SUMMARY OF 1989 EVENTS

UE NUMBER	EVENT DATE	DATE NOTIFIED	BUILDING	TYPE INVS	IIR/UOR Number	Title
UE89-550-R	11/08/89	11/08/89	371	NFI	N/A	High Wind Damage
UE89-551	11/07/89	11/08/89	371	NFI	N/A	Low Amp Shock
UE89-552	11/07/89	11/08/89	371	NFI	N/A	Shutdown of PROVE
UE89-553	11/08/89	11/08/89	904 Pad	NFI	N/A	Vehicle Accident with Injury
UE89-554-R	11/09/89	11/09/89	123	IIR	89-149 123-3	Unaccounted for Source
UE89-555	11/09/89	11/09/89	774	IIR	89-147 774-2	Domestic Water Line Damage
UE89-556	11/09/89	11/09/89	131	NFI	N/A	Unknown Source - Overheated Object Smell
UE89-557-R	11/09/89	11/09/89	777	NFI	N/A	Odor of Carbon Tetrachloride
UE89-558	11/09/89	11/10/89	707	NFI	N/A	Glovebox Overheat Alarm
UE89-559	11/09/89	11/10/89	707	NFI	N/A	Glovebox Overheat Alarm
UE89-560	11/10/89	11/10/89	900	NFI	N/A	Property Damage
UE89-561-R	11/10/89	11/10/89	374	NFI	N/A	Disabled Alarm Panel
UE89-562-R	11/10/89	11/13/89	371	NFI	N/A	Raschig Ring and Contamination Problem
UE89-563	11/10/89	11/13/89	460	NFI	N/A	Smoking Exit Sign
UE89-564	11/10/89	11/13/89	883	NFI	N/A	Inadvertent Fire Alarm
UE89-565-R	11/11/89	11/13/89	444	UOR	89-19--444 89-3	Vacuum Cleaner Fire
UE89-566	11/12/89	11/13/89	776	NFI	N/A	Inadvertent Fire Alarm
UE89-567	11/12/89	11/13/89	559	NFI	N/A	Glovebox Overheat Alarm
UE89-568	11/12/89	11/13/89	776	NFI	N/A	Glovebox Overheat Alarm
UE89-569	11/13/89	11/13/89	750 Pad	NFI	N/A	Leaking Pondcrete Box
UE89-570	11/13/89	11/13/89	447	NFI	N/A	Hydraulic Oil Leak
UE89-571-R	11/13/89	11/13/89	771	UOR	89-21--771 89-3	Overfilled Tank

SUMMARY OF 1989 EVENTS

UE NUMBER	EVENT DATE	DATE NOTIFIED	BUILDING	TYPE INVS	IIR/UOR Number	Title
UE89-572-R	11/13/89	11/14/89	729	NFI	N/A	Antifreeze Discharge
UE89-573	11/14/89	11/14/89	776	NFI	N/A	Puncture Wound
UE89-574	11/14/89	11/14/89	130	NFI	N/A	Cut Telephone Cable
UE89-575-R	11/16/89	11/16/89	566	NFI	N/A	Dislodged Sewer Manhole Cover
UE89-576	11/18/89	11/20/89	251	NFI	N/A	Flow Alarm Activation
UE89-577	11/19/89	11/20/89	771	IIR	89-151 771-17	Inadvertent Activation of Neutron Alarm System
UE89-578	11/20/89	11/20/89	865	IIR	89-152 865-2	Process Cooling Water Spill
UE89-579	11/17/89	11/20/89	707	IIR	89-153 707-16	Nuclear Materials Safety Procedural Infraction 89-23
UE89-580-R	11/17/89	11/20/89	566	NFI	89-154 566-1	Confined Space Entry - 566
UE89-581	11/20/89	11/20/89	779	NFI	N/A	Personnel Contamination
UE89-582	11/18/89	11/20/89	460	NFI	N/A	De-ionized Water Spill - 460
UE89-583	11/18/89	11/20/89	771	NFI	N/A	Alarm Panel Malfunction
UE89-584	11/20/89	11/21/89	111	NFI	N/A	Scorched Paper/Copy Machine
UE89-585	11/21/89	11/21/89	251	NFI	N/A	Flow Alarm/Fire Suppression - Windsite
UE89-586	11/21/89	11/21/89	675	NFI	N/A	Sub-station Power Outage
UE89-587	11/21/89	11/21/89	251	NFI	N/A	Interrupted Power
UE89-588	11/21/89	11/21/89	T690B	NFI	N/A	Manual Fire Alarm
UE89-589	11/21/89	11/22/89	559	NFI	N/A	Sump Pump Failure
UE89-590	11/21/89	11/22/89	865	NFI	N/A	Cutting Oil Spill
UE89-591	11/22/89	11/22/89	788	NFI	N/A	Cyanide Alarm

SUMMARY OF 1989 EVENTS

UE NUMBER	EVENT DATE	DATE NOTIFIED	BUILDING	TYPE INVS	IIR/UOR Number	Title
UE89-592-R	11/23/89	11/27/89	460	UOR	89-20--460 89-2	Passivating Tank Fire
UE89-593	11/23/89	11/27/89	374	IIR	89-158 374-5	Low Level Waste Spill
UE89-594-R	11/24/89	11/27/89	776	UOR	89-22--776 89-1	Room Contamination
UE89-595	11/24/89	11/27/89	122	NFI	N/A	Heating System Leaking Pump
UE89-596-R	11/25/89	11/27/89	707	IIR	89-178 709-1	Emergency Pump/Ruptured Line
UE89-597	11/25/89	11/27/89	251	NFI	N/A	Flow Alarm, Fire Suppression System
UE89-598	11/26/89	11/27/89	251			Mercury Contamination in Fire Suppression System
UE89-599-R	11/26/89	11/27/89	788	NFI	N/A	Cyanide Alarms
UE89-600-R	11/27/89	11/27/89	886	IIR	89-173 866-1	Steam Condensate Spill
UE89-601	11/27/89	11/27/89	125	NFI	N/A	Smoke Alarm - 125
UE89-602	11/27/89	11/27/89	883	NFI	N/A	HazMat Response
UE89-603	11/27/89	11/28/89	762A	NFI	N/A	Slip and Fall - Personal Injury
UE89-604	11/28/89	11/28/89	776	NFI	N/A	Glovebox Overheat Alarm
UE89-605	11/27/89	11/28/89	371	NFI	N/A	Cooling Water Leak
UE89-606	11/28/89	11/28/89	881	NFI	N/A	Temporary Air Compressor Malfunction
UE89-607	11/28/89	11/28/89	779	IIR	89-160 779-8	Building Evacuation - Ventalation
UE89-608	11/28/89	11/28/89	750 Pad	NFI	N/A	Water Seepage
UE89-609	11/28/89	11/29/89	776	NFI	N/A	Personnel Contamination
UE89-610-R	11/28/89	11/29/89	251	NFI	N/A	Condensate Water Leak
UE89-611-R	11/28/89	11/29/89	RFP	NFI	N/A	Compliance Notification
UE89-612	11/28/89	11/29/89	566	NFI	N/A	Unattended Heaters

SUMMARY OF 1989 EVENTS

UE NUMBER	EVENT DATE	DATE NOTIFIED	BUILDING	TYPE INVS	IIR/UOR Number	Title
UE89-613	11/29/89	11/29/89	777	NFI	N/A	Procedure Violation
UE89-614	11/29/89	11/29/89	771	NFI	N/A	Inadvertent Activation of Fire Alarm
UE89-615	11/29/89	11/29/89	374	IIR	89-159 374-6	Brine Spill
UE89-616	11/29/89	11/29/89	881	NFI	N/A	Water Main Rupture
UE89-617	11/29/89	11/30/89	788	NFI	N/A	Cyanide Alarm
UE89-618	11/29/89	11/30/89	444	NFI	N/A	Building Evacuation - Precautionary
UE89-619	11/30/89	11/30/89	779	IIR	89-161 779-9	Work Permit Violation
UE89-620-R	12/01/89	12/01/89	707	NFI	N/A	HazMat Team Response
UE89-621-R	12/01/89	12/01/89	460	NFI	N/A	Sludge Spill
UE89-622	12/01/89	12/04/89	770	NFI	N/A	Fire Panel Alarm
UE89-623	12/01/89	12/04/89	771	NFI	N/A	Manual Fire Alarm
UE89-624	12/01/89	12/04/89	707	NFI	N/A	Domestic Water Spill
UE89-625	12/03/89	12/04/89	771	NFI	N/A	Employee Injury
UE89-626	12/04/89	12/04/89	788	NFI	N/A	Cyanide Alarm Activation
UE89-627-R	12/04/89	12/04/89	569	IIR	89-162 569-3	Electrical Burn
UE89-628-R	12/05/89	12/05/89	000	IIR	89-163 112-1	Telephone System Outage
UE89-629	12/02/89	12/05/89		TBD		Excavation Site Water Drainage
UE89-630	12/04/89	12/05/89	371	NFI	N/A	Personnel Contamination
UE89-631	12/01/89	12/05/89	251	NFI	N/A	Valve Leak
UE89-632	12/06/89	12/06/89	707	NFI	N/A	Glovebox Overheat Alarm
UE89-633	12/06/89	12/06/89	E.Access	NFI	N/A	Auto Fire Report
UE89-634	12/06/89	12/07/89	559	NFI	N/A	Smoke - PELS Computer Screen

