Radiation Protection
Radiological Improvement Reports (RIR)

Welcome, **Steve Trujillo**

Radiological Improvement Report Details

RIR No.:	00-362
Originator:	
Project:	771
Date Entered:	9/13/2000 12:00:00 AM
Event Date:	9/12/2000 12:00:00 AM
Status:	CLOSED
DateClosed:	10/2/2000 12:00:00 AM
Building:	771
Location:	114
Description:	While removing instrument air line a CAM alarmed. RCT surveyed 3rd laborer, 73,000 dpm right leg 2 sq. ft., 25,000 dpm on chest 16 sq. in of anti-cs; 1st laborer, 3,000 dpm left shoulder 1 sq ft anti-cs; 2nd laborer 3,000 dpm right knee 16 sq. in. anti-cs. 3rd laborer had no contamination on modesty clothing; 1st laborer had 3,000 dpm on modesty clothing left shoulder 16 sq in that was cross contamination when he undressed; 2nd laborer had 1,000 dpm on modesty clothing right knee, 8 sq in. No skin contamination. See survey levels in the room. 1st CAM 5,000 dpm on filter, 2nd 2,500 dpm filter; 3rd filter 841 dpm filter 4th 67 dpm filter 5th 75 dpm on filter.
RS Supervisor	D. Sinner
Immediate Corrective Action:	Workers exited the room. Removed anti-cs of personnel at doorway of 114 and Corridor A. Notified CCA, RCTTS. PIF completed. Laborer #1 was 1.875. Nasal completed. Removed CAM. Pulled air sampling 4.6 DAC. Started surveys. Posted HCA where needed.
Primary Event Code:	B6
Secondary Event Codes:	B5, C9
Apparent Cause:	PROCEDURE
Facility Mgr:	A. B. Adams
DOE Categorization:	Completed
Occurrence Rpt. No.:	2000-0526
Responsible Mgr.:	B. Stewart
Responsible Dir.:	K. Trice
Target Date:	10/12/2000 12:00:00 AM
Corrective Actions:	KHC 771 Construction personnel attended training on 9/12/00. This training was designed by B771 senior management to increase awareness with records to working within the work package and how to identify and recognize hazards associated with assigned work. Action: Completed 9/12/00. RISS safety oversight reviewed all existing minor maintenance work packages currently assigned to KHC. Action complete.

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Radiological Improvement Report Details

RIR No.:	01-033
Originator:	
Project:	771
Date Entered:	1/22/2001 12:00:00 AM
Event Date:	1/18/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	3/9/2001 12:00:00 AM
Building:	771
Location:	114
Description:	D&D Worker was wearing someone else's TLD and wrist dosimeter while in the RBA and CA of 771 while doing scans on bottles room 114 line 13, employee 1 was wearing employee 2 dosimeter for approximately 2 hours.
RS Supervisor	D. Sinner
Immediate Corrective Action:	D&D Worker was pulled out of the area and his TLD and the TLD he was using were sent to be read.
Primary Event Code:	C1
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	H.Lerum
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	T. Dieter
Responsible Dir.:	K. Trice
Target Date:	2/17/2001 12:00:00 AM
Corrective Actions:	Employee was counseled on the importance of looking at the picture carefully before wearing the TLD. Both TLDs were sent to External Dosimetry for a special read and both employees were issued new TLDs.
PATS No.:	
Comments:	

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Radiation Protection
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Radiological Improvement Report Details

RIR No.:	**01-072**
Originator:	
Project:	771
Date Entered:	2/14/2001 12:00:00 AM
Event Date:	2/14/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	3/23/2001 12:00:00 AM
Building:	771
Location:	Room Annex
Description:	RWP 01-771-5265. TLD fell off and broke open in CA.
RS Supervisor	S. McNitt
Immediate Corrective Action:	Left CA, surveyed TLD, sent individual to external dosimetry for new TLD.
Primary Event Code:	C7
Secondary Event Codes:	
Apparent Cause:	EQUIPMENT
Facility Mgr:	T. R. Hergert
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	M. Waldroop
Responsible Dir.:	K. Trice
Target Date:	3/16/2001 12:00:00 AM
Corrective Actions:	TLD surveyed out and employee sent to dosimetry for new TLD.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	01-128
Originator:	
Project:	771
Date Entered:	3/20/2001 12:00:00 AM
Event Date:	3/19/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	3/29/2001 12:00:00 AM
Building:	771
Location:	180E
Description:	During D&D activities on RWP #01-771-5259, a flange was broken and liquid ran out of the flange. The flange was tightened up during this evolution. The individuals glove was tore. His left thumb was contaminated to 222,000 dpm left middle finger to 4,500 dpm and left knee to 6,600 dpm. Approximately 242 sq. foot of floor area contaminated from 1,000 dpm to 1,000,000 dpm. Seven other personnel had anti-c contamination ranging from 15,000 dpm to 60,000 dpm. PIF was 2.75.
RS Supervisor	M. Welling
Immediate Corrective Action:	The individual was taken to the decon room where his hand was flushed with water for 15 minutes. The liquid was confirmed to be acid and the individual was transported to medical for decontamination. The individual was decontaminated to < MDA of an Electra. The MDA was 44 dpm. PIF was 2.75 and the individual was sent to Internal Dosimetry for evaluation. All other PIFs were <1.
Primary Event Code:	B4
Secondary Event Codes:	B5, A1
Apparent Cause:	PLANNING
Facility Mgr:	H. Lerum
DOE Categorization:	Completed
Occurrence Rpt. No.:	2001-0166
Responsible Mgr.:	T. Dieter
Responsible Dir.:	K. Trice
Target Date:	4/18/2001 12:00:00 AM
Corrective Actions:	All immediate corrective actions and responses performed correctly. Work package reviewed and steps added to correct deficiency. All crews trained on proper sleeving techniques on house vacuum systems and remaining actinide systems. Taps will be used on all house vacuums to verify vent and drain paths.
PATS No.:	
Comments:	Confirmed intake of 100 mrem CEDE for employee # 1.

