

DEFENSE NUCLEAR FACILITIES SAFETY BOARD

March 8, 2019

TO: Christopher J. Roscetti, Technical Director
FROM: M. T. Sautman and Z. C. McCabe, Resident Inspectors
SUBJECT: Savannah River Site Activity Report for Week Ending March 8, 2019

H-Canyon: A series of errors led to H-Canyon Operations personnel establishing a lock out (L/O) on the incorrect component. The canyon dissolvers have a set of upper (cooling water and steam) and lower (only cooling water) pot coils, each equipped with an air regulator system. Operations personnel were tasked with locking out the 6.1D dissolver lower pot coils to allow maintenance personnel to work on the air regulator system. Each coil has a set of valves with identical Component Location Identifier (CLI) numbers except for the upper and lower designation (e.g., “H-S-221-PLTA-VLV-6.1D-CASH8 (LOWER)”). The L/O Order includes the “LOWER” in the CLI numbers as do the identification tags in the field. The individual installing the L/O erroneously locked out the upper coils valves, which are nearby, but not adjacent to the lower coil valves. The individual who established the L/O and the verifier both failed to recognize the error when they performed their duties. Before beginning work (i.e., line break), a maintenance mechanic noted that the pressure gauge on the system was greater than zero. They appropriately called a time-out and elevated the issue. H-Canyon personnel are still determining the appropriate corrective actions.

Operator Rounds: The resident inspector (RI) observed operator rounds at an SRNS-operated facility and noted several issues.

- In several instances, the operator failed to read the component tag to verify that they were reading from the correct component (three of these instances were for Technical Safety Requirement (TSR)-related equipment).
- On two occasions, the operator skipped several steps in the round sheet when they found a specific type of reading out of range. The skipped steps directed the operator to notify the shift operations manager (SOM) and request maintenance to confirm the out of range reading. When questioned, the operator informed the RI that the SOM already knew this information and that the intent was not to perform these steps every time.
- Twice the operator read TSR-related equipment in a contamination area (CA) and wrote down three numerical readings from memory instead of using an approved method for working in a CA (e.g., reader/worker).
- The operator mistakenly recorded the readings from a set of three TSR-related components in the incorrect location (i.e., the location for the readings of a similar set of TSR-related components) and noted the issue a few minutes later. Rather than line-out and initial the erroneous readings or inform supervision, they wrote a reminder to themselves on a “sticky-note.” The operator did not confirm the readings recorded in the incorrect location until approximately two hours later.
- After the operator completed a TSR-related verification, the RI questioned the meaning of the step and what they were intended to verify. The operator’s response was incorrect.

Solid Waste Management Facility: DOE-SR and SRNS began their separate readiness assessments of TRUPACT-III loading activities. The RI observed the pre-job brief, part of the field evolution and DOE-SR’s interviews with Mobile Loading Unit personnel.