

**Radiation Protection  
Radiological Improvement Reports (RIR)**

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[Home](#) [Back](#) [Create RIR](#)

Home > Databases > Radiological Improvement Reports (RIR)

**Radiological Improvement Report Details**

<b>RIR No.:</b>	03-166
<b>Originator:</b>	
<b>Project:</b>	7071776/777
<b>Date Entered:</b>	8/11/2003 11:56:00 AM
<b>Event Date:</b>	8/11/2003 10:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	9/18/2003 12:00:00 AM
<b>Building:</b>	776
<b>Location:</b>	Room 227 inside the 207 plenum 1st stage airlock
<b>Description:</b>	Upon exiting the plenum at 10 am after removing their outer set of anti-c clothing, found contamination on two workers neck. Worker 1 had 1200 dpm/100 cm2 and worker 2 had 1000 dpm/100 cm2. Additionally, worker 1 had 5000 dpm/100 cm2 on his inner set of anti-c clothing in the chest area, and worker 2 had 5000 dpm/100 cm2 on his elbow and 30,000 dpm/100 cm2 on the bottom of his pant leg.
<b>RS Supervisor</b>	J. Satterfield
<b>Immediate Corrective Action:</b>	Removed contaminated clothing. Survey of modesty clothing, no contamination found. Did tape press of the contaminated skin. Resurveyed skin and found a removal factor of 50%. Used water and decon solution and pat the affected area. Resurveyed with no reduction. Used antiseptic wipe to pat area. Resurveyed and found no contamination. Workers entered PCM2 and passed without alarm.
<b>Primary Event Code:</b>	H
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	PEOPLE
<b>Facility Mgr:</b>	R. A. Russell
<b>DOE Categorization:</b>	Completed
<b>Occurrence Rpt. No.:</b>	2003-0140
<b>Responsible Mgr.:</b>	Terry Vaughn
<b>Responsible Dir.:</b>	Tom Dieter
<b>Target Date:</b>	9/10/2003 12:00:00 AM
<b>Corrective Actions:</b>	See Occurrence Report RFO-KHLL-SOLIDWST-2003-0019 for corrective actions, including sitewide corrective action plan. Manager Meeting Minutes were issued 08/13/2003. Nasal/mouth smears were less than decision level.
<b>PATS No.:</b>	
<b>Comments:</b>	

**Rad Protection Site Links**

- [# Radiation Protection](#)
- [# Alpha Group](#)
- [# Briefings](#)
- [# Calc Log](#)
- [# Databases](#)
- [# Documents](#)
- [# Final Surveys](#)
- [# Forms](#)
- [# Mission](#)
- [# Procurement](#)
- [# TBD Log](#)
- [# Training](#)
- [# Video Library](#)

**Database Links**

- [# Create RIR](#)
- [# Radiation Generating Devices \(RGD\)](#)
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Home Back < Create RIR

Home > Databases > Radiological Improvement Reports (RIR)

Radiological Improvement Report Details

Rad Protection Site Links

**RIR No.:** 03-190

**Originator:**

**Project:** 70717761777

**Date Entered:** 10/21/2003 7:32:00 AM

**Event Date:** 10/14/2003 8:00:00 AM

**Status:** CLOSED

**Date Closed:** 10/28/2003 12:00:00 AM

**Building:** 776

**Location:** Between Rooms 158 and 138

**Description:** Individual entered an ARA without required respiratory protection.

**RS Supervisor:** J. Crider

**Immediate Corrective Action:** Individual was escorted from the area. Nasal/mouth smears were taken. Individual TLD was pulled and held by supervision.

**Primary Event Code:** O-A

**Secondary Event Codes:**

**Apparent Cause:** PEOPLE

**Facility Mgr:** R. A. Russell

**DOE Categorization:** Not Applicable

**Occurrence Rpt. No.:**

**Responsible Mgr.:** T. L. Vaughn

**Responsible Dir.:** Dieter

**Target Date:** 11/20/2003 12:00:00 AM

**Corrective Actions:** Disciplinary action was taken and individual was counseled.

**PATS No.:**

**Comments:**

- Radiation Protection
- Alpha Group
- Briefings
- Calc Log
- Databases
- Documents
- Final Surveys
- Forms
- Mission
- Procurement
- TBD Log
- Training
- Video Library

Database Links

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

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[Home](#) [Back](#) [Create RIR](#)

Home > Databases > Radiological Improvement Reports (RIR)

**Radiological Improvement Report Details**

<b>RIR No.:</b>	04-027
<b>Originator:</b>	
<b>Project:</b>	7071776/777
<b>Date Entered:</b>	3/30/2004 2:37:00 PM
<b>Event Date:</b>	9/24/2003 3:00:00 PM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	3/31/2004 12:00:00 AM
<b>Building:</b>	776
<b>Location:</b>	207 Plenum
<b>Description:</b>	Positive nasal smear and positive fecal results. Assigned dose of 111 millirem CEDE.
<b>RS Supervisor</b>	T. L. Vaughn
<b>Immediate Corrective Action:</b>	Fecal sampling following positive nasal smear results.
<b>Primary Event Code:</b>	E
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	PEOPLE
<b>Facility Mgr:</b>	Jim Flora
<b>DOE Categorization:</b>	Not Applicable
<b>Occurrence Rpt. No.:</b>	
<b>Responsible Mgr.:</b>	T. L. Vaughn
<b>Responsible Dir.:</b>	Pizzuto
<b>Target Date:</b>	4/29/2004 12:00:00 AM
<b>Corrective Actions:</b>	Probable cause was poor doffing practices. Radiological Management has improved doffing surveillance to improve worker doffing/frisking practices.
<b>PATS No.:</b>	
<b>Comments:</b>	Worker doffing/frisking practices continue to be monitored through the "CSI" program.

**Rad Protection Site Links**

- [➤ Radiation Protection](#)
- [➤ Alpha Group](#)
- [➤ Briefings](#)
- [➤ Calc Log](#)
- [➤ Databases](#)
- [➤ Documents](#)
- [➤ Final Surveys](#)
- [➤ Forms](#)
- [➤ Mission](#)
- [➤ Procurement](#)
- [➤ TBD Log](#)
- [➤ Training](#)
- [➤ Video Library](#)

**Database Links**

- [➤ Create RIR](#)
- [➤ Radiation Generating Devices \(RGD\)](#)
- [➤ Sealed Radioactive Sources \(SRS\)](#)

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**BUILDING 771**  
**RADIOLOGICAL**  
**INCIDENT REPORTS**  
**(1998 - 2003)**

*SEC 00030*

Monday, July 12, 2004 11:23:31 AM

Portal Directory Portal Search Portal Stemap

Welcome,  
Steve TrujilloRadiation Protection  
Radiological Improvement Reports (RIR)

Home Back &lt; Create RIR

Home &gt; Databases &gt; Radiological Improvement Reports (RIR)

## Radiological Improvement Report Details

**RIR No.:** 98-055

**Originator:**

**Project:** SSOC

**Date Entered:** 2/5/1998 12:00:00 AM

**Event Date:** 2/4/1998 12:00:00 AM

**Status:** CLOSED

**Date Closed:** 4/20/1998 12:00:00 AM

**Building:** 771

**Location:** 149

**Description:** During decon activities, a portable SAAM alarmed. High levels of contamination were discovered on two individuals anti-cs and equipment belts. Initial air sample data indicated levels could have exceeded 50 DAC (one was 1300 DAC). Suspension guide limits exceeded. SAAM was positive.

**RS Supervisor** G. Osburn

**Immediate Corrective Action:** Work place was placed in safe configuration, personnel exited the area, and a spill response was initiated. Personnel were sent to Internal Dosimetry as appropriate.

**Primary Event Code:** B1

**Secondary Event Codes:** A1, B5, B7

**Apparent Cause:** PERSONNEL/PROCEDURE/EQUIPMENT/PLANNING

**Facility Mgr:** R. S. Gaffney

**DOE Categorization:** Not Applicable

**Occurrence Rpt. No.:**

**Responsible Mgr.:** R. Ferguson

**Responsible Dir.:** R. Bacon

**Target Date:** 3/6/1998 12:00:00 AM

**Corrective Actions:** Fact finding meeting was held. As a result, deficiencies were captured in a Rad Con Flash (attached) and distributed in a K-H lessons learned. 5 areas for improvement were identified in the Rad Con Flash. Also a TBD was generated to develop process for resetting CAM alarms higher for work. TBD is attached. No further action required.

**PATS No.:** 1998-000609

**Comments:**

## Rad Protection Site Links

- Radiation Protection
- Alpha Group
- Briefings
- Calc Log
- Databases
- Documents
- Final Surveys
- Forms
- Mission
- Procurement
- TBD Log
- Training
- Video Library

## Database Links

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

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Radiation Protection  
Radiological Improvement Reports (RIR)Welcome,  
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Home Back &lt; Create RIR

Home &gt; Databases &gt; Radiological Improvement Reports (RIR)

## Radiological Improvement Report Details

RIR No.: 98-040

Originator:

Project: SSOC

Date Entered: 2/2/1998 12:00:00 AM

Event Date: 2/1/1998 12:00:00 AM

Status: CLOSED

Date Closed: 4/20/1998 12:00:00 AM

Building: 771

Location: 149

Description: While doing RCRA inspection, process specialist found apparent hole in containment on Value HV517 on tank 451. Surveyed hole. 100,000 dpm removable >1,000,000 dpm direct.

RS Supervisor: D. Sinner

Immediate Corrective Action: Posted area around tank HCA/RWP required for access. Notified Supervision.

Primary Event Code: B11

Secondary Event Codes:

Apparent Cause: EQUIPMENT

Facility Mgr: R. Gaffney

DOE Categorization: Not Applicable

Occurrence Rpt. No.:

Responsible Mgr.: D. Biele

Responsible Dir.: R. Bacon

Target Date: 3/3/1998 12:00:00 AM

Corrective Actions: This RDR is associated with RDR 98-055. Closure actions for 98-055 adequately address these issues.

