that we have to WIPP, it will take us until about 2028 to complete shipping all of the TRU waste from Idaho to WIPP. So this stuff

30 (Pages 117 to 120)

could be in storage for a decade.

BOARD MEMBER ROBERSON: Thank you. CHAIRMAN HAMILTON: So far we've talked about chemical compatibility evaluation in waste drums. One specific adverse chemical reaction is it generates flammable gases, which we were just discussing, which can cause overpressurization of -- or deflagration events. We issued a Board letter on March 12th entitled Idaho Waste Drums With Elevated Methane Concentration.

I'm going to ask Mr. Roscetti to highlight the concerns that we had with the flammable gas generation and mitigation.

(Exhibit Number 10 was entered into the record.)

MR. ROSCETTI: Yes, sir, I would like to enter Exhibit 10 into the record. Solid radiological waste can generate flammable gases and vapors through radiolysis, chemical reactions, microbial activity, and evaporation. If there is a flammable mixture of gases and an ignition source, the gases could burn in what could be a deflagration event. If a deflagration occurs in a drum, the pressure in the drum would quickly increase and the drum could rupture and release radiological materials.

The contractor formal cause analysis does not indicate that a deflagration occurred in the April 2018

drums while those drums are at Idaho. As a result, the Department has not taken such a flammability measurement for thousands of drums that are currently at Idaho. Thus, the Department does not know whether any of these drums are currently flammable or nearly flammable.

After packaging legacy waste into new drums in Idaho, the Department often stores the drums in buildings that lack confinement ventilation systems. If a drum rupture were to occur in those buildings, the exhaust from those buildings is not currently filtered to prevent the release of radiological materials to the outside. Having a confinement ventilation system would mitigate the impacts to people outside the building.

CHAIRMAN HAMILTON: Thank you, Mr. Roscetti. Ms. Connery has some followup questions on this topic.

BOARD MEMBER CONNERY: And I think some of these you have addressed already, but I'm going to try to go through them quickly, but they're in the order that I wished to ask them to lead to something. In your May 7th response to the Department, from the Department to the Board, when we sent you a list of questions, you noted that over 10,000 drums at the site have not yet been tested for flammable conditions. And you said that untested drums would be sampled prior to shipment to

event at Idaho. The Board staff is still evaluating elements of this analysis. The Department often puts solid wastes into drums with vents; that is, each drum has a vent. The purpose of the vent on the drum is to allow any gases to escape from the drum.

The safety bases for the facility where the Idaho event occurred states that a vented drum should not reach flammable conditions; however, the Board's staff has learned that the Department's contractors at Idaho have detected potentially flammable conditions in several drums. This observation demonstrates that simply having a vent will not necessarily prevent a drum from reaching a flammable condition.

If gases generated more quickly than it can leave through the vent, gas will accumulate in the drum and the drum could reach flammable conditions and/or overpressurize. If a drum is known to reach flammable conditions, extra cautions could be enacted to help prevent ignition.

While the Department does measure the concentrations of flammable gases in drums from shipping those drums to WIPP, the Department does this to ensure safe transportation to WIPP as well as the safety of WIPP. There is no requirement for taking this flammability measurement to assess the safety of the

WIPP because that's a requirement for WIPP, but as you noted, they could be sitting there until 2028.

And so my question was going to be, is it feasible for these drums to be tested at an earlier date, and it sounds like you're investigating whether -- what the benefit of that would be. At this point the jury is still out.

MR. ZIMMERMAN: That's correct.

BOARD MEMBER CONNERY: Okay. Are there any additional controls that you apply once you know that a drum is flammable? You said that you isolated those drums and put a note on them so that they're not inadvertently moved, but that does not necessarily prevent anything from igniting them.

MR. ZIMMERMAN: Well, you know, the safety bases does not identify TSR level controls, and it would be required for those drums. The controls that we do have in place are Defense-in-Depth, as well as those that are based on basically industry standards or regulatory requirements.