SUMMARY OF 1989 EVENTS

UE NUMBER	EVENT DATE	DATE NOTIFIED	BUILDING	TYPE INVS	IIR/UOR Number	Title
UE89-635	12/07/89	12/07/89	904 Pad	NFI	N/A	Saltcrete Spill
UE89-636	12/07/89	12/07/89	000	NFI	N/A	Automative Oilpan Drip - POV
UE89-638	12/07/89	12/07/89	777	NFI	N/A	Smoke - PELS Computer Screen
UE89-639	12/07/89	12/08/89	460	NFI	N/A	De-ionized Water Leak
UE89-640	12/07/89	12/08/89	883	NFI	N/A	Soap Spill
UE89-641	12/08/89	12/08/89	707	NFI	N/A	Glovebox Overheat Alarm
UE89-642	10/27/89	12/08/89	707	IIR	89-166 707-19	Nuclear Materials Safety Procedural Infraction 89-22
UE89-643	11/30/89	12/08/89	771	IIR	89-167 771-18	Nuclear Materials Safety Procedural Infraction 89-24
UE89-644	12/05/89	12/08/89	881	IIR	89-165 881-9	Nuclear Materials Safety Procedural Infraction 89-25
UE89-645	12/08/89	12/08/89	130	NFI	N/A	Hydraulic Oil Line Rupture
UE89-646	12/09/89	12/11/89	774	IIR	89-169 774-3	Tank Overflow
UE89-647	12/09/89	12/11/89	776	NFI	N/A	Inadvertent Glovebox Overheat Alarm
UE89-648	12/10/89	12/11/89	447	NFI	N/A	Scheduled Power Outage Problem
UE89-649	12/11/89	12/11/89	881			Soldering Fire
UE89-650	12/11/89	12/12/89	444	NFI	N/A	Leaking Roof
UE89-651	12/11/89	12/12/89	709	NFI	N/A	Activation of Flow Alarm
UE89-652	12/11/89	12/12/89	460	NFI	N/A	Mercury Drops on Shelf
UE89-653	12/11/89	12/12/89	771	NFI	N/A	Acid Fumes Odor
UE89-654	12/13/89	12/13/89	771	NFI	N/A	Contaminated Employee

SUMMARY OF 1989 EVENTS

UE NUMBER	EVENT DATE	DATE NOTIFIED	BUILDING	TYPE INVS	IIR/UOR Number	Title
UE89-655	12/13/89	12/13/89	000	NFI	N/A	Vehicle Accident - Icy Roads
UE89-656	12/13/89	12/13/89	774	IIR	89-170 774-4	Unsampled Process Waste Transfer
UE89-657	12/14/89	12/14/89	777	TBD		Criticality Drain Overflow
UE89-659	12/13/89	12/14/89	750 Pad	NFI	N/A	Storage Container Damage
UE89-661	12/15/89	12/15/89	VV-15	NFI	N/A	Unauthorized Ground Water Pumping
UE89-662	12/15/89	12/15/89	123	NFI	N/A	Process Waste Spill
UE89-663	12/15/89	12/18/89	000	NFI	N/A	Demonstrator Trespasser
UE89-664	12/15/89	12/18/89	700 Cmplx	NFI	N/A	Building Evacuation - Precautionary
UE89-665	12/16/89	12/18/89	881	IIR	89-171 881-11	Injured Employee - Falling Object
UE89-666	12/16/89	12/18/89	774	NFI	N/A	Criticality Alarm
UE89-667	12/17/89	12/18/89	778	NFI	N/A	Manual Fire Alarm
UE89-668	12/17/89	12/18/89	119	NFI	N/A	Ruptured Water Line
UE89-669	12/18/89	12/18/89	762A	NFI	N/A	Property Damage - Vehicle
UE89-670	12/05/89	12/19/89	777	IIR	89-172 777-7	Nuclear Materials Safety Procedural Infraction 89-26
UE89-671	12/19/89	12/20/89	460	NFI	N/A	Personal Illness
UE89-672	12/20/89	12/20/89	777	NFI	N/A	Frozen Fire Suppression Equipment
UE89-673-R	12/20/89	12/20/89	374	NFI	N/A	Frozen Process Waste Drum
UE89-674	12/20/89	12/20/89	Pond A-4	IIR	89-174 000-13	Elevated Contaminates - A/4 Pond
UE89-675-R	12/20/89	12/21/89	877	NFI	N/A	Mercury Contamination
UE89-676	12/21/89	12/21/89	700 Cmplx	NFI	N/A	Building Evacuation - Precautionary

SUMMARY OF 1989 EVENTS

UE NUMBER	EVENT DATE	DATE NOTIFIED	BUILDING	TYPE INVS	IIR/UOR Number	Title
UE89-677	12/21/89	12/21/89	777	NFI	N/A	Flow Alarm
UE89-678	12/21/89	12/21/89	850	NFI	N/A	Employee Injury - Choking
UE89-679	12/21/89	12/21/89	250	NFI	N/A	Personal Injury - Slip and Fall
UE89-680	12/21/89	12/21/89	788	IIR	89-175 788-1	Cut 480 Volt Electrical Wire
UE89-681	12/22/89	12/22/89	865	NFI	N/A	Flow Alarm
UE89-682	12/22/89	12/22/89	439			Flow Alarm
UE90-001	12/22/89	01/02/90	750 Pad			Injured Sub-Contractor Employee
UE90-002	12/22/89	01/02/90	774			Domestic Water Line Rupture
UE90-003	12/23/89	01/02/90	707			Process Water Leak
UE90-004	12/23/89	01/02/90	887			Process Waste Pipe Leak
UE90-005	12/23/89	01/02/90	374			Manual Fire Alarm
UE90-006	12/24/89	01/02/90	709			Cooling Water Leak
UE90-007	12/24/89	01/02/90	707			Lost Items
UE90-008	12/24/89	01/02/90	771			Open Breaker to Filter Plenum
UE90-009	12/25/89	01/02/90	000			Demonstrators
UE90-010	12/26/89	01/02/90	130			Interrupted Power Service
UE90-011	12/26/89	01/02/90	000			Demonstrators
UE90-012	12/27/89	01/02/90	130			Interrupted Telephone and Power Service
UE90-013	12/27/89	01/02/90	371			Secondary Alarm Activation
UE90-014-R	12/27/89	01/02/90	881			Defective Shutoff Switch
UE90-015	12/28/89	01/02/90	371			Alarm Panel Service

SUMMARY OF 1989 EVENTS

UE NUMBER	EVENT DATE	DATE NOTIFIED	BUILDING	TYPE INVS	IIR/UOR Number		Title
UE90-016	12/28/89	01/02/90	000				Demonstrators
UE90-017-R	12/29/89	01/02/90	569				Leaking Heating Coils
UE90-018-R	12/30/89	01/02/90	777				Sight Gauge Leak
UE90-019	12/30/89	01/02/90	991				Flow Alarm
UE90-020	12/31/89	01/02/90	570				Power Outage
UE90-026	12/28/89	01/04/90	788				Property
UE90-057	12/15/89	01/16/90	881	UOR	90-1--881	90-1	Contaminated Filter Plenum
UE90-131	09/29/89	02/01/90	371	CMM			Erroneous High Drum Reading

SIGNED AFFIDAVIT – TECHNICAL BASIS DOCUMENT

May 20, 2005

STEVE TRUJILLO

SEC Tracking Number 00030

I, Steve Trujillo submit the following letter as a signed affidavit in support of the Rocky Flats USWA Special Exposure Cohort Petition.

As Co-Chair of the Hazardous and Toxic Materials Committee, I attest that the attached binder of *Radiological Incident Reports from 1998 – 2003* for building 776,777,771,707, and 779 are non-routine events that have taken place at Rocky Flats. **The Technical Basis Document used by NIOSH to reconstruct doses does not capture radiological incidents or events past 1976.** This Binder is a small fraction of the hundreds of radiological incidents that have occurred at Rocky Flats Plant since 1976, and should all be accounted for. NIOSH can not accurately reconstruct doses unless they take into account all incidents or events that have occurred at Rocky Flats.

Respectfully,

5-20-05

Steve Trujillo

Co-Chair
Hazardous and Toxic Materials Subcommittee

SUBSCRIBED AND SWORN TO
BEFORE ME, IN THE COUNTY OF Jefferson
STATE OF COLORADO. THIS 20th DAY
OF May, 2005

CLARENCE W. BUCHHOLZ, NOTARY PUBLIC
MY COMMISSION EXPIRES SEPTEMBER 23, 2006

CLARENCE W. BUCHHOLZ NOTARY PUBLIC STATE OF COLORADO

BUILDING 776-777
RADIOLOGICAL
INCIDENT REPORTS
(1998 – 2003)

SEC 0030

Radiation Protection
Radiological Improvement Reports (RIR)

Radiological Improvement Report Details

RIR No.:	98-331
Originator:	
Project:	SSOC
Date Entered:	8/20/1998 12:00:00 AM
Event Date:	8/19/1998 12:00:00 AM
Status:	CLOSED
DateClosed:	9/23/1998 12:00:00 AM
Building:	776
Location:	
Description:	Operator inserted left arm in 1101 tank to remove rasching rings. In doing so, his arm was soaked in contaminated oil. Arm was contaminated to 80,000 dpm.
RS Supervisor	W. Sutton
Immediate Corrective Action:	Removed Tyvek, Anti-C clothing and deconned.
Primary Event Code:	B4
Secondary Event Codes:	B13
Apparent Cause:	PERSONNEL
Facility Mgr:	D. Burks
DOE Categorization:	Completed
Occurrence Rpt. No.:	98-0513
Responsible Mgr.:	D. Burks
Responsible Dir.:	R. Bacon
Target Date:	9/18/1998 12:00:00 AM
Corrective Actions:	Employee counseled on procedural compliance (abnormal conditions). work package revised to include additional controls (hold points). Job participants briefed on hazards and this event.
PATS No.:	
Comments:	Individual received a Potential Level I Intake. See attached air sampling forms. Evidence of briefing was not submitted. Returned by RIR Administrator 9/8/98. Received Briefing Roster 9/23/98. Recommended for Close-Out by RIR Administrator 9/23/98. pkm

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- Create RIR
- Radiation Generating Devices (RGD)
- Sealed Radioactive Sources (SRS)

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Savitz, Kenneth R
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Radiological Improvement Report Details

RIR No.:	98-236
Originator:	
Project:	SSOC
Date Entered:	6/15/1998 12:00:00 AM
Event Date:	6/13/1998 12:00:00 AM
Status:	CLOSED
DateClosed:	7/13/1998 12:00:00 AM
Building:	776
Location:	Room 237
Description:	Found 4560 dpm on leather work glove while working in a CA.. Contamination came from inside the wall. Area of contamination is about 6" x 10".
RS Supervisor	G. Tresco
Immediate Corrective Action:	Contained area with plastic. Notified bldg. manager, Rad. Ops. Foreman, bagged up glove, and posted area as HCA.
Primary Event Code:	B6
Secondary Event Codes:	B9
Apparent Cause:	PROCEDURE/PERSONNEL
Facility Mgr:	M. Kriz
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	G. Chandler
Responsible Dir.:	R. Bacon
Target Date:	7/12/1998 12:00:00 AM
Corrective Actions:	A managers meeting was held to determine the root cause of the occurrence and it was determined that an inadequate survey was performed. The RWP was re-written to reflect requirements for individuals when working in isolated areas (hands only) and what PPE is required RWP also now reflects the use of leather gloves as a layer of protection when working in contaminated areas.
PATS No.:	
Comments:	See attached Managers Meeting Minutes and corrected RWP #98-776-0201.