PATS No.: 1998-000605

Comments:

## Rad Protection Site Links

- Radiation Protection
- Alpha Group
- Briefings
- Calc Log
- Databases
- Documents
- Final Surveys
- Forms
- Mission
- Procurement
- TBD Log
- Training
- Video Library

## Database Links

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

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Portal Directory Portal Search Portal Sitemap

## Radiation Protection Radiological Improvement Reports (RIR)

Welcome,  
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[Home](#) [Back](#) [Create RIR](#)

Home &gt; Databases &gt; Radiological Improvement Reports (RIR)

### Radiological Improvement Report Details

**RIR No.:** 98-045

**Originator:**

**Project:** SSOC

**Date Entered:** 2/2/1998 12:00:00 AM

**Event Date:** 2/2/1998 12:00:00 AM

**Status:** CLOSED

**Date Closed:** 4/20/1998 12:00:00 AM

**Building:** 771

**Location:** 149

**Description:** Surveyed right anti-c glove and right leg of anti-c coveralls on above individual. Found 50,000 dpm on right anti-c glove and 10,000 dpm on right leg of anti-c coveralls. Employee was in 400 tank farm, room 149. \*The individual that had the contamination on anti-cs wore only a single set of PPE. To have encountered those levels of contamination, had to have entered the HCA. Also, a door to the HCA was left without posting.

**RS Supervisor:** D. Sinner

**Immediate Corrective Action:** Contained contamination, notified supervision, evaluated for PI, resurveyed area of concern.

**Primary Event Code:** B1

**Secondary Event Codes:** A1

**Apparent Cause:** PERSONNELPLANNING

**Facility Mgr:** R. S. Gaffney

**DOE Categorization:** Not Applicable

**Occurrence Rpt. No.:**

**Responsible Mgr.:** R. Ferguson

**Responsible Dir.:** R. Bacon

**Target Date:** 3/4/1998 12:00:00 AM

**Corrective Actions:** Fact finding meeting was held. (Notes attached). HCA postings were improved. Appropriate disciplinary action with employee was taken. Rad Con Flash initiated (attached.)

**PATS No.:** 1998-000606

**Comments:** This information has been added to further identify the efficiencies that were originally reported. Some information was not available until after the fact finding meeting was held. PDW 2/5/98

#### Rad Protection Site Links

- Radiation Protection
- Alpha Group
- Briefings
- Calc Log
- Databases
- Documents
- Final Surveys
- Forms
- Mission
- Procurement
- TBD Log
- Training
- Video Library

#### Database Links

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

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Home Back Create RIR

Home &gt; Databases &gt; Radiological Improvement Reports (RIR)

## Radiological Improvement Report Details

RIR No.: 98-286

**Originator:**

**Project:** SSOC

**Date Entered:** 7/20/1998 12:00:00 AM

**Event Date:** 7/14/1998 12:00:00 AM

**Status:** CLOSED

**Date Closed:** 10/14/1998 12:00:00 AM

**Building:** 771

**Location:** Room 164

**Description:** RIT was doing rounds and walked through a spill in Room 164, tracking contamination.

**RS Supervisor:** M. Fitzpatrick

**Immediate Corrective Action:** Changed booties on RIT, posted room, notified supervision and did survey of contamination, Completed RIR.

**Primary Event Code:** B5

**Secondary Event Codes:**

**Apparent Cause:** PERSONNEL

**Facility Mgr:** D. Thistlewood

**DOE Categorization:** Not Applicable

**Occurrence Rpt. No.:**

**Responsible Mgr.:** R. Ferguson

**Responsible Dir.:** R. Bacon

**Target Date:** 8/13/1998 12:00:00 AM

**Corrective Actions:** Contamination cleaned up. Area deconned to < 500 dpm.

**PATS No.:** 1998-001224

**Comments:** See attached survey. Amount of contamination was never documented. At time of close out individuals involved could not recall. 10/14/98 pkm

## Rad Protection Site Links

- Radiation Protection
- Alpha Group
- Briefings
- Calc Log
- Databases
- Documents
- Final Surveys
- Forms
- Mission
- Procurement
- TBD Log
- Training
- Video Library

## Database Links

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

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Radiological Improvement Reports (RIR)

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[Home](#) [Back](#) [Create RIR](#)

Home > Databases > Radiological Improvement Reports (RIR)

**Radiological Improvement Report Details**

<b>RIR No.:</b>	98-321
<b>Originator:</b>	
<b>Project:</b>	SSOC
<b>Date Entered:</b>	8/17/1998 12:00:00 AM
<b>Event Date:</b>	8/14/1998 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	10/13/1998 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	Room 149, 114
<b>Description:</b>	A leak from the overhead onto the floor was tracked from room 149 to 114. Contamination was found when individual surveyed on the Combo.
<b>RS Supervisor</b>	G. Osburn
<b>Immediate Corrective Action:</b>	Surveyed personnel, posted room, announced posting, and surveyed area. Individual was sent evaluated and PIF exceeded 10.
<b>Primary Event Code:</b>	A1
<b>Secondary Event Codes:</b>	B5
<b>Apparent Cause:</b>	EQUIPMENT
<b>Facility Mgr:</b>	R. Ferguson
<b>DOE Categorization:</b>	Not Applicable
<b>Occurrence Rpt. No.:</b>	
<b>Responsible Mgr.:</b>	R. Ferguson
<b>Responsible Dir.:</b>	R Bacon
<b>Target Date:</b>	9/13/1998 12:00:00 AM
<b>Corrective Actions:</b>	Valve contained, Areas deconned and deposted.
<b>PATS No.:</b>	1998-001240
<b>Comments:</b>	The individual was sent to RH for bioassay and possible lung count. See attached surveys.

**Rad Protection Site Links**

- [# Radiation Protection](#)
- [# Alpha Group](#)
- [# Briefings](#)
- [# Calc Log](#)
- [# Databases](#)
- [# Documents](#)
- [# Final Surveys](#)
- [# Forms](#)
- [# Mission](#)
- [# Procurement](#)
- [# TBD Log](#)
- [# Training](#)
- [# Video Library](#)

**Database Links**

- [# Create RIR](#)
- [# Radiation Generating Devices \(RGD\)](#)
- [# Sealed Radioactive Sources \(SRS\)](#)

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[Back](#) [Create RIR](#)

Home &gt; Databases &gt; Radiological Improvement Reports (RIR)

### Radiological Improvement Report Details

<b>RIR No.:</b>	98-074
<b>Originator:</b>	
<b>Project:</b>	SSOC
<b>Date Entered:</b>	2/23/1998 12:00:00 AM
<b>Event Date:</b>	2/19/1998 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	5/4/1998 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	149
<b>Description:</b>	During RCRA inspections, a process specialist discovered a leak on tank 934 room 149 at 2320. RCTs notified. Surveys indicated 500,000 dpm over 25 sq. ft. area, value 5389 in overhead above tank source of leak.
<b>RS Supervisor</b>	A. D. Allshouse
<b>Immediate Corrective Action:</b>	Supervision notified. Room posted as ARA. Tank farm posted as HCA. Air samples being pulled. Quick DAC 26.8.
<b>Primary Event Code:</b>	B11
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	EQUIPMENT
<b>Facility Mgr.:</b>	R. S. Gaffney
<b>DOE Categorization:</b>	Not Applicable
<b>Occurrence Rpt. No.:</b>	
<b>Responsible Mgr.:</b>	R. Ferguson
<b>Responsible Dir.:</b>	R. Bacon
<b>Target Date:</b>	3/21/1998 12:00:00 AM
<b>Corrective Actions:</b>	Performed decon on 934 tank. See attached copy of contamination survey. Delay on decon due to powered air purifying respirator (PAPR) training. Developed plant training program for PAPR use. Approval granted to paint fixture for low level contamination and inside tank. This item requires no further actions. Value replaced to stop leak as of 4/30/98.
<b>PATS No.:</b>	
<b>Comments:</b>	

#### Rad Protection Site Links

- [Radiation Protection](#)
- [Alpha Group](#)
- [Briefings](#)
- [Calc Log](#)
- [Databases](#)
- [Documents](#)
- [Final Surveys](#)
- [Forms](#)
- [Mission](#)
- [Procurement](#)
- [TBD Log](#)
- [Training](#)
- [Video Library](#)

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- [Create RIR](#)
- [Radiation Generating Devices \(RGD\)](#)
- [Sealed Radioactive Sources \(SRS\)](#)

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### Radiological Improvement Report Details

<b>RIR No.:</b>	98-080
<b>Originator:</b>	
<b>Project:</b>	SSOC
<b>Date Entered:</b>	2/25/1998 12:00:00 AM
<b>Event Date:</b>	2/24/1998 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	6/23/1998 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	Room 149, Tank 934
<b>Description:</b>	RWP requires "All personnel involved in work in close proximity of the leaking valve shall wear PAPR with HEPA filters"; no PAPRs were worn. RWP 98-771-5020
<b>RS Supervisor</b>	D. Sinner
<b>Immediate Corrective Action:</b>	Wrote RDR
<b>Primary Event Code:</b>	C7
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	OTHER
<b>Facility Mgr:</b>	R. S. Gaffney
<b>DOE Categorization:</b>	Not Applicable
<b>Occurrence Rpt. No.:</b>	
<b>Responsible Mgr.:</b>	G. F. Osburn
<b>Responsible Dir.:</b>	R. Bacon
<b>Target Date:</b>	3/26/1998 12:00:00 AM
<b>Corrective Actions:</b>	RWP was revised to define "close proximity" making it clear what respiratory protection was required at what distance, eliminating any confusion (see attached)
<b>PATS No.:</b>	1998-000764
<b>Comments:</b>	

#### Rad Protection Site Links

- Radiation Protection
- Alpha Group
- Briefings
- Calc Log
- Databases
- Documents
- Final Surveys
- Forms
- Mission
- Procurement
- TBD Log
- Training
- Video Library

#### Database Links

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

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### Radiological Improvement Report Details

<b>RIR No.:</b>	98-358
<b>Originator:</b>	
<b>Project:</b>	SSOC
<b>Date Entered:</b>	9/3/1998 12:00:00 AM
<b>Event Date:</b>	8/28/1998 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	11/10/1998 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	Room 153
<b>Description:</b>	Water dripping from overhead onto gloveboxes 153B&C. Area was surveyed and found to have levels of contamination up to 6600 dpm removable.
<b>RS Supervisor</b>	D. Sinner
<b>Immediate Corrective Action:</b>	Room was posted HCA, ARA, RPR, RWP required. CCA notified, incident logged.
<b>Primary Event Code:</b>	B11
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	EQUIPMENT
<b>Facility Mgr:</b>	J. O'Brien
<b>DOE Categorization:</b>	Not Applicable
<b>Occurrence Rpt. No.:</b>	
<b>Responsible Mgr.:</b>	R. Ferguson
<b>Responsible Dir.:</b>	R. Bacon
<b>Target Date:</b>	9/27/1998 12:00:00 AM
<b>Corrective Actions:</b>	Area was deposed after decontamination to < 500 dpm. Source identified as packing leak on 2nd floor. Packing was tightened and leak stopped.
<b>PATS No.:</b>	1998-001531
<b>Comments:</b>	See attached surveys.