So there are a suite of controls in place, predominantly the controls are driven by RCRA and OSHA. So all the drums are handled and stored in accordance with 1910-120, Part J, and that's consistent, you know, with all the industry standards in how that type of

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drums would be handled or all drums.

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So, you know, some of those controls, you know, we use a trained and qualified work force. We have HEPA filtered air vents. We also have, you know, waste container, you know, integrity inspection programs as well as spilled containment programs have been established.

And we are evaluating, you know, other potential controls that might be appropriate to put in place. And we have had an independent review from Jensen and Hughes to take a look at the controls. You know, they agreed with the controls that we have in place as being adequate.

They did make some recommendations for additional controls, which we are evaluating, but some of the controls they recommended, for example, you know, a blast shield, you know, for the forklift operator on the cab of the forklift, or that the spotters maintain a distance greater than 10 feet away. You know, I met with a group of waste handlers when we got that report, and talked to them about it, as well as the contractor.

In general, the workers have some concerns with those additional controls being added because they actually make their job performance less safe. The blast shield would make the visibility, you know,

1 information that you expect to get in September? Is 2 that when we should expect to see that information?

> 3 MR. GRIFFIN: No. I think it's all part of the 4 overall safety alert you're talking about there.

BOARD MEMBER CONNERY: Yeah.

6 MR. GRIFFIN: It's going to be part of that.

And that was issued the end of May.

BOARD MEMBER CONNERY: You discussed any plans the NNSA generator sites have that have not had --

MR. WYKA: Yes, ma'am. As previously mentioned, we sent out a similar type alert to all the NNSA sites, pretty much the same type of actions for them to look

BOARD MEMBER CONNERY: An EM, you sent out an EM?

MR. WYKA: Yes, and I did that because I knew the Department alert was coming out, so I wanted to get that out rather than waiting for the alert. And the plan is to meet with all the generator sites at the TRU Waste Program Review in October 2019 and review the information.

BOARD MEMBER CONNERY: Thank you. CHAIRMAN HAMILTON: Thank you, Ms. Connery.

Mr. Zimmerman, and Mr. Wyka, I think you've addressed this in pieces and parts already, but I wanted

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less -- less visibility, and it's basically a job where the placement of the drum has to be within inches. And they are aware of the hazards, and they are comfortable with the existing controls that are in place.

So it's one of those, we've got to be careful, it's easy to add controls to address one hazard, but we have to make sure that we balance out the total impact so we ensure the workers do their job in a safe manner.

BOARD MEMBER CONNERY: So obviously human factors play into it. You said there are HEPA filters in place in every place that you store drums at Idaho?

MR. ZIMMERMAN: No, I was talking about there are vents on the drum that are HEPA filtered. Right, not all the facilities.

BOARD MEMBER CONNERY: Oh, okay. So the facilities may or may not have them?

MR. ZIMMERMAN: For the most part they do not have HEPA filtered exhaust in the storage areas.

concentrations measured. Is this part of the

BOARD MEMBER CONNERY: So, Mr. Griffin, in the response to us, again on May 7th, you said that the Department is directing EM to -- asking the generator sites to complete an extent of condition in fiscal '19 to determine the population of product drums at those facilities that have not had their flamm gas

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> So I mean, those are really, you know, focused as far as the response type lessons learned or actions

to ask it very clearly. If you look back at the April 2018 event, what are the lessons learned that have been or should be communicated to the other generator sites, including lessons learned from the initial response to the event?

MR. ZIMMERMAN: I think that if a few of the things, especially on the initial response, you know, in the case in Idaho, there had been a significant number of false alarms with the fire department, and although they are required to basically respond and turn out gear and the respirators, they didn't make their first initial entry in respirators. They opened the door, found smoke, they weren't expecting the condition they had been sort of conditioned to expect there, unfortunately.