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Radiological Improvement Report Details

RIR No.:	98-065
Originator:	
Project:	SSOC
Date Entered:	2/16/1998 12:00:00 AM
Event Date:	2/15/1998 12:00:00 AM
Status:	CLOSED
DateClosed:	3/11/1998 12:00:00 AM
Building:	776
Location:	154A
Description:	Air Sample results were misinterpreted and room 154A was deposted from full face when DAC was .7 and not .07 as thought on 2/15/98.
RS Supervisor	K. Mastriona
Immediate Corrective Action:	Room was posted. 2nd air sample was taken (results .07 DAC) Shift manager notified. PI calculation results & Factor .002 (on 2/16/98)
Primary Event Code:	B9
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	W. Stephens
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	G. T.Chandler
Responsible Dir.:	R. Bacon
Target Date:	3/17/1998 12:00:00 AM
Corrective Actions:	RCT disqualified. Rcvd training on air sampling, quals. reinstated and air sample documentation revised.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	98-389
Originator:	
Project:	SSOC
Date Entered:	9/25/1998 12:00:00 AM
Event Date:	9/25/1998 12:00:00 AM
Status:	CLOSED
DateClosed:	10/22/1998 12:00:00 AM
Building:	776
Location:	Room 154A
Description:	Glove Box Glove failed, resulting in 500,000 dpm on the arm of the Anti-Cs.
RS Supervisor	K. Mastriona
Immediate Corrective Action:	Doffed Anti-Cs, full body frisk and sent to Rad. Ops. office for PI Evaluation, No skin contamination.
Primary Event Code:	B11
Secondary Event Codes:	B13
Apparent Cause:	EQUIPMENT
Facility Mgr:	M. Kriz
DOE Categorization:	Completed
Occurrence Rpt. No.:	98-0605
Responsible Mgr.:	G. Chandler
Responsible Dir.:	R. Bacon
Target Date:	10/24/1998 12:00:00 AM
Corrective Actions:	All actions taken were in accordance with approved procedures. See attached Fact Finding meeting summary sheet for immediate actions and follow-up actions taken. Any further follow-up bioassay requirements will be done in accordance w/Internal dosimetry Procedures.
PATS No.:	
Comments:	Follow up actions included completion of: Change all gloves on GB 505, ensure gloves have not aged > 10 years on GB 505 and 506, Inventory gloves, brief Process Specialist to monitor hands each time they exit gloves.

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Radiological Improvement Report Details

RIR No.:	98-469
Originator:	
Project:	SSOC
Date Entered:	11/24/1998 12:00:00 AM
Event Date:	11/23/1998 12:00:00 AM
Status:	CLOSED
DateClosed:	1/13/1999 12:00:00 AM
Building:	776
Location:	
Description:	Incorrect setting of alarm on SAAM (Effluent) #59. Alarm was set at 50% (5).
RS Supervisor	W. Sutton
Immediate Corrective Action:	Notified supervisor, shift manager, and set setting at 20% (2).
Primary Event Code:	B9
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	G. Chandler
Responsible Dir.:	R. Bacon
Target Date:	12/22/1998 12:00:00 AM
Corrective Actions:	Tool boxed/briefed all the RCTs in the building as well as the Radiation Instrumentation Technicians (RITs) on the importance of attention to detail when performing the surveillance testing of SAAMs.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	**99-007**
Originator:	
Project:	RMRS
Date Entered:	1/11/1999 12:00:00 AM
Event Date:	1/7/1999 12.00:00 AM
Status:	CLOSED
DateClosed:	3/8/1999 12:00:00 AM
Building:	776
Location:	127
Description:	Employee was seeking out drums in room 127 and just did not see sign for full face requirement and entered without respirator protection.
RS Supervisor	K. Mastronia
Immediate Corrective Action:	Incident reported to supervisor, fact finding meeting, RIR, air sample taken, personnel whole body frisked.
Primary Event Code:	B1
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	M. Kriz
DOE Categorization:	Completed
Occurrence Rpt. No.:	99-0011
Responsible Mgr.:	C. Tuck
Responsible Dir.:	A. Crawford
Target Date:	2/6/1999 12:00:00 AM
Corrective Actions:	Counseled individual to importance of verifying status of work area with Shift Manager and reviewing posted signs. Individual will hold tool boxes with other groups explaining the importance of posted signs and verifying work area status.
PATS No.:	
Comments:	RMRS PA Screen No RMRS-99-401 Returned to Resp.Mgr. on 1/26/99, rosters needed to close. DAS

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Radiological Improvement Report Details

RIR No.:	**99-038**
Originator:	
Project:	RMRS
Date Entered:	2/1/1999 12:00:00 AM
Event Date:	1/29/1999 12:00:00 AM
Status:	CLOSED
DateClosed:	3/8/1999 12:00:00 AM
Building:	776
Location:	rm 15A
Description:	While supervising residue sampling, individuals dosimeter badge holder broke and individual could not find his badge while working in the MAA-CA.
RS Supervisor	W. Sutton
Immediate Corrective Action:	Individual left the area, contacted Rad Ops supervision, notified Shift Manager.
Primary Event Code:	C7
Secondary Event Codes:	
Apparent Cause:	EQUIPMENT
Facility Mgr:	M. Kriz
DOE Categorization:	Completed
Occurrence Rpt. No.:	
Responsible Mgr.:	Cleve Tuck
Responsible Dir.:	Clegg Crawford
Target Date:	3/1/1999 12:00:00 AM
Corrective Actions:	
PATS No.:	
Comments:	RMRS PA Screen No. RMRS-99-417

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Radiological Improvement Report Details

RIR No.:	99-136
Originator:	
Project:	RMRS
Date Entered:	3/22/1999 12:00:00 AM
Event Date:	3/21/1999 12:00:00 AM
Status:	CLOSED
DateClosed:	4/8/1999 12:00:00 AM
Building:	776
Location:	134W
Description:	Personnel found with contamination due to contaminated glove. 20, 000 dpm found on glove.
RS Supervisor	W. J. Sutton
Immediate Corrective Action:	Donned respiratory protection, contained contamination on personnel, contain contamination in room, posted room.
Primary Event Code:	B5
Secondary Event Codes:	B15
Apparent Cause:	EQUIPMENT
Facility Mgr:	R. V. Harder
DOE Categorization:	Completed
Occurrence Rpt. No.:	99-0181
Responsible Mgr.:	E. A. Blush
Responsible Dir.:	A. Crawford
Target Date:	4/20/1999 12:00:00 AM
Corrective Actions:	Replaced glove, evaluated GB for puncture hazards (found one not related to this event and taped it up). Held briefing for PS, RCTs stressing a need for a greater depth of survey (not just hands) when pulling out of gloves. Will perform more frequent glove inspections. PI Eval/bioassay ongoing. All personnel cleared by Internal Dosimetry for return to work.
PATS No.:	
Comments:	RMRS PA Screen No. RMRS-99-527. CEDE <100 mrem confirmed, B15 event code added 2/16/00. (das)

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Radiological Improvement Report Details

RIR No.:	99-335
Originator:	
Project:	RMRS
Date Entered:	7/26/1999 12:00:00 AM
Event Date:	7/25/1999 12:00:00 AM
Status:	CLOSED
DateClosed:	8/5/1999 12:00:00 AM
Building:	776
Location:	131
Description:	During GB operations, both employees had 150,000 dpm on their left hand of anti-cs. RWP # 99-776-3028. 1 employee had 2,000 dpm on anti-c coveralls.
RS Supervisor	W. J. Sutton
Immediate Corrective Action:	Removed gloves removed coveralls, surveyed area, contained glove port. Notified supervision. Pulled Hi Vol sample.
Primary Event Code:	A1
Secondary Event Codes:	B11
Apparent Cause:	EQUIPMENT
Facility Mgr:	K. N. Smith
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	G. T. Chandler
Responsible Dir.:	A. Crawford
Target Date:	8/24/1999 12:00:00 AM
Corrective Actions:	Glove port was immediately contained. Area was then posted and failed glove was changed. Airborne radioactivity monitoring was performed and indicated <10 DAC. Nasal and mouth smears were taken: 2 individuals were less than the decision level, 1 individual >decision level (9.7 dpm) with 9.9 dpm results. Follow up bioassay will be in accordance with Internal Dosimeter procedures.
PATS No.:	1999-001155
Comments:	RMRS PA Screen No. RMRS-99-851

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Radiological Improvement Report Details

RIR No.:	99-495
Originator:	
Project:	RMRS
Date Entered:	11/4/1999 12:00:00 AM
Event Date:	11/4/1999 12:00:00 AM
Status:	CLOSED
DateClosed:	11/15/1999 12:00:00 AM
Building:	776
Location:	Room 131 GB 622
Description:	After surveying the top of GB 622, checked feet and found 7,000 dpm on the bottom of the rubber overshoes. Laid wipes on the floor and surveyed immediate floor area and detected 200,000 dpm on wipe.
RS Supervisor	W. J. Sutton
Immediate Corrective Action:	Notified supervision, left room 131, and posted room HCA, Respiratory Protection required.
Primary Event Code:	B11
Secondary Event Codes:	B13
Apparent Cause:	EQUIPMENT
Facility Mgr:	
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	
Responsible Dir.:	A. Crawford
Target Date:	12/3/1999 12:00:00 AM
Corrective Actions:	Area decontaminated and deposted on 11/4/99. Cause of contamination on floor is unknown. No evidence of floor chipping was found.
PATS No.:	
Comments:	RMRS PA Screen No. RMRS-99-1046

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Radiation Protection
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Welcome,
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Radiological Improvement Report Details

RIR No.:	00-008
Originator:	
Project:	RMRS
Date Entered:	1/7/2000 12:00:00 AM
Event Date:	1/7/2000 12:00:00 AM
Status:	CLOSED
DateClosed:	1/18/2000 12:00:00 AM
Building:	776
Location:	134E
Description:	Found 10,000 dpm on bootie while performing govebox work. Also found 10,000 dpm on floor.
RS Supervisor	A. Wolff
Immediate Corrective Action:	Removed personnel Posted area HCA, Airborne. Performed PI and surveyed area. PI results 6.25. Referred to internal dosimetry.
Primary Event Code:	B11
Secondary Event Codes:	B13
Apparent Cause:	EQUIPMENT
Facility Mgr:	K. Smith
DOE Categorization:	Completed
Occurrence Rpt. No.:	2000-0016
Responsible Mgr.:	G. T. Chandler
Responsible Dir.:	A. C. Crawford
Target Date:	2/6/2000 12:00:00 AM
Corrective Actions:	Paint dripping on floor was contained. Bioassay follow up from PI calculation will be in accordance with RSP 14.01. Floor scheduled for repainting the week of 1/17/00 on POD.
PATS No.:	
Comments:	PA Screen # RMRS-0-1092.