#### Rad Protection Site Links

- Radiation Protection
- Alpha Group
- Briefings
- Calc Log
- Databases
- Documents
- Final Surveys
- Forms
- Mission
- Procurement
- TBD Log
- Training
- Video Library

#### Database Links

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

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Radiological Improvement Reports (RIR)Welcome,  
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<b>RIR No.:</b>	98-352
<b>Originator:</b>	
<b>Project:</b>	SSOC
<b>Date Entered:</b>	9/1/1998 12:00:00 AM
<b>Event Date:</b>	8/30/1998 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	10/21/1998 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	Room 114
<b>Description:</b>	Exceeded CA limits and RWP hold point limits upon trying to remove drain pipe on PRV. Stopped work and left area. 40,000 dpm removable.
<b>RS Supervisor</b>	D. Sinner
<b>Immediate Corrective Action:</b>	Posted affected area as HCA and room as ARA, notified supervision.
<b>Primary Event Code:</b>	B11
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	EQUIPMENT
<b>Facility Mgr:</b>	J. O'Brian
<b>DOE Categorization:</b>	Not Applicable
<b>Occurrence Rpt. No.:</b>	
<b>Responsible Mgr.:</b>	R. Ferguson
<b>Responsible Dir.:</b>	R. Bacon
<b>Target Date:</b>	9/29/1998 12:00:00 AM
<b>Corrective Actions:</b>	Area decontaminated to 5,000 dpm. Valve contained. No further action until system removal.
<b>PATS No.:</b>	1998-001519
<b>Comments:</b>	See attached survey.

**Rad Protection Site Links**

- [➤ Radiation Protection](#)
- [➤ Alpha Group](#)
- [➤ Briefings](#)
- [➤ Calc Log](#)
- [➤ Databases](#)
- [➤ Documents](#)
- [➤ Final Surveys](#)
- [➤ Forms](#)
- [➤ Mission](#)
- [➤ Procurement](#)
- [➤ TBD Log](#)
- [➤ Training](#)
- [➤ Video Library](#)

**Database Links**

- [➤ Create RIR](#)
- [➤ Radiation Generating Devices \(RGD\)](#)
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## Radiation Protection Radiological Improvement Reports (RIR)

Welcome,  
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[Home](#) [Back](#) [Create RIR](#)

Home &gt; Databases &gt; Radiological Improvement Reports (RIR)

### Radiological Improvement Report Details

<b>RIR No.:</b>	98-372
<b>Originator:</b>	
<b>Project:</b>	SSOC
<b>Date Entered:</b>	9/15/1998 12:00:00 AM
<b>Event Date:</b>	9/9/1998 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	10/22/1998 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	SOP
<b>Description:</b>	Found table at SOP to be contamination to levels of 50,000 dpm fixed plus removable (2000 dpm)
<b>RS Supervisor</b>	M. Fitzpatrick
<b>Immediate Corrective Action:</b>	Removed personnel from SOP, notified supervision and contained, announcement made.
<b>Primary Event Code:</b>	A5
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	OTHER/UNKNOWN
<b>Facility Mgr:</b>	J. Hilbig
<b>DOE Categorization:</b>	Completed
<b>Occurrence Rpt. No.:</b>	98-0563
<b>Responsible Mgr.:</b>	P. Worley
<b>Responsible Dir.:</b>	R. Bacon
<b>Target Date:</b>	10/8/1998 12:00:00 AM
<b>Corrective Actions:</b>	An extensive review of this event did not identify beyond question the source. However, it is unlikely the source will ever be clearly identified. The attached documents discuss what was none. At this point, no further action is required.
<b>PATS No.:</b>	1998-001458
<b>Comments:</b>	See attached surveys and records.

#### Rad Protection Site Links

- Radiation Protection
- Alpha Group
- Briefings
- Calc Log
- Databases
- Documents
- Final Surveys
- Forms
- Mission
- Procurement
- TBD Log
- Training
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#### Database Links

- Create RIR
- Radiation Generating Devices (RGD)
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Radiation Protection  
Radiological Improvement Reports (RIR)

Welcome,  
Steve Trujillo

Back < | Create RIR

Home > Databases > Radiological Improvement Reports (RIR)

**Radiological Improvement Report Details**

<b>RIR No.:</b>	98-304
<b>Originator:</b>	
<b>Project:</b>	SSOC
<b>Date Entered:</b>	7/31/1998 12:00:00 AM
<b>Event Date:</b>	7/26/1998 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	10/13/1998 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	Room 149
<b>Description:</b>	A condensate drain line spilled. The liquid is normally non-radiological and discharges through the sanitary drain system without problems. However, the spilled liquid that may have entered the sanitary drain is potentially contaminated.
<b>RS Supervisor</b>	G. Osburn
<b>Immediate Corrective Action:</b>	Efforts to divert the liquid are underway. Also, samples of liquid are being collected for analysis.
<b>Primary Event Code:</b>	C7
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	EQUIPMENT
<b>Facility Mgr:</b>	A. Adams
<b>DOE Categorization:</b>	Not Applicable
<b>Occurrence Rpt. No.:</b>	
<b>Responsible Mgr.:</b>	R. Ferguson
<b>Responsible Dir.:</b>	R. Bacon
<b>Target Date:</b>	8/25/1998 12:00:00 AM
<b>Corrective Actions:</b>	Samples returned were under limits for reportability. Bern built to prevent any possible future release. No further action required.
<b>PATS No.:</b>	1998-001334
<b>Comments:</b>	See attached documentation.

**Rad Protection Site Links**

- Radiation Protection
- Alpha Group
- Briefings
- Calc Log
- Databases
- Documents
- Final Surveys
- Forms
- Mission
- Procurement
- TBD Log
- Training
- Video Library

**Database Links**

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

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### Radiological Improvement Report Details

<b>RIR No.:</b>	98-319
<b>Originator:</b>	
<b>Project:</b>	SSOC
<b>Date Entered:</b>	8/14/1998 12:00:00 AM
<b>Event Date:</b>	8/13/1998 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	9/21/1998 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	Annex
<b>Description:</b>	Radiation area not posted in building 771 annex. Survey was not done.
<b>RS Supervisor</b>	G. Osburn
<b>Immediate Corrective Action:</b>	Supervision notified, survey taken and area posted.
<b>Primary Event Code:</b>	A6
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	PLANNING
<b>Facility Mgr:</b>	J. O'Brien
<b>DOE Categorization:</b>	Not Applicable
<b>Occurrence Rpt. No.:</b>	
<b>Responsible Mgr.:</b>	G. Osburn
<b>Responsible Dir.:</b>	R. Bacon
<b>Target Date:</b>	9/12/1998 12:00:00 AM
<b>Corrective Actions:</b>	Drums that were staged to be shipped had been moved around to be swipe surveyed and a Radiation Area was exposed while survey was being completed. Tool box briefed all RCTs on the need to complete all required surveys. NOTE: There was at no time any unmonitored exposure in this area.
<b>PATS No.:</b>	1998-001219
<b>Comments:</b>	See attached briefing rosters and survey. Drums were moved that same day.

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- [➤ Radiation Protection](#)
- [➤ Alpha Group](#)
- [➤ Briefings](#)
- [➤ Calc Log](#)
- [➤ Databases](#)
- [➤ Documents](#)
- [➤ Final Surveys](#)
- [➤ Forms](#)
- [➤ Mission](#)
- [➤ Procurement](#)
- [➤ TBD Log](#)
- [➤ Training](#)
- [➤ Video Library](#)

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- [➤ Create RIR](#)
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Welcome,  
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[Back](#) | [Create RIR](#)

Home &gt; Databases &gt; Radiological Improvement Reports (RIR)

### Radiological Improvement Report Details

<b>RIR No.:</b>	98-322
<b>Originator:</b>	
<b>Project:</b>	SSOC
<b>Date Entered:</b>	8/17/1998 12:00:00 AM
<b>Event Date:</b>	8/14/1998 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	9/21/1998 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	Room 149
<b>Description:</b>	After exiting room 149, following announcement for possible spread of contamination, individual re-entered room 149 without respiratory protection.
<b>RS Supervisor</b>	G. Osburn
<b>Immediate Corrective Action:</b>	Called individual out of room, full body monitored, notified supervision.
<b>Primary Event Code:</b>	C7
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	COMMUNICATIONS
<b>Facility Mgr:</b>	L. Rosebrock
<b>DOE Categorization:</b>	Not Applicable
<b>Occurrence Rpt. No.:</b>	
<b>Responsible Mgr.:</b>	L. Rosesbrock
<b>Responsible Dir.:</b>	R. Bacon
<b>Target Date:</b>	9/13/1998 12:00:00 AM
<b>Corrective Actions:</b>	No posting violation occurred. Corrective action to post a person in hallway during high noise activities was implemented.
<b>PATS No.:</b>	
<b>Comments:</b>	Fact finding meeting was held on 8/17/98. As a result it was decided to implement placing an individual to stand watch and listen for LSDW announcement during high noise evolutions. This individual would notify crew if an announcement effected the work area. Video taping of all hands meeting held on 8/18/98 shows coverage of the topic to warn everyone not to enter high noise areas unless someone is there to listen for announcement per conversation with G. L. Martinez. See attached Pre-Evolution Briefing.