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Radiological Improvement Report Details

RIR No.:	01-269
Originator:	
Project:	771
Date Entered:	6/14/2001 12:00:00 AM
Event Date:	6/13/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	8/2/2001 12:00:00 AM
Building:	771
Location:	146
Description:	When RITs checked their booties when exiting the room and found that they were contaminated. They contacted an RCT. The RCT found up to 5,000 dpm removable on the bottom of their booties. Further investigation showed that a 17 inch bag port was leaking.
RS Supervisor	D. Sinner
Immediate Corrective Action:	RIT stopped and contacted an RCT. The booties were changed. PIF was done, both <1.0. The RCT surveyed the area and found the source of the contamination. It was contained and deconned.
Primary Event Code:	B5
Secondary Event Codes:	C8
Apparent Cause:	OTHER
Facility Mgr:	T. R. Hergert
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	J. Harris
Responsible Dir.:	K. Trice
Target Date:	7/13/2001 12:00:00 AM
Corrective Actions:	The bag out bag was changed and the area of concern was decontaminated. All other bags were inspected for deterioration.
PATS No.:	
Comments:	

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Radiation Protection
Radiological Improvement Reports (RIR)

Welcome,
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Radiological Improvement Report Details

RIR No.:	**01-278**
Originator:	
Project:	771
Date Entered:	6/20/2001 12:00:00 AM
Event Date:	6/19/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	8/6/2001 12:00:00 AM
Building:	771
Location:	Room 149
Description:	During the performance of process pipe removal liquid leaked from the pipe when vacuum was inadvertently lost. The individual's anti-cs became contaminated. The liquid absorbed through the anti-c's contaminating his skin of the right knee to 2280 dpm and the modesty clothing to 2400 dpm.
RS Supervisor	M. Welling
Immediate Corrective Action:	Made notifications, took the contaminated individual to the decontamination room, decontaminated the skin to <68 dpm which was the MDA of the Electra, calculated the PIFs which were <1 and completed the RSIR.
Primary Event Code:	B4
Secondary Event Codes:	B5
Apparent Cause:	OTHER
Facility Mgr:	H. Lerum
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	T. Heifer
Responsible Dir.:	M. Ferri
Target Date:	7/19/2001 12:00:00 AM
Corrective Actions:	Re-emphasized the need for knee pads when working on or in spaces that require workers to be on their knees. Evaluated the engineering controls in place for adequacy.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	**00-452**
Originator:	
Project:	771
Date Entered:	11/17/2000 12:00:00 AM
Event Date:	11/16/2000 12:00:00 AM
Status:	CLOSED
DateClosed:	1/8/2001 12:00:00 AM
Building:	771
Location:	
Description:	An individual received an uptake which resulted in a dose of greater than the ACL.
RS Supervisor	M. Welling
Immediate Corrective Action:	The individual has been restricted from the radiological area and an ACL extension is in progress.
Primary Event Code:	B2
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	A. B. Adams
DOE Categorization:	Completed
Occurrence Rpt. No.:	2000-0484
Responsible Mgr.:	D. Boone
Responsible Dir.:	K. Trice
Target Date:	12/16/2000 12:00:00 AM
Corrective Actions:	This RIR is written for continunity, corrective actions not required for closure.
PATS No.:	
Comments:	Cross Reference to RIR 00-334-bjs

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Radiological Improvement Report Details