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Radiation Protection
Radiological Improvement Reports (RIR)

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Radiological Improvement Report Details

RIR No.:	00-011
Originator:	
Project:	RMRS
Date Entered:	1/10/2000 12:00:00 AM
Event Date:	1/10/2000 12:00:00 AM
Status:	CLOSED
DateClosed:	1/18/2000 12:00:00 AM
Building:	776
Location:	134E
Description:	Employee was doing glovebox work, removed left arm from gloves, found 5,000 dpm under armpit of anti-cs. Also found 100,000 dpm on glove.
RS Supervisor	A. Wolff
Immediate Corrective Action:	Contained contamination, donned full face, found hole in glove, contained glove, removed anti-c and left area. Passed PCM2, performed PI; results 3.125.
Primary Event Code:	B11
Secondary Event Codes:	B13
Apparent Cause:	EQUIPMENT
Facility Mgr:	R. V. Harder
DOE Categorization:	Completed
Occurrence Rpt. No.:	2000-0020
Responsible Mgr.:	G. T. Chandler
Responsible Dir.:	A. C. Crawford
Target Date:	2/9/2000 12:00:00 AM
Corrective Actions:	
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	**00-254**
Originator:	
Project:	776/777
Date Entered:	6/27/2000 12:00:00 AM
Event Date:	6/22/2000 12:00:00 AM
Status:	CLOSED
DateClosed:	7/3/2000 12:00:00 AM
Building:	776
Location:	
Description:	Working on RWP 0301. Work exceeded suspension guide limits. D&D pump down table. 1st employee had 4,000,000 dpm on right hand (glove). 2nd employee had 2,500 dpm on left hand (glove).
RS Supervisor	W. J. Sutton
Immediate Corrective Action:	Notify foreman, posted room , warned workers to exit room. Did PI. 1st employee Level 1, 2nd employee level II.
Primary Event Code:	B15
Secondary Event Codes:	B16, B11
Apparent Cause:	EQUIPMENT
Facility Mgr:	K. Smith
DOE Categorization:	Completed
Occurrence Rpt. No.:	
Responsible Mgr.:	G. T. Chandler
Responsible Dir.:	M. Ferri
Target Date:	7/22/2000 12:00:00 AM
Corrective Actions:	All actions taken when contamination was discovered were appropriate and in accordance with procedures. Follow up bioassay will be performed in accordance with Internal Dosimetry procedures. Area was cleaned up and/or contained.
PATS No.:	
Comments:	CEDE 2 mrem

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Radiological Improvement Report Details

RIR No.:	**00-014**
Originator:	
Project:	RMRS
Date Entered:	1/11/2000 12:00:00 AM
Event Date:	1/11/2000 12:00:00 AM
Status:	CLOSED
DateClosed:	1/18/2000 12:00:00 AM
Building:	776
Location:	430
Description:	Employee entered posted area by going under the glovebox in to HRA.
RS Supervisor	W. J. Sutton
Immediate Corrective Action:	Notified supervision, took employee to Rad Ops office.
Primary Event Code:	B12
Secondary Event Codes:	
Apparent Cause:	MANAGEMENT SYSTEM/COMMUNICATIONS
Facility Mgr:	J. Auxier
DOE Categorization:	Completed
Occurrence Rpt. No.:	2000-0021
Responsible Mgr.:	G. T. Chandler
Responsible Dir.:	A. C. Crawford
Target Date:	2/10/2000 12:00:00 AM
Corrective Actions:	Individual was counseled on not going under gloveboxes without an RCT. All facility personnel were briefed on not going under glovebox lines. Bldg indoctrination revised to reflect not crawling under gloveboxes.
PATS No.:	
Comments:	PA Screen #RMRS-0-1097

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Radiological Improvement Report Details

RIR No.:	01-066
Originator:	
Project:	776/777
Date Entered:	2/13/2001 12:00:00 AM
Event Date:	2/13/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	3/9/2001 12:00:00 AM
Building:	776
Location:	
Description:	Employee mistakenly wore another employee's dosimetry (TLD and wrist dosimeter) into the CA and RA.
RS Supervisor	S. R. Fields
Immediate Corrective Action:	Returned dosimeters of both individuals to external dosimetry for dose investigation.
Primary Event Code:	C1
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	N. A. Holmes
DOE Categorization:	Completed
Occurrence Rpt. No.:	2001-0084
Responsible Mgr.:	G. T. Chandler
Responsible Dir.:	M. Ferri
Target Date:	3/15/2001 12:00:00 AM
Corrective Actions:	Radiation survey of area, neutron and gamma, was performed and delivered to external dosimetry on all employees' TLDs. Further follow up actions and dose reconstruction's will be performed in accordance with External Dosimetry procedures.
PATS No.:	
Comments:	PA# KH-2002-0125

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Radiological Improvement Report Details

RIR No.:	00-326
Originator:	
Project:	776/777
Date Entered:	8/23/2000 12:00:00 AM
Event Date:	8/18/2000 12:00:00 AM
Status:	CLOSED
DateClosed:	8/25/2000 12:00:00 AM
Building:	776
Location:	127
Description:	Employees went through airborne area without respirator protection.
RS Supervisor	W. J. Sutton
Immediate Corrective Action:	Contacted Rad Safety supervisor. Area was in process of being deposted.
Primary Event Code:	B1
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	J. Auxier
DOE Categorization:	Completed
Occurrence Rpt. No.:	2000-0482
Responsible Mgr.:	M. Crocker
Responsible Dir.:	M. Ferri
Target Date:	9/17/2000 12:00:00 AM
Corrective Actions:	Counseled employees regarding rad postings.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	**00-405**
Originator:	
Project:	776/777
Date Entered:	10/25/2000 12:00:00 AM
Event Date:	10/24/2000 12:00:00 AM
Status:	CLOSED
DateClosed:	11/6/2000 12:00:00 AM
Building:	776
Location:	134
Description:	While performing evolution, employee's right Saranex sleeve rolled up exposing his right arm, covered by the single set. Bare right arm was found to have 3,000 dpm.
RS Supervisor	S. R. Fields
Immediate Corrective Action:	Full body monitor at job site, then employee was taken to decon room. Anti-c sleeve was removed at site. Tape press was performed and employee was deconned to
Primary Event Code:	B4
Secondary Event Codes:	
Apparent Cause:	EQUIPMENT
Facility Mgr:	K.Smith
DOE Categorization:	Completed
Occurrence Rpt. No.:	2000-0632
Responsible Mgr.:	G. T. Chandler
Responsible Dir.:	M. Ferri
Target Date:	11/23/2000 12:00:00 AM
Corrective Actions:	Fact finding meeting was held. Cause was tape came loose from nitrile glove and saranex arm sleeve. Additional gloves (long sleeve surgeons) will be worn under saranex and saranex will be taped to surgeon gloves at the wrist. RWP & JHA changed to reflect this method. Long term-a longer nitrile glove is on order.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	**00-413**
Originator:	
Project:	776/777
Date Entered:	10/31/2000 12:00:00 AM
Event Date:	10/30/2000 12:00:00 AM
Status:	CLOSED
DateClosed:	11/6/2000 12:00:00 AM
Building:	776
Location:	
Description:	While working in glovebox, found 10,000 dpm on anti-c glove. Possible PI.
RS Supervisor	W. J. Sutton
Immediate Corrective Action:	Removed anti-c glove, contained glovebox glove, performed PI. Result of PI 6.25
Primary Event Code:	B13
Secondary Event Codes:	
Apparent Cause:	EQUIPMENT
Facility Mgr:	K. Smith
DOE Categorization:	Completed
Occurrence Rpt. No.:	
Responsible Mgr.:	G. T. Chandler
Responsible Dir.:	M. Ferri
Target Date:	11/29/2000 12:00:00 AM
Corrective Actions:	Follow up bioassay will be performed in accordance with internal dosimetry procedures. No further action required.
PATS No.:	
Comments:	

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Radiation Protection
Radiological Improvement Reports (RIR)

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Radiological Improvement Report Details

RIR No.:	**00-467**
Originator:	
Project:	776/777
Date Entered:	12/4/2000 12:00:00 AM
Event Date:	12/4/2000 12:00:00 AM
Status:	CLOSED
DateClosed:	1/8/2001 12:00:00 AM
Building:	776
Location:	154A
Description:	During glove change, the old glove slipped off port. While adjusting glove, contamination was detected on personnel's anti-c gloves 500,000 dpm and CAMs went into alarm.
RS Supervisor	W. J. Sutton
Immediate Corrective Action:	Stopped work, put glove port in safe configuration, notified supervision, full body frisk of all personnel.
Primary Event Code:	B5
Secondary Event Codes:	B11, B13, B16, C9
Apparent Cause:	EQUIPMENT
Facility Mgr:	J. Auxier
DOE Categorization:	Completed
Occurrence Rpt. No.:	2000-0721
Responsible Mgr.:	G. T. Chandler
Responsible Dir.:	M. Ferri
Target Date:	1/3/2001 12:00:00 AM
Corrective Actions:	Decon area and removed contaminated anti-c from individual. No skin or clothing contamination occurred. Follow up bioassay will be in accordance with Internal Dosimetry procedures. Area returned to CA status after decontamination.
PATS No.:	
Comments:	

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Radiation Protection
Radiological Improvement Reports (RIR)