#### Rad Protection Site Links

- [# Radiation Protection](#)
- [# Alpha Group](#)
- [# Briefings](#)
- [# Calc Log](#)
- [# Databases](#)
- [# Documents](#)
- [# Final Surveys](#)
- [# Forms](#)
- [# Mission](#)
- [# Procurement](#)
- [# TBD Log](#)
- [# Training](#)
- [# Video Library](#)

#### Database Links

- [# Create RIR](#)
- [# Radiation Generating Devices \(RGD\)](#)
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Radiation Protection  
Radiological Improvement Reports (RIR)

Welcome,  
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[Home](#) [Back](#) [Create RIR](#)

Home > Databases > Radiological Improvement Reports (RIR)

**Radiological Improvement Report Details**

<b>RIR No.:</b>	98-390
<b>Originator:</b>	.....
<b>Project:</b>	SSOC
<b>Date Entered:</b>	9/25/1998 12:00:00 AM
<b>Event Date:</b>	9/23/1998 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	10/21/1998 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	Room 149
<b>Description:</b>	Called from room 149, said he had contaminated booties, clean booties were taken to him and booties found to have 1800 dpm. Surveyed out completely at SOP and found 600 dpm on knees of yellows and 600 dpm on gloves.
<b>RS Supervisor</b>	D. Sinner
<b>Immediate Corrective Action:</b>	Yellows were removed at the SOP, resurveyed in modesty < MDA
<b>Primary Event Code:</b>	B5
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	OTHER/SCAFFOLDING
<b>Facility Mgr:</b>	R. Gaffney
<b>DOE Categorization:</b>	Not Applicable
<b>Occurrence Rpt. No.:</b>	
<b>Responsible Mgr.:</b>	W. Abeyta
<b>Responsible Dir.:</b>	R. Bacon
<b>Target Date:</b>	10/22/1998 12:00:00 AM
<b>Corrective Actions:</b>	Contaminated clothing was removed. No violation to any suspension limit. This is adequate to close Radiological Improvement Report. The source of contamination was found to be scaffolding and this was reported via RIR 98-391.
<b>PATS No.:</b>	
<b>Comments:</b>	Individual was working in room 114 on scaffolding.

**Rad Protection Site Links**

- [# Radiation Protection](#)
- [# Alpha Group](#)
- [# Briefings](#)
- [# Calc Log](#)
- [# Databases](#)
- [# Documents](#)
- [# Final Surveys](#)
- [# Forms](#)
- [# Mission](#)
- [# Procurement](#)
- [# TBD Log](#)
- [# Training](#)
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- [# Create RIR](#)
- [# Radiation Generating Devices \(RGD\)](#)
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Welcome,  
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[Home](#) [Back](#) [Create RIR](#)

Home &gt; Databases &gt; Radiological Improvement Reports (RIR)

### Radiological Improvement Report Details

<b>RIR No.:</b>	98-382
<b>Originator:</b>	
<b>Project:</b>	K-H
<b>Date Entered:</b>	9/23/1998 12:00:00 AM
<b>Event Date:</b>	9/22/1998 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	1/29/1999 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	Room 114
<b>Description:</b>	Entered Room 114 while posted Respiratory Protection Required.
<b>RS Supervisor</b>	G. Osburn
<b>Immediate Corrective Action:</b>	Work stopped, TLD taken, Fact-finding scheduled today at 1300.
<b>Primary Event Code:</b>	B1
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	PERSONNEL
<b>Facility Mgr:</b>	R. Gaffney
<b>DOE Categorization:</b>	Completed
<b>Occurrence Rpt. No.:</b>	
<b>Responsible Mgr.:</b>	K. Lavorato
<b>Responsible Dir.:</b>	J Hill
<b>Target Date:</b>	10/21/1998 12:00:00 AM
<b>Corrective Actions:</b>	1. Self report 2. TLD taken. 3. Work stopped. 4. Report occurrence. 5. Refresher training. 6. Request approval for TLD. 7. Lessons learned.
<b>PATS No.:</b>	1998-001607
<b>Comments:</b>	

#### Rad Protection Site Links

- Radiation Protection
- Alpha Group
- Briefings
- Calc Log
- Databases
- Documents
- Final Surveys
- Forms
- Mission
- Procurement
- TBD Log
- Training
- Video Library

#### Database Links

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

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Radiological Improvement Reports (RIR)

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[Home](#) [Back](#) [Create RIR](#)

Home > Databases > Radiological Improvement Reports (RIR)

### Radiological Improvement Report Details

<b>RIR No.:</b>	98-387
<b>Originator:</b>	
<b>Project:</b>	SSOC
<b>Date Entered:</b>	9/25/1998 12:00:00 AM
<b>Event Date:</b>	9/23/1998 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	10/6/1998 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	RBA
<b>Description:</b>	Left Hand 360 dpm. He had just come into the RCT office, had not been in the CA. Office surveyed < 20 dpm.
<b>RS Supervisor</b>	D. Sinner
<b>Immediate Corrective Action:</b>	Left hand was washed, resurveyed, < MDA of Electra.
<b>Primary Event Code:</b>	C7
<b>Secondary Event Codes:</b>	B15
<b>Apparent Cause:</b>	OTHER/UNKNOWN
<b>Facility Mgr:</b>	R. Gaffney
<b>DOE Categorization:</b>	Completed
<b>Occurrence Rpt. No.:</b>	98-0601
<b>Responsible Mgr.:</b>	L. Rosebrock
<b>Responsible Dir.:</b>	R. Bacon
<b>Target Date:</b>	10/22/1998 12:00:00 AM
<b>Corrective Actions:</b>	Employee's hand washed per RCT direction and procedure. RCT office and "A" vestibule area surveyed. No source located. Source could have been radon but RCT did not check with tape and count tape for decay.
<b>PATS No.:</b>	
<b>Comments:</b>	Event code corrected to show C7 from a B4. 10/23/98 pkm CEDE-0 mrem

#### Rad Protection Site Links

- [➤ Radiation Protection](#)
- [➤ Alpha Group](#)
- [➤ Briefings](#)
- [➤ Calc Log](#)
- [➤ Databases](#)
- [➤ Documents](#)
- [➤ Final Surveys](#)
- [➤ Forms](#)
- [➤ Mission](#)
- [➤ Procurement](#)
- [➤ TBD Log](#)
- [➤ Training](#)
- [➤ Video Library](#)

#### Database Links

- [➤ Create RIR](#)
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Radiological Improvement Reports (RIR)**

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[Home](#) [Back](#) [Create RIR](#)

[Home](#) > [Databases](#) > [Radiological Improvement Reports \(RIR\)](#)

**Radiological Improvement Report Details**

<b>RIR No.:</b>	98-435
<b>Originator:</b>	
<b>Project:</b>	SSOC
<b>Date Entered:</b>	11/3/1998 12:00:00 AM
<b>Event Date:</b>	10/30/1998 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	11/12/1998 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	149
<b>Description:</b>	3,000 dpm found on floor in the aisle between Line 42 and 400 tank farm. Area 1,000 sq ft. Mids did a follow up survey and found up to 10,000 dpm removable on the floor. It's believed the 400 tank farm is the source.
<b>RS Supervisor</b>	D. Sinner
<b>Immediate Corrective Action:</b>	Room posted HCA/ARA
<b>Primary Event Code:</b>	B11
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	EQUIPMENT
<b>Facility Mgr:</b>	A. B. Adams
<b>DOE Categorization:</b>	Not Applicable
<b>Occurrence Rpt. No.:</b>	
<b>Responsible Mgr.:</b>	R. Ferguson
<b>Responsible Dir.:</b>	R. Bacon
<b>Target Date:</b>	11/29/1998 12:00:00 AM
<b>Corrective Actions:</b>	Area decontaminated to < 500 dpm. Room deposited as HCA. Source identified as HCA's in tank farm. Containment for HCA's verified intact. Leaks in the tank farm is to be corrected during liquids strip-out or as resources allow.
<b>PATS No.:</b>	
<b>Comments:</b>	See attached surveys.

**Rad Protection Site Links**

- [➤ Radiation Protection](#)
- [➤ Alpha Group](#)
- [➤ Briefings](#)
- [➤ Calc Log](#)
- [➤ Databases](#)
- [➤ Documents](#)
- [➤ Final Surveys](#)
- [➤ Forms](#)
- [➤ Mission](#)
- [➤ Procurement](#)
- [➤ TBD Log](#)
- [➤ Training](#)
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- [➤ Create RIR](#)
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Radiation Protection  
Radiological Improvement Reports (RIR)

Welcome,  
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Home Back < Create RIR

Home > Databases > Radiological Improvement Reports (RIR)

**Radiological Improvement Report Details**

<b>RIR No.:</b>	98-437
<b>Originator:</b>	
<b>Project:</b>	SSOC
<b>Date Entered:</b>	11/3/1998 12:00:00 AM
<b>Event Date:</b>	10/29/1998 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	11/12/1998 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	149
<b>Description:</b>	RCT attempted to leave room, at Combo found booties hot. Notified supervision, room posted. Several areas on diamond plate were found contaminated up to 10,000 dpm removable.
<b>RS Supervisor</b>	D. Sinner
<b>Immediate Corrective Action:</b>	Contaminated areas were covered with tape and labeled. Remaining areas on floor <500 dpm removable.
<b>Primary Event Code:</b>	B11
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	EQUIPMENT
<b>Facility Mgr.:</b>	A. B. Adams
<b>DOE Categorization:</b>	Not Applicable
<b>Occurrence Rpt. No.:</b>	
<b>Responsible Mgr.:</b>	R. Ferguson
<b>Responsible Dir.:</b>	R. Bacon
<b>Target Date:</b>	11/28/1998 12:00:00 AM
<b>Corrective Actions:</b>	Area contained and labeled. Not further action at this time. Contamination source possibly from pint chips near new line 30. Area is contained and painted.
<b>PATS No.:</b>	
<b>Comments:</b>	See attached survey. Booties were contaminated to approximately 2000 dpm per RCT. Pkm 11/11/98.