RIR No.:	00-459
Originator:	
Project:	771
Date Entered:	11/29/2000 12:00:00 AM
Event Date:	11/27/2000 12:00:00 AM
Status:	CLOSED
DateClosed:	3/8/2001 12:00:00 AM
Building:	771
Location:	
Description:	Received a call from laundry. They found a respirator ID# 771-032 with 2,000 dpm fixed.
RS Supervisor	D. Sinner
Immediate Corrective Action:	Item double bagged and contacted 771 Rad Safety units. Sent to 771 CA. Bag opened and unit checked. 2,000 dpm fixed. Smear taken and counted on Oasis 200 dpm removable. Respirator disposed of as waste.
Primary Event Code:	B9
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	A. B. Adams
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	D. Boone
Responsible Dir.:	K. Trice
Target Date:	12/27/2000 12:00:00 AM
Corrective Actions:	This unit was one of several released in a group. No other problems noted. The unit was retrieved and disposed of as rad waste. No survey available.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	**01-311**
Originator:	
Project:	771
Date Entered:	7/17/2001 12:00:00 AM
Event Date:	7/16/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	8/20/2001 12:00:00 AM
Building:	771
Location:	180A
Description:	While working in the glovebox, the individual found his left anti-c glove contaminated to 15,000 dpm and the back of his anti-c coveralls contaminated to 8,000 dpm. The contamination came from a hole in a glovebox glove. The PIF was calculated at 14.375.
RS Supervisor	M. J. Welling
Immediate Corrective Action:	Whole body frisk was performed, notifications made, removed contaminated clothing, performed the PIF calculations, nasal samples taken and the individual sent to Internal Dosimetry for evaluation.
Primary Event Code:	B5
Secondary Event Codes:	B13
Apparent Cause:	EQUIPMENT
Facility Mgr:	T. R. Hergert
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	M. Brown
Responsible Dir.:	K. Trice
Target Date:	8/15/2001 12:00.00 AM
Corrective Actions:	Sent employee for bioassay. Clean area, change glove and review work practices. Work practice were satisfactory. Moving items in box caused hole. Return to work.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	**01-285**
Originator:	
Project:	771
Date Entered:	6/27/2001 12:00:00 AM
Event Date:	6/26/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	8/6/2001 12:00:00 AM
Building:	771
Location:	180A
Description:	Employee #1 anti-cs became contaminated to 600,000 dpm while wearing an APR. Employee #1's skin became contaminated to 4,800 dpm on left hand. PIF was 7.5. The individual was decontaminated to
RS Supervisor	M. J. Welling
Immediate Corrective Action:	Made notification, performed PIFs, decontaminated the individual, performed nasal smears.
Primary Event Code:	B4
Secondary Event Codes:	B5, B13
Apparent Cause:	TRAINING
Facility Mgr:	T. R. Hergert
DOE Categorization:	Completed
Occurrence Rpt. No.:	2001-0336
Responsible Mgr.:	T. Dieter
Responsible Dir.:	K. Trice
Target Date:	7/26/2001 12:00:00 AM
Corrective Actions:	Conducted training for bag cuts pigtail requirements. The supervisors will train each crew.
PATS No.:	
Comments:	

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Radiation Protection
Radiological Improvement Reports (RIR)

Welcome, **Steve Trujillo**

Radiological Improvement Report Details

RIR No.:	01-016
Originator:	
Project:	771
Date Entered:	1/12/2001 12:00:00 AM
Event Date:	10/31/2000 12:00:00 AM
Status:	CLOSED
DateClosed:	3/29/2001 12:00:00 AM
Building:	771
Location:	114
Description:	An airborne radioactive area was improperly posted in room 114. Announcements were made for the posting prior to a sweep of the room. As a result of the confusion, workers were in the room without respiratory protection.
RS Supervisor	M. J. Welling
Immediate Corrective Action:	Sweep of the room was conducted and all workers were directed to don respirators. No work required respiratory protection was commenced until respirators were donned.
Primary Event Code:	B12
Secondary Event Codes:	
Apparent Cause:	TRAINING
Facility Mgr:	
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	J. Harris
Responsible Dir.:	K. Trice
Target Date:	2/11/2001 12:00:00 AM
Corrective Actions:	Reinforced the requirements to sweep the affected area prior to posting to ensure all personnel were in proper PPE.
PATS No.:	2001-000389
Comments:	

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Radiation Protection
Radiological Improvement Reports (RIR)

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Radiological Improvement Report Details