Welcome,
Steve Trujillo

Radiological Improvement Report Details

RIR No.:	01-006
Originator:	
Project:	776/777
Date Entered:	1/8/2001 12:00:00 AM
Event Date:	1/5/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	3/8/2001 12:00:00 AM
Building:	776
Location:	452
Description:	At approximately 1015, employee removed his hands from glovebox 26, room 452 and had his hands checked by an RCT. 100,000 dpm was found on his left hand (index finger) anti-c glove tip.
RS Supervisor	S. R. Fields
Immediate Corrective Action:	Notified supervision, went to decon room and removed contaminated anti-c glove. No skin contamination was found. Performed nasal, mouth swabs.
Primary Event Code:	B11
Secondary Event Codes:	B13
Apparent Cause:	EQUIPMENT
Facility Mgr:	N. A. Holmes
DOE Categorization:	Completed
Occurrence Rpt. No.:	2001-0004
Responsible Mgr.:	G. T. Chandler
Responsible Dir.:	M. Ferri
Target Date:	2/4/2001 12:00:00 AM
Corrective Actions:	Glvoe was replaced on the Glovebox due to failure. No other spread of contamination occurred. Follow up bioassay will be performed in accordance with Internal Dosimetry procedures.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	**00-371**
Originator:	
Project:	776/777
Date Entered:	9/21/2000 12:00:00 AM
Event Date:	9/20/2000 12:00:00 AM
Status:	CLOSED
DateClosed:	10/2/2000 12:00:00 AM
Building:	776
Location:	152
Description:	Used wrong dosimeter badge. Self reported when he saw he had used wrong dosimeter.
RS Supervisor	W. J. Sutton
Immediate Corrective Action:	Pulled dosimeter. Did dose reconstruction of area.
Primary Event Code:	C1
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	J. D. Auxier
DOE Categorization:	Completed
Occurrence Rpt. No.:	2000-0544
Responsible Mgr.:	G. T. Chandler
Responsible Dir.:	M. Ferri
Target Date:	10/20/2000 12:00:00 AM
Corrective Actions:	Individual counseled on looking at TLD when retrieving it from storage board. Recommended to individual to also use bar code reader on HIS 20 terminal. Surveys performed in work area and forwarded to external dosimetry for dose reconstruction.
PATS No.:	
Comments:	

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Radiation Protection
Radiological Improvement Reports (RIR)

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Radiological Improvement Report Details

RIR No.:	**01-161**
Originator:	
Project:	776/777
Date Entered:	4/12/2001 12:00:00 AM
Event Date:	4/10/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	4/30/2001 12:00:00 AM
Building:	776
Location:	433
Description:	Worked in CA without TLD.
RS Supervisor	S. R. Fields
Immediate Corrective Action:	Took TLD from employee. Performed dose reading in area where employee worked.
Primary Event Code:	B3
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	N. A. Holmes
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	G. T. Chandler
Responsible Dir.:	M. Ferri
Target Date:	5/10/2001 12:00:00 AM
Corrective Actions:	Performed gamma and neutron surveys in the areas that the individual transversed and worked. Sent individual to external dosimetry for dose reconstruction.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	**01-343**
Originator:	
Project:	776/777
Date Entered:	8/1/2001 12:00:00 AM
Event Date:	8/1/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	10/29/2001 12:00:00 AM
Building:	776
Location:	
Description:	Violated RWP 01-776-0201 by not wearing TLD during JHA walkdown in room 430, 437, and 463.
RS Supervisor	J. Satterfield
Immediate Corrective Action:	Counseled employee to slow down and double check all PPE prior to entry into hazardous area.
Primary Event Code:	B3
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	R. A. Russell
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	M. W. Johnson
Responsible Dir.:	M. Ferri
Target Date:	8/31/2001 12:00:00 AM
Corrective Actions:	Individual wore dosimeter into back area with him. Accidentally took it off and placed in into bump cap to put his respirator on at the SOP dress out area. He then walked into the area without TLD to perform a job walkdown. Individual was counseled on attention to detail.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	01-185
Originator:	
Project:	776/777
Date Entered:	4/26/2001 12:00:00 AM
Event Date:	4/26/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	6/12/2001 12:00:00 AM
Building:	776
Location:	
Description:	Employee wore wrong TLD in the back area of bldg. 776/777.
RS Supervisor	W. J. Sutton
Immediate Corrective Action:	Exited area. Checked with Rad Foreman. Performed rad reconstruction.
Primary Event Code:	C1
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	T. A. Ferris
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	G. T. Chandler
Responsible Dir.:	M. Ferri
Target Date:	5/26/2001 12:00:00 AM
Corrective Actions:	Both individuals took tlds to external dosimetry for exchange. Employee will have dose reconstruction performed in accordance with external dosimetry procedures.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	01-359
Originator:	
Project:	776/777
Date Entered:	8/16/2001 12:00:00 AM
Event Date:	8/15/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	8/20/2001 12:00:00 AM
Building:	776
Location:	104C
Description:	While doing bagouts put a hole in corner of bag. Employee got 400,000 dpm on right anti-c glove and 400,000 dpm on coveralls.
RS Supervisor	G. T. Chandler
Immediate Corrective Action:	Contained contamination on coveralls, removed coveralls and gloves. Employee was then surveyed at SOP with NE Tech Electra >MDA.
Primary Event Code:	B5
Secondary Event Codes:	B13
Apparent Cause:	PERSONNEL
Facility Mgr:	N. H. Holmes
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	G. T. Chandler
Responsible Dir.:	M. Ferri
Target Date:	9/14/2001 12:00:00 AM
Corrective Actions:	Area was decontaminated and returned to CA status. Follow up bioassay on individual will be in accordance with Internal Dosimetry procedures.
PATS No.:	
Comments:	

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RIR No.:	01-361
Originator:	
Project:	776/777
Date Entered:	8/20/2001 12:00:00 AM
Event Date:	8/16/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	8/20/2001 12:00:00 AM
Building:	776
Location:	437
Description:	While performing D&D work under RWP 01-776-3201, CAM #19 went into alarm. In two subsequent recovery efforts. The CAM again alarmed. All three CAMs were positive.
RS Supervisor	J. Mattson
Immediate Corrective Action:	Room was evacuated each time. Air sampling was performed for each re-entry. Working DACs were performed each time as well. All working DACs were <50 DAC. PI factor calculations performed. All <1.0. Notifications made to appropriate personnel each time.
Primary Event Code:	C9
Secondary Event Codes:	
Apparent Cause:	EQUIPMENT
Facility Mgr:	R. Thomas
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	G. T. Chandler
Responsible Dir.:	M. Ferri
Target Date:	9/15/2001 12:00:00 AM
Corrective Actions:	All alarms were chronic (720 second) alarm. The use of a drape with appropriate ventilation was used. An ABC fixative was used prior to the last alarm and will be re-applied under the drape/ventilation prior to further dismantlement of the wall.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	01-383
Originator:	
Project:	371/374
Date Entered:	8/30/2001 12:00:00 AM
Event Date:	8/30/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	9/5/2001 12:00:00 AM
Building:	776
Location:	131
Description:	While working in the glovebox under RWP 01-776-3201, individual exited gloves and was found to have 6,000 dpm on the left elbow are of his anti-c coveralls. This results in a level I PI. PIF=3.75
RS Supervisor	J. Mattson
Immediate Corrective Action:	Contained contamination. Made notifications. Performed nasal/mouth samples.
Primary Event Code:	B13
Secondary Event Codes:	
Apparent Cause:	EQUIPMENT
Facility Mgr:	N. A. Holmes
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	G. T. Chandler
Responsible Dir.:	M. S. Spears
Target Date:	9/29/2001 12:00:00 AM
Corrective Actions:	Actions taken were in accordance with approved procedures. No other spread of contamination occurred or was found. Follow up bioassay will be in accordance with Internal Dosimetry procedures.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	01-433
Originator:	
Project:	776/777
Date Entered:	10/5/2001 12:00:00 AM
Event Date:	10/5/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	10/18/2001 12:00:00 AM
Building:	776
Location:	134E
Description:	Removing lead on D line, operator had 50,000 dpm on right front pant leg. Performed several tape presses, levels came down to 3,000 dpm. Contained with tape and sent to decon room. PI 1.28 Level I.
RS Supervisor	S. R. Fields
Immediate Corrective Action:	Whole body frisk of all personnel and survey of area. No spread of contamination. Worker taken to decon room for removal of anti-cs. No skin contamination. Performed nasal/mouth swabs on worker.
Primary Event Code:	O
Secondary Event Codes:	
Apparent Cause:	EQUIPMENT
Facility Mgr:	N. A. Holmes
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	G. T. Chandler
Responsible Dir.:	M. Ferri
Target Date:	11/4/2001 12:00:00 AM
Corrective Actions:	No other contamination spread was found or occurred. Follow up bioassay will be performed in accordance with Internal Dosimetry procedures.
PATS No.:	
Comments:	PA# KH-2001-3020

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Radiation Protection
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Radiological Improvement Report Details

RIR No.:	01-472
Originator:	
Project:	776/777
Date Entered:	11/29/2001 12:00:00 AM
Event Date:	11/28/2001 12:00.00 AM
Status:	CLOSED
DateClosed:	12/14/2001 12:00:00 AM
Building:	776
Location:	158
Description:	After emptying trash into IP2, 5,000 dpm was found on employee's anti-c gloves, 100,000 dpm was found on floor, 1,000,000 dpm/100cm2 was found on plastic bag. PI results 2.5.
RS Supervisor	S. R. Fields
Immediate Corrective Action:	Anti-c gloves were removed, personnel exited and the room posted ARA, HCA. Re-entered area to containe IP2 and decon the floor.
Primary Event Code:	O
Secondary Event Codes:	O-G
Apparent Cause:	PERSONNEL/Equipment
Facility Mgr:	A. W. Smith
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	G.T. Chandler
Responsible Dir.:	M. Ferri
Target Date:	12/28/2001 12:00:00 AM
Corrective Actions:	Individual had nasal/mouth swabs taken. Follow up bioassay will be in accordance with Internal Dosimetry Procedure. IP-2 waste crate was moved to room 144 and posted as ARA from this point forward. The waste bin liner will be removed from the bin and taped closed, rather than dumping the bin to save the liner, from this point forward. The waste will be taped closed and placed in the IP-2 crate in a properly posted ARA with air sampling in the airflow of the work being performed. Room 144 is now and will remain negative to the surrounding area while waste operations are being performed.
PATS No.:	
Comments:	PA# KH-2001-3085

