DEFENSE NUCLEAR FACILITIES SAFETY BOARD

December 2, 2005

TO: K. Fortenberry, Technical Director
FROM: R. Quirk and W. Linzau, Hanford Site Representatives
SUBJ: Activity Report for the Week Ending December 2, 2005

Waste Treatment and Immobilization Plant (WTP): Contractor management pereformed their yearly assessment of the functioning of the WTP Project Safety Committee (PSC). This assessment focused on the functioning of the PSC relative to senior management's expectations and emerging issues in the Authorization Basis (AB) maintenance program. Some senior managers expressed that the PSC was not fulfilling its role as the internal safety oversight organization. These opinions were based on the poor nuclear safety culture made evident by recurring AB compliance issues, the lack of specific improvement recommendations made by the PSC, and too much time spent on less significant issues while failing to prevent the recurrence of more serious errors. The report makes two recommendations: change the PSC charter to focus attention on nuclear and process safety oversight; and continue senior management efforts to create a nuclear safety culture with stronger emphasis on compliance with procedures. The report relates senior management thoughts on transforming the PSC into an organization more inline with the nuclear power industry by using guidelines from the Institute for Nuclear Power Operations on safety oversight.

Remote Water Lance (RWL) Operation: The RWL testing in tank S-112 continued this week, and additional hard heel in the bottom of the tank was mobilized. Concurrent operation of the RWL and the sludge retrieval pump was approved this week after an adequate evaluation by CH2M Hill Hanford Group (CHG) and the Office of River Protection (ORP). The objectives of the RWL test were met. ORP is evaluating if additional funds should be expended to use the RWL to retrieve more waste from tank S-112.

Fire Protection Program Assessment: ORP completed their periodic assessment of the CHG Fire Protection Safety Management Program and identified six preliminary findings and six observations during the exit briefing. The most significant preliminary finding was that CHG was not performing internal fire protection program assessments at the required frequency nor were they at an adequate breadth.