RIR No.:	01-020
Originator:	
Project:	771
Date Entered:	1/17/2001 12:00:00 AM
Event Date:	1/12/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	3/8/2001 12:00:00 AM
Building:	771
Location:	149
Description:	The individual found 10,000 dpm on 2 square inches on sleeve of anti-cs while checking himself with a combo The individual had already removed his respirator. PIF was calculated at 6.25 (Level I).
RS Supervisor	M. J .Welling
Immediate Corrective Action:	Contained contamination, removed anti-cs, performed PIF and nasal smears.
Primary Event Code:	B13
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	T. R. Hergert
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	R. T. VonFeldt
Responsible Dir.:	K. Trice
Target Date:	2/10/2001 12:00:00 AM
Corrective Actions:	Contamination removed from anti-c at step-off pad. PIF calculations determined (see above). No additional actions required.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	01-271
Originator:	
Project:	771
Date Entered:	6/15/2001 12:00:00 AM
Event Date:	6/15/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	8/2/2001 12:00:00 AM
Building:	771
Location:	180A
Description:	When the D&D worker went to exit from the glovebox glove the RCT surveyed and found 150,000 dpm removable on the sleeve of the anti-c coveralls by the shoulder. Upon further investigation, the RCT found a small hole in the glove and two other gloves with 5,000 dpm and 1,000 dpm removable. There was no contamination on the modesty clothing or skin of the individual.
RS Supervisor	D. Sinner
Immediate Corrective Action:	Removed the contaminated anti-c clothing and performed a full body frisk. No other contamination detected. A PIF was done and the results were level II 93.75. Nasal/mouth done.
Primary Event Code:	B5
Secondary Event Codes:	B13
Apparent Cause:	EQUIPMENT
Facility Mgr:	T. R. Hergert
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	R. T. VonFeldt
Responsible Dir.:	K. Trice
Target Date:	7/15/2001 12:00:00 AM
Corrective Actions:	The affected glove was changed out and glove inspections performed on all gloves in room 180A. As a result of inspections, another glove was found to be suspect and changed out.
PATS No.:	
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Radiological Improvement Report Details

RIR No.:	01-294
Originator:	
Project:	771
Date Entered:	7/3/2001 12:00:00 AM
Event Date:	6/30/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	8/6/2001 12:00:00 AM
Building:	771
Location:	180A
Description:	A hole in a glovebox glove was the source of contamination on two workers anti-c gloves. One worker had 50,000 dpm on right glove, and the other worker had 500,000 dpm on right glove. The glovebox glove had 600,000 dpm on the middle finger where a hole was found.
RS Supervisor	B. Ott
Immediate Corrective Action:	Contained the contaminated gloves and had the individuals exit the CA. No further contamination was found on either person. Posted the room as an Airborne Area, contained the glovebox glove. Surveyed all working gloves in the room. Performed a glove change out on the effected glove
Primary Event Code:	B5
Secondary Event Codes:	B13
Apparent Cause:	EQUIPMENT
Facility Mgr:	T. R. Hergert
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	M. Brown
Responsible Dir.:	K. Trice
Target Date:	7/30/2001 12:00:00 AM
Corrective Actions:	Stopped work, notify CCA and Rad. Remove individuals from area and send for bioassay. Change gloves to thicker glove and return to work.
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Comments:	

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Radiation Protection
Radiological Improvement Reports (RIR)