So we've basically, on the site, we are improving that communication between the project and the fire department. We're making sure that the -- that they are aware of the potential hazards in every facility, and we are also looking at whether or not we have the ability to provide, you know, some sort of remote identification of the potential hazard as they

32 (Pages 125 to 128)

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we have. So I really want them to pause, think, and be

CHAIRMAN HAMILTON: Okay. Thank you.

I think this question is to you, Mr. Chung. A

BOARD MEMBER ROBERSON: Thank you, Mr. Chairman.

focused on these contributing causes.

Ms. Roberson?

129 131 1 that we are taking. And as far as the event, I think I few minutes ago, somebody on the panel raised the panel 1 2 2 kind of touched on it. For us it's that basically any of Defense-in-Depth. So if you would, please, discuss 3 form of uranium should be assumed to be reactive until the concept of Defense-in-Depth, and how it's been 4 you've proven otherwise. I think that's probably the 4 implemented in environmental management and generator big takeaway for us, one that we've been conditioned, 5 5 unfortunately, you know, for the last 15 years, been 6 6 MR. CHUNG: Defense-in-Depth philosophy and its 7 7 conditioned in another way, that basically it's the application and how it's implemented throughout the 8 roaster oxides that are potentially pyrophoric reactive 8 complex have been fairly well articulated in various DOE 9 material. 9 directives and standards and whatnot. In particular, we 10 CHAIRMAN HAMILTON: I'm sorry to interrupt you, 10 need to not rely on a single control for adequate 11 but my question is how have you taken those lessons to protection. We have to have multiple layers, and we 11 12 other sites? 12 have been trying to institutionalize the hierarchy of 13 MR. ZIMMERMAN: You know, for us, we issued the 13 control selection, prevention first, and then 14 ORPS report, as we're required to do. So we issued the 14 mitigation. 15 15 ORPS report, and that was the primary mode that we have In terms of the safety classification of 16 done it. We have also provided presentations and 16 controls, we, of course, have safety class level 17 briefings in various, you know, public settings, such as 17 controls for public protection. For collocated and 18 Waste Management Symposium, that provided an overview of 18 significant worker safety, we have service safety 19 the event, as well as the lessons learned and some of 19 control. We also have administrative controls that 20 the actions that we were taking. As well as providing 20 provide some aspect of Defense-in-Depth. Although it 21 input to headquarters with regard to the development of 21 was not called out as safety bases driven controls that Mr. Zimmerman talked about, post ARP V event, those two 22 the operating experience announcement. 22 23 We also -- you know, I personally shared this 23 operational restrictions that are written much like 24 information through the biweekly call that the field 24 specific admin controls that are now referenced in 25 managers have and alerted folks, and I think that -- and 25 technical safety requirements are, in fact, a form of 130 132 1 my safety staff did the same thing through their typical 1 Defense-in-Depth measures that we have decided to add. 2 communications. 2 So it's basically, you know, have multiple areas 3 CHAIRMAN HAMILTON: Okay. Okay. Thank you. 3 of controls so that we have a reliable set that provides 4 Mr. Wyka, did you want to add anything to that? 4 adequate protection. 5 MR. WYKA: Yes, sir, just a couple of things. 5 BOARD MEMBER ROBERSON: Thank you. 6 6 First, we provided the alert, we sort of summarized the Mr. Roscetti, can you summarize the DNFSB 7 7 event to all of our NNSA sites, as well as the staff's understanding of how the concept of 8 8 contractor's report on the dynamics and specifics of the Defense-in-Depth is being implemented at DOE waste 9 9 event. And we linked that a little bit, we linked that generator sites? 10 with the WIPP event as well, especially, and we focused 10 (Exhibit Number 11 was entered into the record.) 11 on the two root causes, I'd call them contributing 11 MR. ROSCETTI: Yes, ma'am. I would like to causes within the alert, which is, you know, management 12 enter Exhibit 11 into the record. DOE Standard 3009 12 13 13 failed to understand, characterize and establish and defines Defense-in-Depth as a fundamental approach to 14 implement adequate processes, controls for treating 14 hazard control for nuclear facilities that is based on 15 waste that lacked documented origin and process 15 several layers of protection to prevent the release of 16 radioactive or other hazardous material to the 16 information, as well as management failed to continue to 17 develop the safety culture over a number of years. You 17 environment. 18 know, those are two significant contributing causes 18 Having multiple layers of protection is 19 which are probably would be similar to most events that 19 especially important with the hazards we are discussing