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Radiological Improvement Report Details

RIR No.:	01-480
Originator:	
Project:	776/777
Date Entered:	12/18/2001 12:00:00 AM
Event Date:	12/13/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	12/20/2001 12:00:00 AM
Building:	776
Location:	131
Description:	While removing tape from a flange on the underside of glovebox 627, a CAM alarmed. Working DAC was 5,904 DAC. Room evacuated when CAM alarmed.
RS Supervisor	S. R. Fields
Immediate Corrective Action:	RCTs performed a whole body frisk of all personnel. Nasal, mouth swabs taken on all personnel that were in the room (see above). Air sampling performed prior to re-entry. Area decontaminated after entry. No personnel contamination. CAM was a 720 second alarm with an average of 2.19 DAC and a threshold of 2.16 DAC.
Primary Event Code:	J
Secondary Event Codes:	O-G, O-H
Apparent Cause:	PERSONNEL/EQUIPMENT
Facility Mgr:	A. W. Smith
DOE Categorization:	Completed
Occurrence Rpt. No.:	2001-0631
Responsible Mgr.:	G. T. Chandler
Responsible Dir.:	M. Ferri
Target Date:	1/13/2002 12:00:00 AM
Corrective Actions:	Nasal/mouth swabs taken. Results back. All less than decision level. Fecal kits issued. Follow up bioassay sampling will be in accordance with Internal Dosimetry procedures. All actions taken in response to alarm was correct. Follow up corrective action, if applicable, will be in accordance with OR.
PATS No.:	
Comments:	PA# KH-2001-3098

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Radiological Improvement Report Details

RIR No.:	T-01-025
Originator:	
Project:	
Date Entered:	12/18/2001 12:00:00 AM
Event Date:	12/17/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	
Building:	776
Location:	134 East
Description:	While preparing a valve sleeving for a pigtail cut, a portable CAM alarmed in room 134 East. The worker identified above was contaminated on his outer layer of anti-cs and was also found to be contaminated on his yellow anti-cs. Contamination was spread and confined to the tope of the glovebox.
RS Supervisor	S. R. Fields
Immediate Corrective Action:	Personnel evacuated area. The RCTs performed whole body monitoring. Air sampling was performed. Nasal/mouth swabs were taken on the individual listed above. Worker's re-entered area after air sampling results to decontaminate the spill.
Primary Event Code:	O-G
Secondary Event Codes:	O-H
Apparent Cause:	
Facility Mgr:	R. Thomas
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	
Responsible Dir.:	
Target Date:	1/17/2002 12:00:00 AM
Corrective Actions:	
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	T-02-004.1
Originator:	
Project:	776/777
Date Entered:	1/15/2002 12:00:00 AM
Event Date:	1/14/2002 12:00:00 AM
Status:	CLOSED
DateClosed:	1/15/2002 12:00:00 AM
Building:	776
Location:	Rooms 127/430
Description:	Individual lifted his respirator off his face to talk to a co-worker(s).
RS Supervisor	J. Satterfield
Immediate Corrective Action:	Person removed from ARA, CA, RBA. Nasal/mouth swabs performed. Internal Dosiemtry notified.
Primary Event Code:	O-A
Secondary Event Codes:	
Apparent Cause:	
Facility Mgr:	J. D. Auxier
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	
Responsible Dir.:	M. Ferri
Target Date:	2/14/2002 12:00:00 AM
Corrective Actions:	
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	02-068
Originator:	
Project:	776/777
Date Entered:	4/10/2002 12:00:00 AM
Event Date:	4/10/2002 12:00:00 AM
Status:	CLOSED
DateClosed:	4/29/2002 12:00:00 AM
Building:	776
Location:	West Dock
Description:	Individual entered RBA without proper dosimetry.
RS Supervisor	S. R. Fields
Immediate Corrective Action:	Retrieved employee's TLD. Performed dose reconstruction survey. Sent employee to External Dosimetry.
Primary Event Code:	S
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	A. W. Smith
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	W. Sproles
Responsible Dir.:	Mark Ferri
Target Date:	5/10/2002 12:00:00 AM
Corrective Actions:	Counseled employee on wearing dosimeter in radiological posted areas.
PATS No.:	
Comments:	PA # KH-2002-0129.

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Radiological Improvement Report Details

RIR No.:	**02-070**
Originator:	
Project:	776/777
Date Entered:	4/11/2002 12:00:00 AM
Event Date:	4/10/2002 12:00:00 AM
Status:	CLOSED
DateClosed:	4/29/2002 12:00:00 AM
Building:	776
Location:	SRU
Description:	Air sample DAC exceeding respiratory protection factor. 116 DAC. Drum repack work required APR's (full-face air purifying respirators).
RS Supervisor	J. Satterfield
Immediate Corrective Action:	Contacted supervisor. However all workers had either ate, drank, or smoked prior to being informed. PI worksheet factor is 0.0145. Started DAC-hr Tracking for all concerned individuals.
Primary Event Code:	T
Secondary Event Codes:	
Apparent Cause:	EQUIPMENT
Facility Mgr:	R. Thomas
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	G. Chandler
Responsible Dir.:	Mark Ferri
Target Date:	5/10/2002 12:00:00 AM
Corrective Actions:	No other contamination was detected in the work area or on individuals involved in the work. The air filter was suspected of being cross contaminated and quartered The results of counting the filter in quarters indicates the sample could have been mishandled.
PATS No.:	
Comments:	*PA# KH-2002-0128.*

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Radiation Protection
Radiological Improvement Reports (RIR)

Welcome,
Steve Trujillo

Radiological Improvement Report Details

RIR No.:	02-079
Originator:	
Project:	776/777
Date Entered:	5/2/2002 12:00:00 AM
Event Date:	4/30/2002 12:00:00 AM
Status:	CLOSED
DateClosed:	5/20/2002 12:00:00 AM
Building:	776
Location:	131
Description:	While cutting into a machine coolant line the CAMs in the room alarmed (6 total - 2 room CAMs & 4 Portables). All CAMs were set at 20 DAC hr thresholds. Contamination was spread over an area of approximately 600 square feet. Contamination was also detected on outer Seranex of two workers, the respirator filters of one worker. Working under RWP# 02-776-3201.
RS Supervisor	S. R. Fields
Immediate Corrective Action:	Tape was immediately placed over the cut in the pipe. All personnel evacuated the room and were whole body frisked. The worker who was performing the cut had 8K dpm on one respirator filter, and 7K dpm on the other. 4K dpm was detected on the anti-C Hood of the same worker. Both workers had 1K dpm on the outer Seranex. There was no modesty or skin contamination. Nasal/Mouth swipes were taken on the two D&D workers. Air samples were started for re-entry purposes. Once determined safe, the CAMs were reset, working DAC samples retrieved and counted, and a decon plan established for clean up. The D&D workers and the RCT were sent to Internal Dosimetry for Bioassay determination the next
Primary Event Code:	K
Secondary Event Codes:	O, O-G
Apparent Cause:	PERSONNEL
Facility Mgr:	R. Thomas
DOE Categorization:	Completed
Occurrence Rpt. No.:	
Responsible Mgr.:	Gary Chandler
Responsible Dir.:	Mark Ferri
Target Date:	5/30/2002 12:00:00 AM
Corrective Actions:	Fact Finding meeting and corrective actions meeting was held. Nasal results on 1st individual < Decision level. Nasals on 2nd individual > Decision level. Nasals on RCT were not taken due to his error. Follow-up bioassay will be in accordance w/ Int. Dos. Procecures. Corrective actions

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Radiation Protection
Radiological Improvement Reports (RIR)

Welcome,
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Radiological Improvement Report Details

RIR No.:	T-02-044
Originator:	
Project:	776/777
Date Entered:	5/2/2002 12:00:00 AM
Event Date:	5/1/2002 12:00:00 AM
Status:	CLOSED
DateClosed:	5/2/2002 12:00:00 AM
Building:	776
Location:	154 B
Description:	45 minutes after personnel left room 154B a room CAM alarmed. Results was positive.
RS Supervisor	J. Mattson
Immediate Corrective Action:	RCT responded. Pulled air sample and performed survey. DAC= 3.17. No contamination detected. Notification made.
Primary Event Code:	O-H
Secondary Event Codes:	
Apparent Cause:	
Facility Mgr:	R. Thomas
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	
Responsible Dir.:	Mark Ferri
Target Date:	6/1/2002 12:00:00 AM
Corrective Actions:	
PATS No.:	
Comments:	

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Radiation Protection
Radiological Improvement Reports (RIR)

Radiological Improvement Report Details

RIR No.:	**02-082**
Originator:	
Project:	776/777
Date Entered:	5/8/2002 12:00:00 AM
Event Date:	5/7/2002 12:00:00 AM
Status:	CLOSED
DateClosed:	5/20/2002 12:00:00 AM
Building:	776
Location:	131
Description:	02-776-3201, Personnel handed tape into a HCA and rubbed against a wet, contaminated piece of lead on a little cart. Person was not wearing 2 pr of tyvex. Person had 10K on yellow anti-C's. We removed anti-C's and found 1000 dpm/100 cm on modesty shirt & cut off. No skin contamination.
RS Supervisor	J. Satterfield
Immediate Corrective Action:	Contaminated area of modesty clothing was cut off of indivudal. Individual surveyed for skin contamination - none found. After leaving CA, the individual cleared the PC unit.
Primary Event Code:	Q
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	R. Russell
DOE Categorization:	Completed
Occurrence Rpt. No.:	
Responsible Mgr.:	Gary Chandler
Responsible Dir.:	Mark Ferri
Target Date:	6/6/2002 12:00:00 AM
Corrective Actions:	Counselled individual on leaving the work area when he is not in the same PPE as his fellow workers or don the appropriate PPE.
PATS No.:	
Comments:	Price Anderson Screen initiated? - Yes PA report/event # KH-2002-0161

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Radiological Improvement Report Details