Welcome, **Steve Trujillo**

Radiological Improvement Report Details

RIR No.:	01-330
Originator:	
Project:	771
Date Entered:	7/26/2001 12:00:00 AM
Event Date:	7/20/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	8/26/2001 12:00:00 AM
Building:	771
Location:	182
Description:	While lifting a mill with a hydraulic lift, contamination was discovered under the mill up to 300,000 dpm. Two CAMs alarmed. Personnel were not in respiratory protection. One individual had 4,000 dpm on booties. Three nasal smears were above the decision level.
RS Supervisor	M. J. Welling
Immediate Corrective Action:	Evacuated the area, performed whole body frisk of all individuals, calculated PIFs, performed nasal smears and made notifications
Primary Event Code:	B5
Secondary Event Codes:	B13, B7
Apparent Cause:	EQUIPMENT
Facility Mgr:	T. R. Hergert
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	M. Brown
Responsible Dir.:	K. Trice
Target Date:	8/19/2001 12:00:00 AM
Corrective Actions:	Send personnel to submit bioassay. All RWPs, IWCPs were followed. Re-wrap mill and decon area and return to work.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	01-305
Originator:	
Project:	771
Date Entered:	7/17/2001 12:00:00 AM
Event Date:	7/14/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	8/20/2001 12:00:00 AM
Building:	771
Location:	183
Description:	While in premaire air, employee punctured left index finger. A whole body frisk was performed with no contamination detected. Employee was escorted to medical for a wound count. The first set of counts indicated a positive wound count. The individual was gloved and allowed to sit for approximately 15 minutes while waiting for medical personnel to arrive. A second set of wound counts were then performed which were below the decision level. Internal dosimetry was notified of the event and the subsequent wound counts. Their instructions were to issue the individual a bioassay kit.
RS Supervisor	M. J. Welling
Immediate Corrective Action:	Notifications made, wound count perform, bioassay kit issued.
Primary Event Code:	B14
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	T. R. Hergert
DOE Categorization:	Completed
Occurrence Rpt. No.:	2001-0186
Responsible Mgr.:	M. Brown
Responsible Dir.:	K. Trice
Target Date:	8/13/2001 12:00:00 AM
Corrective Actions:	Individual submitted bioassay and ISM meeting was held to re-enforce hand safety and attention to detail. Crew was then allowed to return to work.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	01-320
Originator:	
Project:	771
Date Entered:	7/19/2001 12:00:00 AM
Event Date:	7/18/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	8/20/2001 12:00:00 AM
Building:	771
Location:	146
Description:	During the removal of a hose from the vacuum source for process pipe removal , the hose popped off contaminating the two employees. Employee 2 had 700 dpm on the skin (back of neck), 500,000 dpm on his anti-cs and on the filters of his respirator. Employee 1 had 10,000 dpm on anti-cs and 6,000 dpm on the skin of left hand. Both individuals decontaminated in the facility.
RS Supervisor	M. J. Welling
Immediate Corrective Action:	Removed personnel from the room, whole body frisks performed, notifications made, personnel decon performed, PIF performed (employee 1 = 33 3 PIF, employee 2 = 2.8 PIF) Recovered the air sample.
Primary Event Code:	B4
Secondary Event Codes:	B5, B13
Apparent Cause:	PERSONNEL
Facility Mgr:	T. R. Hergert
DOE Categorization:	Completed
Occurrence Rpt. No.:	2001-0397
Responsible Mgr.:	R. T. VonFeldt
Responsible Dir.:	K. Trice
Target Date:	8/17/2001 12:00:00 AM
Corrective Actions:	Decon room 146 is contenting. Work packages and JHAs will be reviewed and revised to ensure hazards and controls are adequate for the removal of tygon tubing outside of a glovebox.
PATS No.:	
Comments:	

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Radiation Protection
Radiological Improvement Reports (RIR)

Welcome, **Steve Trujillo**

Radiological Improvement Report Details

RIR No.:	01-141
Originator:	
Project:	771
Date Entered:	3/31/2001 12:00:00 AM
Event Date:	3/28/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	4/26/2001 12:00:00 AM
Building:	771
Location:	182 tent
Description:	Upon exiting the SSC in room 182, it was discovered that employee's inner anti-cs were contaminated at the left knee to 4,000 dpm. Employee's modesty clothing was contaminated to 2,000 dpm. Employees left knee (skin) was contaminated to 414 dpm. Employee had been performing housekeeping activities in an attempt to maintain airborne radioactivity levels ALARA. RWP was 01-771-5289.
RS Supervisor	S. McNitt
Immediate Corrective Action:	Employee taken to decon room and successfully decontaminated. Results of decon are as follows 1st=192 dpm; 2=156, 3rd was
Primary Event Code:	B6
Secondary Event Codes:	C8
Apparent Cause:	PERSONNEL
Facility Mgr:	T. R. Hergert
DOE Categorization:	Completed
Occurrence Rpt. No.:	2001-0190
Responsible Mgr.:	T. Dieter
Responsible Dir.:	K. Trice
Target Date:	4/27/2001 12:00:00 AM
Corrective Actions:	771/774 closure project is requiring the use of masslinn mops to perform decontamination. When it is required to be on your knees, the use of knee pads is required to prevent wetted areas from absorbing through protective clothing.
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Comments:	

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Radiological Improvement Report Details