33 (Pages 129 to 132)

today. The WIPP and Idaho events show that the

example to demonstrate how the Department uses

may not always be successful.

Department's efforts and controls to prevent such events

I will use the second slide of Exhibit 11 as an

Defense-in-Depth to protect the public. The picture on

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the left shows drums of waste inside a facility and the picture on the right shows waste that has been packaged and stored outside a facility.

On the left, the waste inside of a facility normally has several layers of controls for release events. These layers of controls can include a confinement ventilation system that filters air before it leaves the building, as well as equipment to monitor the air for release.

The example also includes fire protection controls, such as fire detection and suppression controls. These controls illustrate the concept of Defense-in-Depth because there are several layers of protection to prevent or mitigate the release of radioactive material.

Contrast this with the picture on the right. The only control to prevent or mitigate a release of radioactive material for the waste stored outside of the facility is the waste container itself, including the passive vent. Several sites store waste, drums and containers outside. Therefore, they rely on the drum and passive vent as the only engineered controls to prevent or mitigate a release due to reactions inside the drum.

Given the uncertainty in the waste contents that

do not have confinement ventilation. However, the case in the April 2018 event, the drums happened to still be in a location with confinement ventilation. This system helped avoid any releases outside the building.

BOARD MEMBER ROBERSON: Thank you. We should just leave this exhibit up.

CHAIRMAN HAMILTON: Thank you, Ms. Roberson. Ms. Connery?

BOARD MEMBER CONNERY: So I know this looks like a setup, it wasn't intended to be a setup, we're actually trying to make a point here. So my question is for Mr. Griffin. Obviously Mr. Roscetti just highlighted the lack of Defense-in-Depth for waste drums in certain situations, especially when stored outside. Given the experience at WIPP and Idaho, it's prudent to assume that drum ruptures can and do occur, and those are just two of the most recent examples. There have been many over the years.

Can you just let us know what your expectations are for having multiple layers of controls at EM facilities and how you've communicated this expectation or whether or not you are going to take some of this information into consideration as you're getting the information back from the safety alert going forward.

MR. GRIFFIN: Well, of course, I'm going to

we have already established in this session, the Board staff believes that this represents an opportunity for additional layers of controls.

(Exhibit Number 12 was entered into the record.)

MR. ROSCETTI: I would like to enter Exhibit 12 into the record. This exhibit uses several facilities at Los Alamos National Laboratory as examples to show how controls are implemented inconsistently with respect to potential chemical reaction events within waste.

As I said before, confinement ventilation systems limit the amount of radiological contamination released from a facility, but several storage locations do not have this control. Exhibit 12 also shows that many of the facilities do not have continuous air monitoring and only have relatively infrequent monitoring for contamination on surfaces.

Therefore, in the case of a potential chemical reaction event, there would be no realtime notification of the event to enable a response unless a worker happened to be in the area to see the event. The Board's staff again believes that this represents an opportunity for additional layers of controls.

The Idaho event illustrates the importance of having Defense-in-Depth. After drums are packaged, the contractor at Idaho often moves them to locations that

contrast the last point. We're obviously going to take that kind of information into consideration going forward. I mean, we clearly want to do that. You know, we're trying to be a learning organization that, you know, understands -- strives to understand where we can improve and makes those improvements.

Regarding the earlier exhibit, I guess, the pictures there and all that, I understand the point of the pictures is to perhaps a little bit out of -- there's not any real context there. I mean, it's outdoors and indoors and it pointed out the potential lack of information, but again, I don't know the particulars there and what information did we have or do we really know about the outdoors drums versus the indoor drums.