RIR No.:	T-02-049
Originator:	
Project:	776/777
Date Entered:	5/31/2002 12:00:00 AM
Event Date:	5/29/2002 12:00:00 AM
Status:	CLOSED
DateClosed:	5/31/2002 12:00:00 AM
Building:	776
Location:	154A
Description:	Workers were removing tape from GB 501 under RWP 02-776-3227. Point source ventilation was in place but contamination escaped the capture area. The result was 2 positive CAMs and spread of contamination. Levels were up to 30,000 dpm on the floor and >10E6 dpm on the point source funnel.
RS Supervisor	Jerry Mattson
Immediate Corrective Action:	Room was evacuated. Air sampling performed for re-entry. Recovery and decon of area performed. Made notifactions. The working DAC during decon and recovery was 8.27 however, it is believed that the sample head was too close to the source of contamination and not representative of the workers breathing zone. One of the crew was wearing a lapel sampler DAC results on filter >5.64.
Primary Event Code:	O-G
Secondary Event Codes:	O-H
Apparent Cause:	
Facility Mgr:	Rhonda Thomas
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	
Responsible Dir.:	Mark Ferri
Target Date:	1/1/1900 12:00:00 AM
Corrective Actions:	
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	**02-109**
Originator:	
Project:	776/777
Date Entered:	6/24/2002 12:00:00 AM
Event Date:	6/22/2002 12:00:00 AM
Status:	CLOSED
DateClosed:	7/8/2002 12:00:00 AM
Building:	776
Location:	Pad
Description:	When pulling a glovebox that would not fit into a cargo, the waste crew rubbed the side of the glovebox along the inside of the cargo container breaking the glovebox and contaminating the insides of the cargo and releasing contamination onto the asphalt outside of the container.
RS Supervisor	Satterfield
Immediate Corrective Action:	Stopped work, notified CCA. Surveyed glovebox, ground, and inside cargo container up to 3 feet inside container. Contained all contamination found with tape. Closed and sealed cargo doors. Notified shift superintendant. The area isolated, resurveyed, and all contamination was contained using paint.
Primary Event Code:	D
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	R.A. Russell
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	Gary Chandler
Responsible Dir.:	Mark Ferri
Target Date:	7/23/2002 12:00:00 AM
Corrective Actions:	All personnel responded to incident correctly. For more info on corrective actions see Occur. Report 2002-300.
PATS No.:	
Comments:	PA Screen - #KH-2002-0210 = Minor

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Radiological Improvement Report Details

RIR No.:	**02-129**
Originator:	
Project:	776/777
Date Entered:	7/29/2002 12:00:00 AM
Event Date:	7/26/2002 12:00:00 AM
Status:	CLOSED
DateClosed:	8/12/2002 12:00:00 AM
Building:	776
Location:	154A
Description:	While performing D&D work in the overhead of room 154A, a release of contaminaiton ocured. This resulted in one individual receiving a level 2 potential inhalation and another person getting skin contamination. PI factor was calculated to equal 20. Initial skin contamination level was 1800 dpm. There were 2 positive CAM's associated with the event.
RS Supervisor	Jerry Mattson
Immediate Corrective Action:	RCT's surveyed personnel out of the area. Person with skin contamination was successfully deconned in the building. Person with level 2 PI was given nasal/mouth sample kit. All other individuals in the room submitted nasal/mouth samples as a precaution. Air sampling performed to re-enter room. Results <50 DAC. Decon efforts initiated. All notifications made.
Primary Event Code:	H
Secondary Event Codes:	O, O-G, O-H
Apparent Cause:	EQUIPMENT
Facility Mgr:	J.D. Auxier
DOE Categorization:	Completed
Occurrence Rpt. No.:	
Responsible Mgr.:	Gary Chandler
Responsible Dir.:	Mark Ferri
Target Date:	8/28/2002 12:00:00 AM
Corrective Actions:	All personnel involved had nasal/mough swabs taken. All results from lab were
PATS No.:	
Comments:	PA# - KH-2002-0229 - Minor

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Radiological Improvement Report Details

RIR No.:	T-02-072
Originator:	
Project:	776/777
Date Entered:	8/1/2002 12:00:00 AM
Event Date:	7/31/2002 12:00:00 AM
Status:	CLOSED
DateClosed:	8/1/2002 12:00:00 AM
Building:	776
Location:	R146
Description:	Exceeded protection factor of respiratory protection during application of CC-FIX inside room 146 (size reduction vault). The CC-FIX was sprayed into a drum which caused the release of contamination into the air.
RS Supervisor	J. Satterfield
Immediate Corrective Action:	Upon determination of the protection factor exceeded, work was stopped and the room evacuated. Breathing lo-vol and all lapels were counted to determine DAC levels. Precautionary nasal and mouth swipes taken on all individuals in the SRV.
Primary Event Code:	O-L
Secondary Event Codes:	
Apparent Cause:	
Facility Mgr:	N.A. Holmes
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	
Responsible Dir.:	Mark Ferri
Target Date:	8/31/2002 12:00:00 AM
Corrective Actions:	
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	**02-158**
Originator:	
Project:	707/776/777
Date Entered:	9/5/2002 12:00:00 AM
Event Date:	9/4/2002 12:00:00 AM
Status:	CLOSED
DateClosed:	9/25/2002 12:00:00 AM
Building:	776
Location:	
Description:	3 positive CAM alarms while cutting on transition piece. The Ionex Air Mover shut down due to being "Dead Headed." The air mover was being used to maintain a negative pressure on system during D&D activities.
RS Supervisor	J. Satterfield
Immediate Corrective Action:	Put work in safe condition and responded in accordance with RSP 4.01. Restarted Ionex Air Mover & lower HE. Deconned work area.
Primary Event Code:	K
Secondary Event Codes:	O-D, O-G
Apparent Cause:	EQUIPMENT
Facility Mgr:	A.W. Smith
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	Gary Chandler
Responsible Dir.:	Mark Ferri
Target Date:	10/4/2002 12:00:00 AM
Corrective Actions:	Electrical troubleshooting of the air mover and electrical supply (Bargboard) was performed. The air mover and tagged suspecting a malfunction in the voltage regulator. Contacting manufacturer for information and replacement parts. Another air mover installed to finish the P&D work in Rm 131.
PATS No.:	
Comments:	PA# KH-2002-0254 - N/A

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Radiation Protection
Radiological Improvement Reports (RIR)

Welcome,
Steve Trujillo

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RIR No.:	**02-159**
Originator:	
Project:	707/776/777
Date Entered:	9/12/2002 12:00:00 AM
Event Date:	9/5/2002 12:00:00 AM
Status:	CLOSED
DateClosed:	9/25/2002 12:00:00 AM
Building:	776
Location:	146 Size Reduction Vault
Description:	After exiting the SRV in premaire respiratory protection the above mentioned workers failed to submit nasal/mouth swabs to Radiological Operations per procedure RSP 04.04 section 7.4(3) page 17. Lapel air sampling resulted in 35 DAC for Mr. Champlain and 9.4 DAC for Mr. Rielley.
RS Supervisor	S. R. Fields
Immediate Corrective Action:	Attempts were made to contact workers. One worker reported to the Rad Ops office too late, and the other never showed. Thier TLDs are being held in the Rad Ops office until a determination is made. The individual's supervisor and the CCA were notified of this action.
Primary Event Code:	J
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	J. D. Auxier
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	Mark Crocker
Responsible Dir.:	Mark Ferri
Target Date:	10/12/2002 12:00:00 AM
Corrective Actions:	Counseled employees as to severity of procedure compliance (not following procedural requirements in order to properly track dose)
PATS No.:	
Comments:	PA #KH-2002-0255 - minor

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Radiological Improvement Report Details

RIR No.:	**02-190**
Originator:	
Project:	707/776/777
Date Entered:	9/27/2002 10:48:00 AM
Event Date:	9/25/2002 9:20:00 AM
Status:	CLOSED
DateClosed:	10/21/2002 12:00:00 AM
Building:	776
Location:	776/Room 146A & B, and room 134
Description:	During D & D in the size reduction vault (SRV), three continuous air monitors (CAMs) alarmed. Personnel were cleaning an area in the SRV when a ladder was inadvertently knocked over. It fell into the door of the vault causing it to open into the airlock (Room 146A). The CAMs in Room 146A, then 134, then 146B alarmed. Two individuals received Level 2 potential intake calculation. Nasal/mouth smears and lung counts were both less than decision level. An additional 12 individuals in Room 134 had potential intakes at Level 1. All workers were shole body frisked. 12,000 disintegrations per minute (dpm) was detected on one worker's anti-contamination clothing (worker was in Room 146A). Areas on the floor around the doorways were identified with from 2,000 to 10,000 dpm. All areas were decontaminated.
RS Supervisor	S.R. Fields
Immediate Corrective Action:	Workers were whole body frisked by the RCT. 12000 dpm was detected on one worker's anti-Cs from room 146A. Announcements were made and the area posted. Air sampling was performed. Nasal/Mouth swabs were taken.
Primary Event Code:	K
Secondary Event Codes:	
Apparent Cause:	PEOPLE
Facility Mgr:	J. D. Auxier
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	Gary Chandler
Responsible Dir.:	Mark Ferri
Target Date:	10/27/2002 10:48:00 AM
Corrective Actions:	All nasal/mouth swabs were less than decision level. Both individuals with Level 2 had lung counts that were less than decision level. Any further follow-up actions will be in accordance with Internal Dosimetry procedures based on fecal sample results.
PATS No.:	N/A

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Radiation Protection
Radiological Improvement Reports (RIR)

Welcome, **Steve Trujillo**

Radiological Improvement Report Details

RIR No.:	**02-199**
Originator:	
Project:	707/776/777
Date Entered:	10/3/2002 5:34:00 PM
Event Date:	10/3/2002 3:00:00 AM
Status:	CLOSED
DateClosed:	10/30/2002 12:00:00 AM
Building:	776
Location:	776
Description:	Indications from TLD reading were that an employee exceeds ACL of 750 mrem
RS Supervisor	S. R. Fields
Immediate Corrective Action:	The worker's TLD was pulled until an investigation could be initiated. History was reviewed through surveys to determine the source of dose.
Primary Event Code:	O-P
Secondary Event Codes:	
Apparent Cause:	EQUIPMENT
Facility Mgr:	Mike Casey
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	Gary Chandler
Responsible Dir.:	Ferri
Target Date:	11/2/2002 5:34:00 PM
Corrective Actions:	An investigation meeting was held. Minutes of that meeting may be found with the original RIR. Cause was determined to be an over-response of a chip in the dosimeter. Recalculations were completed with a different chip. The assigned dose does not exceed the ACL.
PATS No.:	N/A
Comments:	