RIR No.:	01-349
Originator:	
Project:	771
Date Entered:	8/9/2001 12:00:00 AM
Event Date:	8/3/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	10/29/2001 12:00:00 AM
Building:	771
Location:	146A
Description:	While working in a glovebox, a hole was punctured in the glovebox glove. The individuals left anti-c glove was contaminated to 100,000 dpm without respiratory protection.
RS Supervisor	M. Welling
Immediate Corrective Action:	Whole body frisk of the individual, contained the contamination, made notifications, performed PIF calculations (62.5). Notified internal dosimetry, performed nasal smears and sent the individual to internal dosimetry.
Primary Event Code:	B5
Secondary Event Codes:	B13
Apparent Cause:	OTHER
Facility Mgr:	A. B. Adams
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	R. Kurd
Responsible Dir.:	K. Trice
Target Date:	9/2/2001 12:00:00 AM
Corrective Actions:	Glove was changed out. No spread of contamination. No CAM/SAAM alarms. Individual bioassay results were negative. No further action required.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	**01-409**
Originator:	
Project:	771
Date Entered:	9/21/2001 12:00:00 AM
Event Date:	9/20/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	9/24/2001 12:00:00 AM
Building:	771
Location:	183
Description:	While cutting Tank 716 in the bird cage, the working DAC for the tent was 66,000 DAC. This was above the RWP suspension guide limit.
RS Supervisor	M. J. Welling
Immediate Corrective Action:	Removed personnel from the tent and made notifications.
Primary Event Code:	B16
Secondary Event Codes:	
Apparent Cause:	MANAGEMENT SYSTEM
Facility Mgr:	T. R. Hergert
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	B. Kury
Responsible Dir.:	K. Trice
Target Date:	10/20/2001 12:00:00 AM
Corrective Actions:	All immediate corrective actions taken were correct and sufficient for closure.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	01-437
Originator:	
Project:	771
Date Entered:	10/11/2001 12:00:00 AM
Event Date:	10/8/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	10/23/2001 12:00:00 AM
Building:	771
Location:	183
Description:	RWP 5141. Individual was exiting the tent in a premier suit. He cross contaminated his anti-c's from his suit while doffing premier. Initially 2,500 dpm/100cm2 was found on the back of his anti-c's. This was taped over, no further contamination found by tent RCT. He removed his respirator and proceeded to the SOP. Another survey was performed and 4,200 dpm/100cm2 was found on the left anti-c leg. This was taped over and ant-c's doffed.
RS Supervisor	B. Ott
Immediate Corrective Action:	Taped over contamination, surveyed area under anti-cs, no contamination above MDA, individual passed through PCM, no further contamination was found. Performed nasal and mouth smears. Calculated PIF and sent individual to internal dosimetry.
Primary Event Code:	O
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	T. R. Hergert
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	B. Kury
Responsible Dir.:	K. Trice
Target Date:	11/7/2001 12:00:00 AM
Corrective Actions:	Immediate corrective action sufficient. No further action required.
PATS No.:	
Comments:	PA# KH-2001-3036

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Radiological Improvement Report Details

RIR No.:	01-459
Originator:	
Project:	771
Date Entered:	11/12/2001 12:00:00 AM
Event Date:	11/9/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	1/8/2002 12:00:00 AM
Building:	771
Location:	182
Description:	During size reduction of piping in the 182 tent, PU nitrate solution dripped from a sight glass onto the individual. The liquid penetrated his anti-cs contamination his skin. The areas affected area as follows: right hand & wrist 24,000 dpm, left hand & wrist 6,000 dpm, left thigh 1,722 dpm, left knee 1,626 dpm, lower left leg 960 dpm, and right buttocks 600 dpm. The individual could not be completely decontaminated in the facility, therefore, he was transported to Occupational Medicine were decontamination was completed. All area decontaminated to
RS Supervisor	M. J. Welling
Immediate Corrective Action:	Removed the individual from the tent, initiated decontamination activities within the facility, transported the individual to Occupational Medicine for continued decontamination efforts, notified Internal Dosimetry and issued bioassay kit and completed the RIR paper work.
Primary Event Code:	H
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	K. Blue
DOE Categorization:	Completed
Occurrence Rpt. No.:	2001-0586
Responsible Mgr.:	B. Kury
Responsible Dir.:	K. Trice
Target Date:	12/9/2001 12:00:00 AM
Corrective Actions:	See attached fact finding
PATS No.:	
Comments:	PA# KH-2001-3073

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Radiological Improvement Report Details

RIR No.:	01-463
Originator:	
Project:	771
Date Entered:	11/15/2001 12:00:00 AM
Event Date:	11/11/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	11/28/2001 12:00:00 AM
Building:	771
Location:	149
Description:	During D&D activities for GB 43, the individuals anti-c clothing became contaminated to 72,000 dpm with a total activity of 144,000 dpm. This resulted in a level 1 PI.
RS Supervisor	M. J. Welling
Immediate Corrective Action:	Contamination was contained, the clothing removed, notifications made, PIF calculated and nasal smears taken.
Primary Event Code:	O
Secondary Event Codes:	
Apparent Cause:	EQUIPMENT
Facility Mgr:	T. R. Hergert
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	R. Kury
Responsible Dir.:	K. Trice
Target Date:	12/11/2001 12:00:00 AM
Corrective Actions:	Several CAMs resulted during the initial size reduction steps for line 43. Line 43 is an old box and during initial glove checks and internal removal, contamination was found outside GB. Attempts were made to paint/seal GB were only partially successful. Respirators now required for all activities on line 43.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	01-464
Originator:	
Project:	771
Date Entered:	11/15/2001 12:00:00 AM
Event Date:	11/12/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	11/21/2001 12:00:00 AM
Building:	771
Location:	114
Description:	While removing plastic which contained removable contamination the individuals anti-cs became contaminated to 30,000 dpm with a total activity of 100,000 dpm. This resulted in a level 1 PI.
RS Supervisor	M. J. Welling
Immediate Corrective Action:	Contamination was contained and the clothing removed. PIF calculated and notifications made.
Primary Event Code:	O
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	T. R. Hergert
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	R. Kury
Responsible Dir.:	K. Trice
Target Date:	12/12/2001 12:00:00 AM
Corrective Actions:	While performing preps for painting the pedestal area following removal of 9A GB contamination levels under plastic exceeded 100K dpm/100cm2. Wet method was being used to remove plastic but individual's PCs became contaminated.
PATS No.:	
Comments:	PA# KH-2001-3100