I'm not trying to get legalistic on it, but it's a little bit hard to comment on something that's just a picture. You know, clearly there's a point to be made there, and I understand, you know, that the potential point is there, but I think we also have to consider that we're not dealing with quite that sort of -- we're not dealing with pictures, we're dealing with real drums with real -- where we either have an understanding or we don't and we try to work with those particular circumstances.

34 (Pages 133 to 136)

So, but going forward, yes, we clearly — you know, that's the point of the safety alert and the information we'll be gathering from that is to look at these situations. And then as you note, if you've read that we are going to fold this into or we're asking sites to use \$5506 to address it in their safety analysis and we will be folding that into any improvements we BOARD MEMBER CONNERY: And I take your point MR. GRIFFIN: I understand. BOARD MEMBER CONNERY: The drums are not necessarily — don't necessarily have the same content, they don't necessarily — they're not necessarily the same site, so it was representative versus definitive. BOARD MEMBER CONNERY: So, Mr. Wyka, again, same question to you with regards to NNSA. I'm assuming you're going to have a similar answer, but I want to 1 procedures are in place, using the enhanced AK to mak sure that the waste through the interface waste document sure that the waste through the interface waste document sure that the waste through the interface waste document sure that the waste through the interface waste document sure that the waste through the interface waste document sure that the waste through the interface waste document sure that the waste through the interface waste document sure that the waste through the interface waste document the waste being generated. Th's also processes and procedures. One lessons learned from the WIPP event is as we change things, ye have to make sure that those changes, no matter how small they are, are evaluated, because collectively, you small they are, are evaluated, because collectively, you small they are, are evaluated. because collectively, you know, changes can make a significant impact, you know, our sight strategy as well. Getting back to my initial point that, you know, our mission at hand. Not only the current mission, but our future mission	
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you're going to have a similar answer, but I want to 22 I mean, we look at everything you guys produce, and o	e that.
	e
23 make sure we address this to both. 23 of the things we noted in the I don't want to use the	
MR. WYKA: It would be a similar answer. It is 24 acronym Generator Site Technical Reviews, that I	
something we need to continue to learn especially with 25 would say is a vulnerability, is insufficient	
138	140
this alert and the waste management area 1 specificity in procurement controls for chemical	
2 CHAIRMAN HAMILTON: Is your mic' on? 2 absorbance that may come in contact with the waste, and	
3 MR. WYKA: Sorry. Thank you. As a learning 3 they noted this as a concern for Livermore, Los Alamos,	
4 organization, this is something we're going to have to 4 Savannah River, Oak Ridge, and Idaho. And to me, I	
5 learn as well and probably learn collaboratively with 5 don't know what NNSA has done with that. But maybe	ou
6 our partners, and I think this slide is accurate. One 6 can tell me.	
7 of my biggest concerns is, you know, the storage of the 7 MR. WYKA: That's a good point. I can't	
8 drums at the hang pad. You know, I know there's a 8 actually expand on that, but I know that and that's	
9 concerted effort to get them from the outside and get 9 something I'll obviously take back with me, because as I	
them into the transuranic waste facility. You know, 10 mentioned previously, I do value those GSTRs, because	
which is a safety significant 2 facility built very 11 they look at you broad programmatically and some of the	
robustly, in a much safer place than outside. 12 same principles apply, you know, across the board, not	
13 CHAIRMAN HAMILTON: Thank you, Ms. Connery. 13 just waste management.	
Board Member Roberson? 14 BOARD MEMBER ROBERSON: So maybe you o	n take
BOARD MEMBER ROBERSON: Thank you, Mr. Chairman. 15 that for the record.	
So, Mr. Wyka, we've spent a lot of time talking 16 MR. WYKA: Yes, ma'am.	
about legacy waste here, and even though EM will be 17 BOARD MEMBER ROBERSON: Thank you, sir.	
generating waste, in the foreseeable future, too, let's 18 And I think my last question, Mr. Chung, is to	
focus a little bit on what NNSA is doing to make sure 19 you. So the Department has previously employed	
20 that in two decades, we wouldn't be having this 20 stabilization methods to treat certain wastes at Los	
21 conversation about waste you're generating now. 21 Alamos to make it less reactive by adding inert	
So, what is NNSA's strategy for ensuring safety 22 materials. What's the Department's perspective on more	
23 throughout the life cycle of newly generated waste? 23 widespread use of such methods to make waste less	
MR. WYKA: I think a lot of what we talked about 24 hazardous? And I'm not suggesting one-size-fits-all,	
25 today, you know, to make sure the processes and 25 but is this a strategy in the toolbox that the	