**Rad Protection Site Links**

- Radiation Protection
- Alpha Group
- Briefings
- Calc Log
- Databases
- Documents
- Final Surveys
- Forms
- Mission
- Procurement
- TBD Log
- Training
- Video Library

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Steve Trujillo[Home](#) [Back](#) < [Create RIR](#)[Home](#) > [Databases](#) > [Radiological Improvement Reports \(RIR\)](#)**Radiological Improvement Report Details**

<b>RIR No.:</b>	98-442
<b>Originator:</b>	
<b>Project:</b>	SSOC
<b>Date Entered:</b>	11/3/1998 12:00:00 AM
<b>Event Date:</b>	11/3/1998 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	12/8/1998 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	149
<b>Description:</b>	At about 09:15 entered MAA with 2 D&D workers for Building Indoc. After entering CA, room 149, at about 10:00, D&D worker noticed employee was wearing wrong TLD.
<b>RS Supervisor</b>	J. Harris
<b>Immediate Corrective Action:</b>	Exited MAA after scanning at SOP and notified RS Supervisor.
<b>Primary Event Code:</b>	C7
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	PERSONNEL
<b>Facility Mgr:</b>	J. J. Obrien
<b>DOE Categorization:</b>	Not Applicable
<b>Occurrence Rpt. No.:</b>	
<b>Responsible Mgr.:</b>	L. Resenbrock
<b>Responsible Dir.:</b>	R. Bacon
<b>Target Date:</b>	12/2/1998 12:00:00 AM
<b>Corrective Actions:</b>	The individual picked up the TLD next to his on the board. The individual has been counseled on the need to pay strict attention to detail. I am certain this counseling in adequate to prevent recurrence.
<b>PATS No.:</b>	
<b>Comments:</b>	

**Rad Protection Site Links**

- [? Radiation Protection](#)
- [? Alpha Group](#)
- [? Briefings](#)
- [? Calc Log](#)
- [? Databases](#)
- [? Documents](#)
- [? Final Surveys](#)
- [? Forms](#)
- [? Mission](#)
- [? Procurement](#)
- [? TBD Log](#)
- [? Training](#)
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- [? Create RIR](#)
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Welcome,  
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[Home](#) [Back](#) [Create RIR](#)
[Home](#) > [Databases](#) > [Radiological Improvement Reports \(RIR\)](#)

### Radiological Improvement Report Details

<b>RIR No.:</b>	98-485
<b>Originator:</b>	
<b>Project:</b>	RMRS
<b>Date Entered:</b>	12/8/1998 12:00:00 AM
<b>Event Date:</b>	12/4/1998 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	3/11/1999 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	Room 180R
<b>Description:</b>	Approximately one teaspoon of liquid was found accumulated on plastic on the floor. Two workers had contaminated booties, floor contamination found from 500 dpm to 20,000 dpm removable. Upon exit one individual was found to have 24,000 dpm on the right shoulder of modesty clothing in the PCM2.
<b>RS Supervisor</b>	D. Sinner
<b>Immediate Corrective Action:</b>	Area posted HCA, leak contained, clothing contamination contained, no skin contamination.
<b>Primary Event Code:</b>	B5
<b>Secondary Event Codes:</b>	B6, B11
<b>Apparent Cause:</b>	EQUIPMENT
<b>Facility Mgr.:</b>	J. O'Brien
<b>DOE Categorization:</b>	Completed
<b>Occurrence Rpt. No.:</b>	98-0740
<b>Responsible Mgr.:</b>	D. Stewart
<b>Responsible Dir.:</b>	A. Crawford
<b>Target Date:</b>	1/3/1999 12:00:00 AM
<b>Corrective Actions:</b>	Closed by Occurrence Report # RFO-KHLL-771OPS-1998-0047.
<b>PATS No.:</b>	
<b>Comments:</b>	See attached typed statement sheet.

#### Rad Protection Site Links

- [➤ Radiation Protection](#)
- [➤ Alpha Group](#)
- [➤ Briefings](#)
- [➤ Calc Log](#)
- [➤ Databases](#)
- [➤ Documents](#)
- [➤ Final Surveys](#)
- [➤ Forms](#)
- [➤ Mission](#)
- [➤ Procurement](#)
- [➤ TBD Log](#)
- [➤ Training](#)
- [➤ Video Library](#)

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- [➤ Create RIR](#)
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Radiological Improvement Reports (RIR)**

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[Home](#) [Back](#) [Create RIR](#)

Home > Databases > Radiological Improvement Reports (RIR)

**Radiological Improvement Report Details**

<b>RIR No.:</b>	99-077
<b>Originator:</b>	
<b>Project:</b>	RMRS
<b>Date Entered:</b>	2/22/1999 12:00:00 AM
<b>Event Date:</b>	2/21/1999 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	3/1/1999 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	114
<b>Description:</b>	During pre-job surveys for housekeeping in room 114, an RCT found 30,000 dpm/100cm <sup>2</sup> in a 4ft <sup>2</sup> area under the tank 549 and 5,000 dpm/100cm <sup>2</sup> under line 3. The contamination appears to be legacy. There are no apparent leaks.
<b>RS Supervisor</b>	J. Harris
<b>Immediate Corrective Action:</b>	Posted the immediate area as an HCA and room 114 as an ARA. Both areas were decontaminated and the room was deposited from an ARA.
<b>Primary Event Code:</b>	B11
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	EQUIPMENT
<b>Facility Mgr:</b>	J. J. O'Brien
<b>DOE Categorization:</b>	Not Applicable
<b>Occurrence Rpt. No.:</b>	
<b>Responsible Mgr.:</b>	R. Ferguson
<b>Responsible Dir.:</b>	A. Crawford
<b>Target Date:</b>	2/23/1999 12:00:00 AM
<b>Corrective Actions:</b>	Deconned area to <500 dpm. Source of contamination identified as legacy. This item is closed.
<b>PATS No.:</b>	
<b>Comments:</b>	RMRS PA Screen No. RMRS-99-494

**Rad Protection Site Links**

- [# Radiation Protection](#)
- [# Alpha Group](#)
- [# Briefings](#)
- [# Calc Log](#)
- [# Databases](#)
- [# Documents](#)
- [# Final Surveys](#)
- [# Forms](#)
- [# Mission](#)
- [# Procurement](#)
- [# TBD Log](#)
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### Radiological Improvement Report Details

<b>RIR No.:</b>	99-143
<b>Originator:</b>	
<b>Project:</b>	RMRS
<b>Date Entered:</b>	3/24/1999 12:00:00 AM
<b>Event Date:</b>	3/23/1999 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	3/31/1999 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	165
<b>Description:</b>	At the time of dosimetry exchange it was discovered that a picture had been affixed to badge without his knowledge. Employee did not have a photo when this badge was issued and the picture that was affixed inadvertently covered the beta window of his badge.
<b>RS Supervisor</b>	M. Fitzpatrick
<b>Immediate Corrective Action:</b>	Employee sent to dosimetry for a new picture to be affixed to badge.
<b>Primary Event Code:</b>	C7
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	PERSONNEL
<b>Facility Mgr:</b>	R. S. Gaffney
<b>DOE Categorization:</b>	Not Applicable
<b>Occurrence Rpt. No.:</b>	
<b>Responsible Mgr.:</b>	K. E. Harrawood
<b>Responsible Dir.:</b>	A. Crawford
<b>Target Date:</b>	4/22/1999 12:00:00 AM
<b>Corrective Actions:</b>	Individual was verbally counseled and sent to dosimetry to have picture taken. We also have completed a check of the dosimeter board to check for other similar problems. None were discovered.
<b>PATS No.:</b>	
<b>Comments:</b>	RMRS PA Screen No. RMRS-99-601

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- [➤ Radiation Protection](#)
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- [➤ Briefings](#)
- [➤ Calc Log](#)
- [➤ Databases](#)
- [➤ Documents](#)
- [➤ Final Surveys](#)
- [➤ Forms](#)
- [➤ Mission](#)
- [➤ Procurement](#)
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[Home](#) [Back](#) < [Create RIR](#) >

Home &gt; Databases &gt; Radiological Improvement Reports (RIR)

### Radiological Improvement Report Details

<b>RIR No.:</b>	99-151
<b>Originator:</b>	
<b>Project:</b>	RMRS
<b>Date Entered:</b>	3/30/1999 12:00:00 AM
<b>Event Date:</b>	3/26/1999 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	4/26/1999 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	180K
<b>Description:</b>	While performing bag-in operations in room 180k, the RCT discovered that the workers had contamination on their hands, levels found were 10,000 dpm on one worker's anti-c glove. Second employee had 10,000 on his left anti-c glove, also found 5,000/dpm on first worker's bootie. However survey of the floor found no removable contamination in the room.
<b>RS Supervisor</b>	M. Fitzpatrick
<b>Immediate Corrective Action:</b>	PIFs taken on workers was .0125, area surveyed on contamination found, anti-c gloves changed pip bagged-in air sample taken .09% DAC, RIR written.
<b>Primary Event Code:</b>	B5
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	EQUIPMENT
<b>Facility Mgr:</b>	R. S. Gaffney
<b>DOE Categorization:</b>	Not Applicable
<b>Occurrence Rpt. No.:</b>	
<b>Responsible Mgr.:</b>	D. Burks
<b>Responsible Dir.:</b>	A. Crawford
<b>Target Date:</b>	4/25/1999 12:00:00 AM
<b>Corrective Actions:</b>	Employees interviewed about contamination control practices during bag in/bag out operations. Employees reminded to follow them.
<b>PATS No.:</b>	
<b>Comments:</b>	RMRS PA Screen No. RMRS-99-608