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Radiological Improvement Report Details

RIR No.:	02-217
Originator:	
Project:	707/776/777
Date Entered:	10/18/2002 10:37:00 AM
Event Date:	10/18/2002 9:40:00 AM
Status:	CLOSED
DateClosed:	10/31/2002 12:00:00 AM
Building:	776
Location:	776/room 134W ASRF
Description:	A D & D worker received a puncture (needle-like) wound to the right index finger while working in the ASRF. The source was apparently a wire from a braided cable that had been cut by plasma arc several years ago. 600 disintegrations per minute per 100 square centimeters (dpm) was found on the skin. Wound count was positive at OMD.
RS Supervisor	Jerry Mattson
Immediate Corrective Action:	600 dpm detected at location of wound. The wound was covered and the individual was escorted to OMD. Multiple decontamination efforts failed. An initial "core cut" sample and second one failed to lower the levels of contamination. Additional wound counts have been scheduled. Bioassay and follow-up performed.
Primary Event Code:	G
Secondary Event Codes:	H
Apparent Cause:	EQUIPMENT
Facility Mgr:	R. A. Russell
DOE Categorization:	Completed
Occurrence Rpt. No.:	2002-0448
Responsible Mgr.:	Gary Chandler
Responsible Dir.:	Mark Ferri
Target Date:	11/17/2002 12:00:00 AM
Corrective Actions:	A manager's meeting was held. Follow-up bioassay sampling will be in accordance with Internal Dosimetry and fecal samplin results. Complete list of corrective actions and further information available at RFO–KHLL-SOLIDWST-2002-0065.
PATS No.:	N/A
Comments:	

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Radiation Protection
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Welcome,
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Radiological Improvement Report Details

RIR No.:	02-268
Originator:	
Project:	707/776/777
Date Entered:	12/10/2002 7:10:00 AM
Event Date:	12/5/2002 3:00:00 PM
Status:	CLOSED
DateClosed:	12/16/2002 12:00:00 AM
Building:	776
Location:	Plenum 205, 1st Stage
Description:	While exiting the SOP a D&D worker who had completed working in the 205 1st Stage Plenum discovered that his bump cap had elevated levels using the Electra. The RCT at the SOP then discovered 1044 dpm on the worker's forehead while performing a whole body frisk.
RS Supervisor	Randy Fields
Immediate Corrective Action:	The bump cap was placed into a plastic bag and treated at radiological waste. A tape press was not performed on the cap because it was very wet with perspiration. Due to heavy perspiration, a tape press was not initially performed on the worker's forehead; however, after a wet dab on the forehead the tape press was performed. No contamination was transferred to the tape. The worker was successfully decontaminated in the building. The worker then cleared the PCM-2. Nasal/mouth smears were taken and the worker was sent to Internal Dosimetry.
Primary Event Code:	H
Secondary Event Codes:	
Apparent Cause:	PEOPLE
Facility Mgr:	Adam Smith
DOE Categorization:	Completed
Occurrence Rpt. No.:	2002-0496
Responsible Mgr.:	Gary Chandler
Responsible Dir.:	Mark Ferri
Target Date:	1/9/2003 12:00:00 AM
Corrective Actions:	The individual's lung count was
PATS No.:	N/A
Comments:	

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Radiation Protection
Radiological Improvement Reports (RIR)

Welcome,
Steve Trujillo

Radiological Improvement Report Details

RIR No.:	03-008
Originator:	
Project:	707/776/777
Date Entered:	1/20/2003 8:44:00 AM
Event Date:	1/15/2003 9:30:00 AM
Status:	CLOSED
DateClosed:	1/21/2003 12:00:00 AM
Building:	776
Location:	Building 776, Rooms 154-A and 37
Description:	While installing the air mover to the exhaust pipe, a small hole was noticed in the containment bag. A further survey showed 10,000 dpm on the bag and 20,000 dpm on the floor. While attempting to contain the contamination in Room 154-1, CAM #7 alarmed followed by CAMS #6 and #3. Approximately 20 minutes later, CAM #46 alarmed in Room 237.
RS Supervisor	James Bartlett
Immediate Corrective Action:	All personnel exited Room 154 and were surveyed (
Primary Event Code:	O-G
Secondary Event Codes:	
Apparent Cause:	PEOPLE
Facility Mgr:	R. A. Russell
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	Gary Chandler
Responsible Dir.:	Mark Ferri
Target Date:	2/19/2003 12:00:00 AM
Corrective Actions:	All personnel responded appropriately. One individual had nasal/mouth swabs at decision level. All other individuals were less than decision level. For follow-up and more information, see Occurrence Report RFO–KHLL-SOLIDWST-2003-0002 (Tracking Number 2003-0010), which was filed as a potential management concern for this and other observations.
PATS No.:	N/A
Comments:	

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- Radiation Generating Devices (RGD)
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Radiological Improvement Report Details

RIR No.:	**03-042**
Originator:	
Project:	707/776/777
Date Entered:	2/28/2003 8:01:00 AM
Event Date:	2/27/2003 10:15:00 AM
Status:	CLOSED
DateClosed:	3/13/2003 12:00:00 AM
Building:	776
Location:	776 SOP
Description:	Contamination was detected on modesty clothing during personnel survey in PCM 2. Tape press by RCT found 3,643 dpm on approximatly 1 square inch of his upper left leg modesty clothing. This equates to 227 dpm / 100cm2. Nasal - mouth swabs were taken (PIF = 1.8) and person was referred to internal dosimetry.
RS Supervisor	James Bartlett
Immediate Corrective Action:	RCT responded in accordance with RSP 07.03 and a tape press was performed for analysis. PIF = 1.8. Nasal/mouth smears were taken and the individual was referred to Internal Dosimetry.
Primary Event Code:	O-O
Secondary Event Codes:	
Apparent Cause:	PEOPLE
Facility Mgr:	Johathan Richter
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	Gary Chandler
Responsible Dir.:	Mark Ferri
Target Date:	3/30/2003 12:00:00 AM
Corrective Actions:	The cause of the contaminatted particle is unknown. The individual was observed on doffing practices and performed very well. Nasal/mouth swabs were >DL. Awaiting fecal sample results.
PATS No.:	N/A
Comments:	

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Radiation Protection
Radiological Improvement Reports (RIR)

Radiological Improvement Report Details

RIR No.:	**03-137**
Originator:	
Project:	707/776/777
Date Entered:	6/12/2003 2:02:00 PM
Event Date:	6/10/2003 11:00:00 AM
Status:	CLOSED
DateClosed:	6/17/2003 12:00:00 AM
Building:	776
Location:	ASRF Room 134W
Description:	While deconning in the ASRF a worker kneeled on the floor. 2,000 dpm/probe area was found on the worker's right knee of her yellow anti-c clothing. The contamination was contained at the job site using tape. After doffing the anti-c clothing, a 10 cm2 area on the worker's DOE blue modesty clothing was contaminated to 4,516 dpm.
RS Supervisor	J. Satterfield
Immediate Corrective Action:	The contamination was removed from the clothing by cutting out the piece that was contaminated. After the piece was cut out, no contamination was found on the modesty clothing nor the individual's skin. Originally the piece was approximately 67.5 cm2. The piece was further reduced in size until all the material that was not contaminated was removed. The final piece size was 10 cm2, calculated to 452 dpm/100 square centimeters. Routine nasal and mouth swabs were performed.
Primary Event Code:	O-O
Secondary Event Codes:	
Apparent Cause:	PEOPLE
Facility Mgr:	Rob Russell
DOE Categorization:	Completed
Occurrence Rpt. No.:	
Responsible Mgr.:	Gary Chandler
Responsible Dir.:	Mark Ferri
Target Date:	7/10/2003 11:00:00 AM
Corrective Actions:	The individual was counseled regarding the need for knee protection when there is a potential for kneeds to contact rough floor/sharp debris. The D & D Manager/RSSM mandated the use of knee protection in these circumstances.
PATS No.:	
Comments:	

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Radiation Protection
Radiological Improvement Reports (RIR)

Welcome,
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Radiological Improvement Report Details

RIR No.:	**03-148**
Originator:	
Project:	707/776/777
Date Entered:	7/8/2003 11:49:00 AM
Event Date:	7/2/2003 1:50:00 PM
Status:	CLOSED
DateClosed:	7/22/2003 12:00:00 AM
Building:	776
Location:	Advanced Size Reduction Facility
Description:	Upon completion of the evolution it was discovered that one of the D&D worker's skin was contaminated up to 2118 dpm/100cm2 and 2604 dpm/100cm2 on their TLD. This was found at the SOP by the worker during self-monitoring. The other workers had Anti-C clothing contamination up to 4000 dpm/100cm2.
RS Supervisor	S. R. Fields
Immediate Corrective Action:	The workers that had hood contamination were whold body frisked after removal of Anti-Cs and found to be free of contamination. No further action was required. The worker who found the skin contamination while self-monitoring notified an RCT who applied a tape press. Skin contamination was reduced to 720 dpm/100cm2 after the tape press. The worker was then taken to the Decon Facility in Building 778 where she was successfully decontaminated. Nasal/Mouth swabs were taken. The PIF was calculated to be a level 1 potential intake. Notifications were made to the CCA and the worker was sent to Internal Dosimetry.
Primary Event Code:	H
Secondary Event Codes:	O
Apparent Cause:	EQUIPMENT
Facility Mgr:	John Auxier
DOE Categorization:	Completed
Occurrence Rpt. No.:	2003-0126
Responsible Mgr.:	Gary Chandler
Responsible Dir.:	Mark Ferri
Target Date:	8/1/2003 11:55:00 AM
Corrective Actions:	Nasal/mouth smears were less than decision level. Crews were briefed on this incident and were specifically directed to wear supplied air when packing used supplied air suits into SWBs Rad Ops briefed the RCTs to ensure personnel were properly dressed in their PPE. Emphasis was placed on zipping the yellow anti-c's to the top of the coveralls: taping the hood to the respirator when working in HCA

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