25

pretreating or thermalizing or stabilizing.

141 143 1 Department still considers? 1 BOARD MEMBER ROBERSON: Okay. Thank you. 2 MR. CHUNG: Jack may have some clarification or 2 CHAIRMAN HAMILTON: Thank you, Ms. Roberson. 3 3 some added feedback on this question, but I think that Do any of our Board, my fellow Board members, 4 4 applies more to the newly generated waste in terms of have any remaining questions for the panel? 5 5 making the waste as that gets generated less hazardous, (No response.) less challenging, as opposed to dealing with the legacy 6 6 CHAIRMAN HAMILTON: Okay. Hearing none, I want 7 7 to thank all of you for being here today, Mr. Zimmerman, 8 8 BOARD MEMBER ROBERSON: So what is the waste Mr. Griffin, Mr. Chung, and Mr. Wyka. And also 9 9 from D&D called? Mr. Shrader, who is still in the audience. Thank you 10 MR. CHUNG: Excuse me? 10 all for taking the time to be here and I know you didn't 11 11 BOARD MEMBER ROBERSON: What would waste from just walk in, you had to do some prep work, so we 12 12 D&D be called? Is that category -- is that in the appreciate that. 13 My acting general counsel says that we have 13 category of newly generated? I'm asking, I really don't 14 14 nobody who has signed up to make a statement in session 15 MR. CHUNG: Well, the D&D activities are ongoing 15 3. Did anybody think he or she signed up and didn't? that we have a much better record in terms of what is in 16 16 (No response.) 17 the building. 17 CHAIRMAN HAMILTON: Okay. In that case, we are 18 BOARD MEMBER ROBERSON: Right. 18 going to dispense with session 3 and I am going to ask 19 19 my Board members for closing remarks. MR. CHUNG: Plus the fact that we go through 20 very careful processes of deactivating the materials 20 Ms. Roberson? 21 21 before we go through the demolition activities, which BOARD MEMBER ROBERSON: Thank you, Mr. Chairman. 22 become the bulk of the waste. So in terms of treating 22 First of all, I want to thank all of the 23 23 any kind of reactive materials, like we used to for participants in the panel. I certainly learned some 24 24 surplus plutonium coming out of Rocky Flats, and for Los information along the way and I hope it was beneficial 25 25 Alamos, we did decide to thermally treat to remove for the Department, including NNSA. The Board takes 142 144 1 certain prohibitive items or moistures or whatnot, so 1 this mission area and the Defense Nuclear Complex very 2 that they become much more stabilized for long-term 2 serious, as I know you do, and our questions were 3 storage, as well as future utilization. 3 intended to both highlight and elevate some of the I'm not sure that that level of treatment, 4 challenges that lie not just today, but in the future as 4 pretreatment, would be required for the typical waste 5 well, too. So I appreciate your participation, and 5 6 that would be generated from our typical D&D activities. thank you. 6 7 7 If we run into those, like it's not a radioactive CHAIRMAN HAMILTON: Ms. Connery? 8 8 material. Like a mercury issue at Oak Ridge, we are --BOARD MEMBER CONNERY: I also would like to echo 9 9 we are designing, and we plan to construct a mercury the thanks for all of you coming today and doing all the 10 treatment plant so we can dispose of that particular 10 prep work. The thing that encouraged me the most is the 11 hazardous material in a safe and environmentally 11 repetition of the phrase "learning organization." I 12 compliant manner. But in general, I haven't really 12 mean, you're going to have to be a learning organization 13 13 as your mission continues, both in the EM side and on thought about coming out with any pretreatment, like 14 14 stabilization, to make the waste management and disposal the NNSA side. 15 15 less hazardous. The reason that we were asking questions 16 relating it back to WIPP is because we believe that DOE 16 BOARD MEMBER ROBERSON: No, and I understand, 17 and as I said at the beginning, I'm not assuming there 17 as an organization has to be less reactive, no pun 18 intended, and more forward thinking with regards to 18 is some across the board, really what we're focusing on 19 19 are the waste anomalies that come up, and the question hazards that could come up and not simply putting out 20 was has the Department negated that as a tool in the 20 lessons learned about the last accident. We need to be 21 toolbox when it comes to challenging waste? 21 able to predict the next one prior to it happening and 22 MR. CHUNG: I don't think we negate it, but we 22 hopefully preventing it or mitigating it as it happens. 23 23 So that was the nature of the questioning and it take it by a case by case in terms of whether or not we 24 24 need to go through that extra measure in terms of wasn't meant to do anything but be thought provoking, 25