#### Rad Protection Site Links

- [# Radiation Protection](#)
- [# Alpha Group](#)
- [# Briefings](#)
- [# Calc Log](#)
- [# Databases](#)
- [# Documents](#)
- [# Final Surveys](#)
- [# Forms](#)
- [# Mission](#)
- [# Procurement](#)
- [# TBD Log](#)
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[Home](#) [Back](#) [Create RIR](#)

[Home](#) > [Databases](#) > [Radiological Improvement Reports \(RIR\)](#)

**Radiological Improvement Report Details**

<b>RIR No.:</b>	99-090
<b>Originator:</b>	
<b>Project:</b>	RMRS
<b>Date Entered:</b>	3/1/1999 12:00:00 AM
<b>Event Date:</b>	2/26/1999 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	4/13/1999 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	146
<b>Description:</b>	While preparing GB operations, several employees were found to have contaminated booties (10,000 dpm). All personnel were frisked out of the room with no other contamination detected. RCT established HCA boundary of approx. 36ft <sup>2</sup> , Contamination ranging from 10,000 to 5,000 dpm removable. Appears source is previous spill that has been contained by painting.
<b>RS Supervisor</b>	J. Harris
<b>Immediate Corrective Action:</b>	Posted the affected area, notified the CCA, performed decontamination of the area <500 dpm and pulled air sample with results of <10 DAC.
<b>Primary Event Code:</b>	B11
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	OTHER/LEGACY
<b>Facility Mgr:</b>	A. B. Adams
<b>DOE Categorization:</b>	Not Applicable
<b>Occurrence Rpt. No.:</b>	
<b>Responsible Mgr.:</b>	R. Ferguson
<b>Responsible Dir.:</b>	A. Crawford
<b>Target Date:</b>	3/28/1999 12:00:00 AM
<b>Corrective Actions:</b>	Immediate Corrective Actions and attached follow up actions completed. Satisfactory to close out. Contamination that was detected as a result of characterization surveys.
<b>PATS No.:</b>	
<b>Comments:</b>	RMRS PA Screen No. RMRS-99-501

**Rad Protection Site Links**

- [➤ Radiation Protection](#)
- [➤ Alpha Group](#)
- [➤ Briefings](#)
- [➤ Calc Log](#)
- [➤ Databases](#)
- [➤ Documents](#)
- [➤ Final Surveys](#)
- [➤ Forms](#)
- [➤ Mission](#)
- [➤ Procurement](#)
- [➤ TBD Log](#)
- [➤ Training](#)
- [➤ Video Library](#)

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- [➤ Create RIR](#)
- [➤ Radiation Generating Devices \(RGD\)](#)
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### Radiological Improvement Report Details

<b>RIR No.:</b>	99-106
<b>Originator:</b>	
<b>Project:</b>	RMRS
<b>Date Entered:</b>	3/8/1999 12:00:00 AM
<b>Event Date:</b>	3/4/1999 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	4/26/1999 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	114
<b>Description:</b>	Employee was supporting the draining of system six when he needed to leave the CA. He exited room 114 through room 149 doffed his APR and then exited room 149 into 114 which was posted as an ARA. The air sample covering the draining operation on the other side of the room from where the employee was without an APR was 11.5 DAC. The employee was in room 114 w/o an APR was approx. 30 seconds. A PIF was calculated <1. Nasal and mouth samples were not given. A high volume air sample was immediately pulled where the employee was standing w/o an APR and the results were <10 DAC.
<b>RS Supervisor</b>	J. Harris
<b>Immediate Corrective Action:</b>	Escorted the individual out of the CA. Denied the employee access to the CA or RBA until further notice.
<b>Primary Event Code:</b>	B1
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	PERSONNEL
<b>Facility Mgr:</b>	A. B. Adams
<b>DOE Categorization:</b>	Completed
<b>Occurrence Rpt. No.:</b>	99-0143
<b>Responsible Mgr.:</b>	D. Burks
<b>Responsible Dir.:</b>	A. Crawford
<b>Target Date:</b>	4/3/1999 12:00:00 AM
<b>Corrective Actions:</b>	Employee was counseled and appropriate disciplinary actions taken.
<b>PATS No.:</b>	
<b>Comments:</b>	RMRS PA Screen No. RMRS-99-509

#### Rad Protection Site Links

- [# Radiation Protection](#)
- [# Alpha Group](#)
- [# Briefings](#)
- [# Calc Log](#)
- [# Databases](#)
- [# Documents](#)
- [# Final Surveys](#)
- [# Forms](#)
- [# Mission](#)
- [# Procurement](#)
- [# TBD Log](#)
- [# Training](#)
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- [# Create RIR](#)
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Home Back &lt; Create RIR

Home &gt; Databases &gt; Radiological Improvement Reports (RIR)

### Radiological Improvement Report Details

<b>RIR No.:</b>	99-106
<b>Originator:</b>	
<b>Project:</b>	RMRS
<b>Date Entered:</b>	3/8/1999 12:00:00 AM
<b>Event Date:</b>	3/4/1999 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	4/26/1999 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	114
<b>Description:</b>	Employee was supporting the draining of system six when he needed to leave the CA. He exited room 114 through room 149 doffed his APR and then exited room 149 into 114 which was posted as an ARA. The air sample covering the draining operation on the other side of the room from where the employee was without an APR was 11.5 DAC. The employee was in room 114 w/o an APR was approx. 30 seconds. A PIF was calculated <1. Nasal and mouth samples were not given. A high volume air sample was immediately pulled where the employee was standing w/o an APR and the results were <10 DAC.
<b>RS Supervisor</b>	J. Harris
<b>Immediate Corrective Action:</b>	Escorted the individual out of the CA. Denied the employee access to the CA or RBA until further notice.
<b>Primary Event Code:</b>	B1
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	PERSONNEL
<b>Facility Mgr:</b>	A. B. Adams
<b>DOE Categorization:</b>	Completed
<b>Occurrence Rpt. No.:</b>	99-0143
<b>Responsible Mgr.:</b>	D. Burks
<b>Responsible Dir.:</b>	A. Crawford
<b>Target Date:</b>	4/3/1999 12:00:00 AM
<b>Corrective Actions:</b>	Employee was counseled and appropriate disciplinary actions taken.
<b>PATS No.:</b>	
<b>Comments:</b>	RMRS PA Screen No. RMRS-99-509

#### Rad Protection Site Links

- Radiation Protection
- Alpha Group
- Briefings
- Calc Log
- Databases
- Documents
- Final Surveys
- Forms
- Mission
- Procurement
- TBD Log
- Training
- Video Library

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

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Home Back &lt; Create RIR &gt;

Home &gt; Databases &gt; Radiological Improvement Reports (RIR)

### Radiological Improvement Report Details

<b>RIR No.:</b>	99-217
<b>Originator:</b>	
<b>Project:</b>	RMRS
<b>Date Entered:</b>	5/4/1999 12:00:00 AM
<b>Event Date:</b>	5/4/1999 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	5/19/1999 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	149
<b>Description:</b>	While pipe removal operations were in progress and room 149 was posted for respiratory protection, employee entered without a respirator. Employee was in room 149 for approx. 1 minute.
<b>RS Supervisor</b>	M. D. Fitzpatrick
<b>Immediate Corrective Action:</b>	Employee exited the area. Air samples were taken and employee checked out at the SOP
<b>Primary Event Code:</b>	B1
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	PERSONNEL
<b>Facility Mgr:</b>	K. D. Stovall
<b>DOE Categorization:</b>	Completed
<b>Occurrence Rpt. No.:</b>	99-0284
<b>Responsible Mgr.:</b>	L. Rosebrock
<b>Responsible Dir.:</b>	A. Crawford
<b>Target Date:</b>	6/3/1999 12:00:00 AM
<b>Corrective Actions:</b>	Employee counseled and appropriate discipline taken. Attended meeting with Rad Safety Management. Briefed 771 at all hands on following all posting and discussing facility conditions at pre-evs.
<b>PATS No.:</b>	
<b>Comments:</b>	RMRS PA Screen No. RMRS-99-650

#### Rad Protection Site Links

- # Radiation Protection
- # Alpha Group
- # Briefings
- # Calc Log
- # Databases
- # Documents
- # Final Surveys
- # Forms
- # Mission
- # Procurement
- # TBD Log
- # Training
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- # Create RIR
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[Home](#) [Back](#) [Create RIR](#)

Home > Databases > Radiological Improvement Reports (RIR)

**Radiological Improvement Report Details**

<b>RIR No.:</b>	99-221
<b>Originator:</b>	
<b>Project:</b>	RMRS
<b>Date Entered:</b>	5/10/1999 12:00:00 AM
<b>Event Date:</b>	5/6/1999 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	6/1/1999 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	149
<b>Description:</b>	While performing pipe cutting operations inside the hood in room 149, two drops of liquid leaked from the end of the pipe, the liquid contaminated approx. a ten square foot area around the hood on the floor. Also one D&D worker was contaminated on his anti-c glove to the level of 506,000 dpm. The worker's TLD was contaminated to a level of 5,000 dpm.
<b>RS Supervisor</b>	M. Fitzpatrick
<b>Immediate Corrective Action:</b>	Pipe cutting operations were suspend, area contained, surveys taken. PIF taken was determined to be a level 2. Air samples taken. 11DAC. Worker hand no other contamination detected. Notifications made.
<b>Primary Event Code:</b>	B11
<b>Secondary Event Codes:</b>	B5
<b>Apparent Cause:</b>	PROCEDURE
<b>Facility Mgr:</b>	J. J. O'Brien
<b>DOE Categorization:</b>	Completed
<b>Occurrence Rpt. No.:</b>	
<b>Responsible Mgr.:</b>	D. Burks
<b>Responsible Dir.:</b>	A. Crawford
<b>Target Date:</b>	6/5/1999 12:00:00 AM
<b>Corrective Actions:</b>	Appropriate controls had been implemented based on sample results. New controls for total containment during all cuts has been implemented to prevent recurrence.
<b>PATS No.:</b>	
<b>Comments:</b>	RMRS PA Screen No. RMRS-99-653