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Radiological Improvement Report Details

RIR No.:	01-465
Originator:	
Project:	771
Date Entered:	11/15/2001 12:00:00 AM
Event Date:	11/15/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	11/21/2001 12:00:00 AM
Building:	771
Location:	146A
Description:	During D&D activities on GB SR-12, the individuals right anti-c glove became contaminated to 18,000 dpm. The individual was not in respiratory protection. This resulted in a level 1 PI.
RS Supervisor	M. J. Welling
Immediate Corrective Action:	Removed the contaminated clothing, made notifications, performed PIF calculations.
Primary Event Code:	O
Secondary Event Codes:	
Apparent Cause:	EQUIPMENT
Facility Mgr:	T. R. Hergert
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	R. Kury
Responsible Dir.:	K. Trice
Target Date:	12/15/2001 12:00:00 AM
Corrective Actions:	Upon survey, found pinhole in GB glove. Deconned area and posted ARA for several activities to ensure no further spread of contamination.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	02-003
Originator:	
Project:	771
Date Entered:	1/2/2002 12:00:00 AM
Event Date:	10/5/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	1/8/2002 12:00:00 AM
Building:	771
Location:	169
Description:	Individual received unplanned confirmed inhalations greater than 100 mrem.
RS Supervisor	M. J. Welling
Immediate Corrective Action:	Performed nasal smears. Upon receipt of positive nasal results, initiated bio-assay sampling, lung count and restricted individual pending final results. Requested assistance for root cause investigation with the Central Radiation Group. Final summary of evaluation is attached with corrective actions.
Primary Event Code:	B
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	T. R. Hergert
DOE Categorization:	Completed
Occurrence Rpt. No.:	2002-0005
Responsible Mgr.:	B. Kury
Responsible Dir.:	K. Trice
Target Date:	2/5/2002 12:00:00 AM
Corrective Actions:	See Attached Analysis Report on Investigation into Bldg 771 Internal Uptake of 10/5/01.
PATS No.:	
Comments:	Employee #1 1,600 mrem CEDE Employee #2 240 mrem CEDE

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Radiation Protection
Radiological Improvement Reports (RIR)

Welcome,
Steve Trujillo

Radiological Improvement Report Details

RIR No.:	02-025
Originator:	
Project:	771
Date Entered:	1/29/2002 12:00:00 AM
Event Date:	1/25/2002 12:00:00 AM
Status:	CLOSED
DateClosed:	2/11/2002 12:00:00 AM
Building:	771
Location:	114
Description:	While performing chemical decontamination inside Glove Box#3, due to a hole in a glove box glove, one individual was found to have 9,000 dpm on his skin on the inside upper arm. RWP# 02-771-5305.
RS Supervisor	M. J. Welling
Immediate Corrective Action:	Responded to the contaminated individual, decontaminated in the building on the first attempt, made notifications, and P.I. factor calculations performed. P.I. factor was 0.05.
Primary Event Code:	H
Secondary Event Codes:	
Apparent Cause:	EQUIPMENT
Facility Mgr:	H. Lerum
DOE Categorization:	Completed
Occurrence Rpt. No.:	2002-0050
Responsible Mgr.:	R. Kury
Responsible Dir.:	K. Trice
Target Date:	2/24/2002 12:00:00 AM
Corrective Actions:	Prior to performing chem decon in glove boxes all gloves must be 30 mil or greater. After decon they can be changed to 20 mil gloves for SCO shipment/packaging.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	02-026
Originator:	
Project:	771
Date Entered:	1/29/2002 12:00:00 AM
Event Date:	1/26/2002 12:00:00 AM
Status:	CLOSED
DateClosed:	2/14/2002 12:00:00 AM
Building:	771
Location:	114
Description:	During PPR of the 3 inch house vacuum header on the east side of Room 114. PuNO3 leaked from the pipe contaminating 5 individuals. This included one indvidual who had approximately 2,000 dpm on the skin of the right hand. This individual was decontaminated within the facility. One other individual had approximately 1,500 dpm on modesty clothing. Individuals were contaminated on their anti-C's with levels up to 500,000 dpm. There were 3 level one P.I's and 1 level 2 P.I. RWP# 02-771-5347.
RS Supervisor	M. J. Welling
Immediate Corrective Action:	Evacated the area and responded to the contaminated individuals. Decontaminated the skin contamination individual, made notifications, performed PIF calculations and notified Internal Dosimetry of the PI's.
Primary Event Code:	H
Secondary Event Codes:	
Apparent Cause:	PROCEDURE
Facility Mgr:	H. Lerum
DOE Categorization:	Completed
Occurrence Rpt. No.:	2002-0052
Responsible Mgr.:	R. Kury
Responsible Dir.:	K. Trice
Target Date:	2/25/2002 12:00:00 AM
Corrective Actions:	Room decontaminated. Briefing held with crew to review work controls. Work package revised to include additional guidance for PPR of house vacuum header. (See attached)
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Radiological Improvement Report Details