not provoking in any other way. So we also do this for

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1	the public because we think it's important for the	1	CERTIFICATE OF REPORTER
2	public to hear how it is that you are protecting the	2	
3	public health and safety, and because of the nature of	3	I, Sally Jo Quade, CERT, do hereby certify that
4	the event at Idaho, I don't know that it got a lot of	4	the foregoing proceedings were recorded by me via
5	attention given to it in the public atmosphere and we've	5	stenotype and reduced to typewriting under my
6	gotten a lot of questions about it.	6	supervision; that I am neither counsel for, related to,
7	So this is for us very important, but also I	7	nor employed by any of the parties to the action in
8	think very important for the public to understand what	8	which these proceedings were transcribed; and further,
9	actually took place, what the investigation looked like,	9	that I am not a relative or employee of any attorney or
10	and then what actions that you're taking to address	10	counsel employed by the parties hereto, nor financially
11	those issues in the future.	11	or otherwise interested in the outcome of the action.
12	So thank you.	12	
13	CHAIRMAN HAMILTON: Thank you, Ms. Connery.	13	
14	And just one more thing for anyone who wants to	14	
15	submit a written comment for the record, we will hold	15	
16	the record of hearing open in order to get those for 30	16	s/Sally Jo Quade
17	days. So if you weren't able to be here, but you would	17	SALLY JO QUADE, CERT
18	like to submit a written comment, please do so within	18	
19	the next 30 days.	19	
20	Our goal for this hearing was to discuss DOE	20	
21	actions to strengthen the safety posture of the nuclear	21	
22	waste operations of solid nuclear waste operations and	22	
23	gather information on the safety controls to address	23	
24	vulnerabilities associated with handling and processing	24	
25	solid nuclear waste at Defense Nuclear Facilities.	25	
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1	To that end, we heard testimony from several		
2	department officials representing both Environmental		
3	Management and the National Nuclear Security		
4	Administration, as well as and we may hear and get		
5	some comments from the public should they submit them.		
6	The Board will consider the information gathered this		
7	afternoon to inform any actions that we may take		
8	regarding these issues.		
9	Once again, I thank everyone for your		
10	participation at this hearing. The record of this		
11	proceeding will remain open until July 20, 2019. This		
12	concludes the public hearing of the Defense Nuclear		
13	Facilities Safety Board. We are adjourned.		
14	(Whereupon, at 3:30 p.m., the meeting was		
15 16	adjourned.)		
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