**Rad Protection Site Links**

- [Radiation Protection](#)
- [Alpha Group](#)
- [Briefings](#)
- [Calc Log](#)
- [Databases](#)
- [Documents](#)
- [Final Surveys](#)
- [Forms](#)
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- [Procurement](#)
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[Home](#) [Back](#) < [Create RIR](#)
[Home](#) > [Databases](#) > [Radiological Improvement Reports \(RIR\)](#)

### Radiological Improvement Report Details

<b>RIR No.:</b>	99-175
<b>Originator:</b>	
<b>Project:</b>	RMRS
<b>Date Entered:</b>	4/12/1999 12:00:00 AM
<b>Event Date:</b>	4/9/1999 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	4/26/1999 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	182
<b>Description:</b>	While performing operations in GB 228 in room 182, employees were found to be contaminated on the back of their left hand. This contamination was confined to their anti-c gloves. Contamination levels were found to be 5,000 dpm. No area contamination was detected as well as no other personnel contamination. PIF worksheet was completed on each individual and personnel were sent to internal dosimetry for follow up bioassay. Nasal and mouth sampling was performed.
<b>RS Supervisor</b>	M. Fitzpatrick
<b>Immediate Corrective Action:</b>	Work in box #228 stopped until glove is changed.
<b>Primary Event Code:</b>	B5
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	EQUIPMENT
<b>Facility Mgr.:</b>	J. J. O'Brien
<b>DOE Categorization:</b>	Completed
<b>Occurrence Rpt. No.:</b>	99-0222
<b>Responsible Mgr.:</b>	G. Martinez
<b>Responsible Dir.:</b>	A. Crawford
<b>Target Date:</b>	5/8/1999 12:00:00 AM
<b>Corrective Actions:</b>	Fact finding meeting was conducted and it was determined that there was a hole in the GB glove that caused the contamination. The glove was changed and personnel were sent to Internal Dosimetry for follow up bioassay. No other contamination was detected.
<b>PATS No.:</b>	
<b>Comments:</b>	RMRS PA Screen No. RMRS-99-631

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- [Radiation Protection](#)
- [Alpha Group](#)
- [Briefings](#)
- [Calc Log](#)
- [Databases](#)
- [Documents](#)
- [Final Surveys](#)
- [Forms](#)
- [Mission](#)
- [Procurement](#)
- [TBD Log](#)
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- [Create RIR](#)
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### Radiological Improvement Report Details

<b>RIR No.:</b>	99-186
<b>Originator:</b>	
<b>Project:</b>	RMRS
<b>Date Entered:</b>	4/19/1999 12:00:00 AM
<b>Event Date:</b>	4/16/1999 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	4/26/1999 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	182
<b>Description:</b>	Employee was working in GB 221 preparing items for removal. All pre-job surveys indicated no contamination present. After preparing several items, the employee removed his right hand out of the GB glove and the RCT surveyed his palm area and discovered 50,000 dpm. The anti-c glove was removed and then hand resurveyed, no contamination found.. The glove port was contained and work was stopped. A PIF calculation identified a possible level two inhalation. Nasal and mouth samples were taken and no activity discovered.
<b>RS Supervisor</b>	J. Harris
<b>Immediate Corrective Action:</b>	Notified Internal Dosimetry, they will evaluate.
<b>Primary Event Code:</b>	A1
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	EQUIPMENT
<b>Facility Mgr:</b>	J. J. O'Brien
<b>DOE Categorization:</b>	Completed
<b>Occurrence Rpt. No.:</b>	99-0242
<b>Responsible Mgr.:</b>	G. Martinez
<b>Responsible Dir.:</b>	A. Crawford
<b>Target Date:</b>	5/15/1999 12:00:00 AM
<b>Corrective Actions:</b>	A fact finding meeting was performed which confirmed that the GB glove was the only source of contamination. The glove was changed out and personnel followed up by reporting to Internal Dosimetry for bioassay.
<b>PATS No.:</b>	
<b>Comments:</b>	RMRS PA Screen No. RMRS-99-635

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- [➤ Alpha Group](#)
- [➤ Briefings](#)
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- [➤ Databases](#)
- [➤ Documents](#)
- [➤ Final Surveys](#)
- [➤ Forms](#)
- [➤ Mission](#)
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### Radiological Improvement Report Details

<b>RIR No.:</b>	99-204
<b>Originator:</b>	
<b>Project:</b>	RMRS
<b>Date Entered:</b>	4/29/1999 12:00:00 AM
<b>Event Date:</b>	4/28/1999 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	5/3/1999 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	114
<b>Description:</b>	While performing a pre-job survey the RCT discovered 400,000 dpm on his left anti-c glove. The glove was removed and the hand was surveyed. No contamination was found. The RCT evacuated the affected area and posted the room as an ARA. PIF calculations reveal a potential level two inhalation. Nasal and mouth samples were taken. Surveys of the samples were
<b>RS Supervisor</b>	J. Harris
<b>Immediate Corrective Action:</b>	Posted the immediate area as an HCA and the room as an ARA. Sent the employee to Internal Dosimetry for evaluation.
<b>Primary Event Code:</b>	B5
<b>Secondary Event Codes:</b>	B15
<b>Apparent Cause:</b>	OTHER
<b>Facility Mgr:</b>	J. J. O'Brien
<b>DOE Categorization:</b>	Not Applicable
<b>Occurrence Rpt. No.:</b>	
<b>Responsible Mgr.:</b>	K. E. Harrawood
<b>Responsible Dir.:</b>	A. Crawford
<b>Target Date:</b>	5/27/1999 12:00:00 AM
<b>Corrective Actions:</b>	Legacy contamination.
<b>PATS No.:</b>	
<b>Comments:</b>	RMRS PA Screen No. RMRS-99-644. CEDE <100 mrem confirmed, A1 event code replaced with B15 2/16/00. (das)

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- ☛ Radiation Protection
- ☛ Alpha Group
- ☛ Briefings
- ☛ Calc Log
- ☛ Databases
- ☛ Documents
- ☛ Final Surveys
- ☛ Forms
- ☛ Mission
- ☛ Procurement
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<b>RIR No.:</b>	99-419
<b>Originator:</b>	
<b>Project:</b>	RMRS
<b>Date Entered:</b>	9/20/1999 12:00:00 AM
<b>Event Date:</b>	9/16/1999 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	9/22/1999 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	114
<b>Description:</b>	During glove inspections on line three, employee was found to have 2,000 dpm on his right hand of the Anti-C glove. A hole in the GB Glove was found and was determined to be source of contamination. A PIF calculated to be 1.25. Nasal and mouth samples were taken and the employee was sent to Internal Dosimetry for further evaluation.
<b>RS Supervisor</b>	J. Harris
<b>Immediate Corrective Action:</b>	Changed the glove.
<b>Primary Event Code:</b>	B5
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	EQUIPMENT
<b>Facility Mgr:</b>	J. J. O'Brien
<b>DOE Categorization:</b>	Not Applicable
<b>Occurrence Rpt. No.:</b>	
<b>Responsible Mgr.:</b>	D. Burks
<b>Responsible Dir.:</b>	A. Crawford
<b>Target Date:</b>	10/16/1999 12:00:00 AM
<b>Corrective Actions:</b>	Employee removed contaminated glove without incident. Glove was changed and no other contamination detected.
<b>PATS No.:</b>	
<b>Comments:</b>	RMRS PA Screen No. RMRS-99-914

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- [# Radiation Protection](#)
- [# Alpha Group](#)
- [# Briefings](#)
- [# Calc Log](#)
- [# Databases](#)
- [# Documents](#)
- [# Final Surveys](#)
- [# Forms](#)
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### Radiological Improvement Report Details

**RIR No.:** 99-227

**Originator:**

**Project:** RMRS

**Date Entered:** 5/10/1999 12:00:00 AM

**Event Date:** 5/8/1999 12:00:00 AM

**Status:** CLOSED

**Date Closed:** 6/1/1999 12:00:00 AM

**Building:** 771

**Location:** 114

**Description:** While performing the valve lineups in room 114, 10,000 dpm was discovered on the right Anti-C glove. The source of contamination is the valve stem for HV-3083 on tank 0951. The stem was contained, and surveyed to <500 dpm. The operator was whole body frisked. No other contamination was found. PI samples were taken and the individual was sent to Internal Dosimetry for evaluation.

**RS Supervisor:** J. Harris

**Immediate Corrective Action:** Posted the room for as an ARA. Evaluated the individual for a possible inhalation (level 1). Notified CCA. Contained the valve stem and pulled a high volume air sample results were .10DAC.

**Primary Event Code:** B11

**Secondary Event Codes:**

**Apparent Cause:** EQUIPMENT

**Facility Mgr:** K. D. Stoval

**DOE Categorization:** Not Applicable

**Occurrence Rpt. No.:**

**Responsible Mgr.:** D. Burks

**Responsible Dir.:** A. Crawford

**Target Date:** 6/7/1999 12:00:00 AM

**Corrective Actions:** Valve had previously been surveyed clean. Appears that manipulation of valve (rising stem) caused contamination on stem.

**PATS No.:**

**Comments:** RMRS PA Screen No. RMRS-99-668

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- [Radiation Protection](#)
- [Alpha Group](#)
- [Briefings](#)
- [Calc Log](#)
- [Databases](#)
- [Documents](#)
- [Final Surveys](#)
- [Forms](#)
- [Mission](#)
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[Home](#) > [Databases](#) > [Radiological Improvement Reports \(RIR\)](#)

### Radiological Improvement Report Details

<b>RIR No.:</b>	99-350
<b>Originator:</b>	
<b>Project:</b>	RMRS
<b>Date Entered:</b>	7/30/1999 12:00:00 AM
<b>Event Date:</b>	7/29/1999 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	8/5/1999 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	180B
<b>Description:</b>	While getting system six pipe out of the 180B vault contamination was found on one end of a pipe. The pipe was leaking liquid. The left hand of anti-c glove of one employee was contaminated to 60,000 dpm. The bootie of another employee was also 60,000 dpm. The floor was contaminated to greater than 2,000,000 dpm. The area is about one square foot.
<b>RS Supervisor</b>	M. Fitzpatrick
<b>Immediate Corrective Action:</b>	Contained leaking pipe and posted room 180B HCA.
<b>Primary Event Code:</b>	B5
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	EQUIPMENT
<b>Facility Mgr:</b>	J. J. O'Brien
<b>DOE Categorization:</b>	Not Applicable
<b>Occurrence Rpt. No.:</b>	
<b>Responsible Mgr.:</b>	D. Burks
<b>Responsible Dir.:</b>	A. Crawford
<b>Target Date:</b>	8/28/1999 12:00:00 AM
<b>Corrective Actions:</b>	Pipe was de-contained and size reduced. Area was deconned and room deposited from HCA status.
<b>PATS No.:</b>	
<b>Comments:</b>	

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- [➤ Radiation Protection](#)
- [➤ Alpha Group](#)
- [➤ Briefings](#)
- [➤ Calc Log](#)
- [➤ Databases](#)
- [➤ Documents](#)
- [➤ Final Surveys](#)
- [➤ Forms](#)
- [➤ Mission](#)
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Home Back &lt; Create RIR

Home &gt; Databases &gt; Radiological Improvement Reports (RIR)

## Radiological Improvement Report Details

<b>RIR No.:</b>	99-354
<b>Originator:</b>	
<b>Project:</b>	RMRS
<b>Date Entered:</b>	8/2/1999 12:00:00 AM
<b>Event Date:</b>	7/31/1999 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	8/5/1999 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	187
<b>Description:</b>	While performing bag-in ops, contamination was detected on the booties of the D&D workers at a level of 50,000 dpm. Also a level of 1800 dpm was detected on the left chest area of one of the workers. Area contamination was found at a level of 50,00 dpm.
<b>RS Supervisor</b>	M. Fitzpatrick
<b>Immediate Corrective Action:</b>	Personnel surveyed, surveys taken, notifications made, floor contained.
<b>Primary Event Code:</b>	B5
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	OTHER
<b>Facility Mgr:</b>	K. D. Stoval
<b>DOE Categorization:</b>	Not Applicable
<b>Occurrence Rpt. No.:</b>	
<b>Responsible Mgr.:</b>	D. Burks
<b>Responsible Dir.:</b>	A. Crawford
<b>Target Date:</b>	8/30/1999 12:00:00 AM
<b>Corrective Actions:</b>	Personnel were assisted with undress with no personnel contamination. Area decontaminated and room deposited.
<b>PATS No.:</b>	
<b>Comments:</b>	

## Rad Protection Site Links

- Radiation Protection
- Alpha Group
- Briefings
- Calc Log
- Databases
- Documents
- Final Surveys
- Forms
- Mission
- Procurement
- TBD Log
- Training
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<b>RIR No.:</b>	99-371
<b>Originator:</b>	
<b>Project:</b>	RMRS
<b>Date Entered:</b>	8/12/1999 12:00:00 AM
<b>Event Date:</b>	1/1/1900 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	9/20/1999 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	114
<b>Description:</b>	While preparing a vent path for system 18 two to three drops of solution dripped out of the installed tap. The drips fell onto a roll-around ladder then splashed onto the front of the employee's front torso, anti-c gloves and the top of the booties. Contamination levels were 50,000 dpm/100cm2 on all three areas. The Anti-Cs were removed and no contamination was detected on the modesty clothing. The PIF calculation was a potential level two. Nasal and mouth smears were taken and surveyed. No activity detected.
<b>RS Supervisor</b>	J. Harris
<b>Immediate Corrective Action:</b>	Posted the room as an ARA and the immediate area as a HCA.
<b>Primary Event Code:</b>	A1
<b>Secondary Event Codes:</b>	
<b>Apparent Cause:</b>	PERSONNEL
<b>Facility Mgr:</b>	D. K. Thistlewood
<b>DOE Categorization:</b>	Completed
<b>Occurrence Rpt. No.:</b>	1999-0047
<b>Responsible Mgr.:</b>	J. Bower
<b>Responsible Dir.:</b>	A. Crawford
<b>Target Date:</b>	9/10/1999 12:00:00 AM
<b>Corrective Actions:</b>	Fact finding meeting held. IWCP was not complied with. Appropriate disciplinary action taken.
<b>PATS No.:</b>	1999-001345
<b>Comments:</b>	RMRS PA Screen No. RMRS-99-887

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- [➤ Radiation Protection](#)
- [➤ Alpha Group](#)
- [➤ Briefings](#)
- [➤ Calc Log](#)
- [➤ Databases](#)
- [➤ Documents](#)
- [➤ Final Surveys](#)
- [➤ Forms](#)
- [➤ Mission](#)
- [➤ Procurement](#)
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### Radiological Improvement Report Details

<b>RIR No.:</b>	99-360
<b>Originator:</b>	
<b>Project:</b>	RMRS
<b>Date Entered:</b>	8/9/1999 12:00:00 AM
<b>Event Date:</b>	8/6/1999 12:00:00 AM
<b>Status:</b>	CLOSED
<b>Date Closed:</b>	8/16/1999 12:00:00 AM
<b>Building:</b>	771
<b>Location:</b>	114
<b>Description:</b>	During glove changes, a glove was pulled to the edge of the port and contamination of 25K removable was released to the floor (approx. 10ft2 area). The CAM supporting the work area alarmed. Two employees that supported the work were not contaminated. The RCT covering the work was found to have 23k dpm/100cm2 on left ear and 15k dpm/100cm2 on right cheek outside of the respirator seal area. The job coverage air sample was 119 DAC. The CAM covering the work was calculated to .2 DAC. The skin decontamination was successfully completed in the building after using several tape presses and six wipe downs using mild soap and lukewarm water. A survey of the inside of the RCTs respirator was <20 dpm/100cm2. A PIF calculations was performed for the two workers not contaminated with a result of 0.013, however, nasal samples were taken. A PIF calculations was performed for the RCT with results of 1.53. Nasal samples were also taken. A second RCT was within six feet of the work and nasal samples were also taken from this RCT.
<b>RS Supervisor</b>	J. Harris
<b>Immediate Corrective Action:</b>	Immediately left the affected area. Surveyed out all personnel involved.
<b>Primary Event Code:</b>	B4
<b>Secondary Event Codes:</b>	B5, B11, B15
<b>Apparent Cause:</b>	PERSONNEL
<b>Facility Mgr.:</b>	J. J. O'Brien
<b>DOE Categorization:</b>	Completed
<b>Occurrence Rpt. No.:</b>	99-0546
<b>Responsible Mgr.:</b>	G. Martinez
<b>Responsible Dir.:</b>	A. Crawford
<b>Target Date:</b>	9/5/1999 12:00:00 AM
<b>Corrective Actions:</b>	Conducted fact finding meeting, contamination was cleaned up. Lessons learned were given to facility personnel. Corrective actions from the fact finding meeting

#### Rad Protection Site Links

- Radiation Protection
- Alpha Group
- Briefings
- Calc Log
- Databases
- Documents
- Final Surveys
- Forms
- Mission
- Procurement
- TBD Log
- Training
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[Home](#) [Back](#) < [Create RIR](#) >

[Home](#) > [Databases](#) > [Radiological Improvement Reports \(RIR\)](#)

### Radiological Improvement Report Details

**RIR No.:** 99-473

**Originator:**

**Project:** RMRS

**Date Entered:** 10/21/1999 12:00:00 AM

**Event Date:** 10/20/1999 12:00:00 AM

**Status:** CLOSED

**Date Closed:** 12/2/1999 12:00:00 AM

**Building:** 771

**Location:** CA

**Description:** In general the entire CA housekeeping is below standard. There are several portable carts used for either PPR or D&D activities that have tools, PPE, supplies, Radiological waste and other misc. items on them. Plastic bags and lead aprons are lying on the floors predominately in rooms 114 and 149. Several bags containing contaminated crimper parts and two ladders continue to be stored on the floor in room 114 near line 14. These items have been there since 07/19/99 when we had problems with the system six PPR. Two platforms continue to sit in room 149 where it appears to be a staging area for radiological waste and tools. A large roll of tygon tubing coming out of line 43 is laying on the floor with only a piece of tape over the other end. A bag containing a contaminated downdraft funnel is lying on the floor near line 18. Throughout the Contamination Area there are new gloves box gloves and bag out bags on the floors and cabinets. We have had many contamination incidents where the quality of these items have been questioned. It is hard to question their quality when they are probably not even being stored properly. It is very difficult to maintain a sound radiological program with housekeeping at this standard.

**RS Supervisor** J. Harris

**Immediate Corrective Action:**

**Primary Event Code:** C3

**Secondary Event Codes:**

**Apparent Cause:** TRAINING

**Facility Mgr:** A. B. Adams

**DOE Categorization:** Not Applicable

**Occurrence Rpt. No.:**

**Responsible Mgr.:** R. Vonfeldt

**Responsible Dir.:** A. Crawford

**Target Date:** 11/19/1999 12:00:00 AM

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- [Radiation Protection](#)
- [Alpha Group](#)
- [Briefings](#)
- [Calc Log](#)
- [Databases](#)
- [Documents](#)
- [Final Surveys](#)
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