RIR No.:	02-032
Originator:	
Project:	771
Date Entered:	2/6/2002 12:00:00 AM
Event Date:	12/2/2001 12:00:00 AM
Status:	CLOSED
DateClosed:	3/5/2002 12:00:00 AM
Building:	771
Location:	771
Description:	Five respirators were found contaminated in Building 549.
RS Supervisor	M. J. Welling
Immediate Corrective Action:	The respirators were returned to Building 771 for processing.
Primary Event Code:	T
Secondary Event Codes:	
Apparent Cause:	PERSONNEL/TRAINING
Facility Mgr:	K. Blue
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	R. Kury
Responsible Dir.:	Kelly Trice
Target Date:	3/8/2002 12:00:00 AM
Corrective Actions:	Have established dedicated RCTs to syrvey respirators. Have set expectations to have zero returns.
PATS No.:	
Comments:	

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Contact
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Radiological Improvement Report Details

RIR No.:	02-067
Originator:	I.
Project:	771
Date Entered:	4/9/2002 12:00:00 AM
Event Date:	4/6/2002 12:00:00 AM
Status:	CLOSED
DateClosed:	5/9/2002 12:00:00 AM
Building:	771
Location:	149
Description:	CAM alarmed in Room 149, 4 individuals received contamination on their Anti-C's. One individual also received 6,800 dpm on his respirator and 336 dpm on his right ear. PIF of 1.12. Working under RWP # 02-771-5372.
RS Supervisor	M. J. Welling
Immediate Corrective Action:	Made notifications, decontaminated the individual in the facility, performed PIF calculations.
Primary Event Code:	O
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	M.W. Beranek
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	Robert Kury
Responsible Dir.:	Kelly Trice
Target Date:	5/6/2002 12:00:00 AM
Corrective Actions:	The RCT was instructed in the proper way to remove a contaminated respirator. No further action required.
PATS No.:	
Comments:	Price-Anderson Screen Initiated - No

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Radiological Improvement Report Details

RIR No.:	02-174
Originator:	
Project:	771/774
Date Entered:	9/19/2002 7:32:00 AM
Event Date:	9/13/2002 3:00:00 PM
Status:	CLOSED
DateClosed:	11/10/2002 12:00:00 AM
Building:	771
Location:	Room 146A
Description:	Two individuals transferred a cart of scaffolding from Rm 149 to the scaffold storage area in Rm 146A. The scaffolding had been previously surveyed while in Rm 149. During the unloading of the cart in Rm 146A, both individuals were found to have contamination on outer PCs. Approximately 50K dpm/100cm2 were found on one individual resulting in a level 2 PI. Both individuals were sent for bioassay.
RS Supervisor	H. Cruickshank
Immediate Corrective Action:	Path from 149 to 146A was surveyed and 2K - 8K dpm/100cm2 was found just outside of Rm 146A. Room was posted HCA until further surveys and decon were completed.
Primary Event Code:	O
Secondary Event Codes:	Q
Apparent Cause:	LEGACY
Facility Mgr:	Kevin Blue
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	Robert Kury
Responsible Dir.:	Tom Dieter
Target Date:	10/18/2002 12:00:00 AM
Corrective Actions:	Held meeting w/all D&D supervisors and reviewed the incident as well as reviewing the commitment for D&D supervisors to ensure that all work activities in the back areas had constant HP coverage. Reviewed w/RCTs at toolbox the importance of thorough surveys and the need for HP coverage on all work activities performed in the back unless approved by RCT Supervision.
PATS No.:	N/A
Comments:	Held meeting w/all D&D supervisors and reviewed the incident as well as reviewing the commitment for D&D supervisors to ensure that all work activities in the back areas had constant HP coverage. Reviewed w/RCTs at toolbox the importance of thorough surveys and the need

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Radiological Improvement Report Details

RIR No.:	02-200
Originator:	
Project:	771/774
Date Entered:	10/4/2002 8:35:00 AM
Event Date:	10/3/2002 8:35:00 AM
Status:	CLOSED
DateClosed:	11/10/2002 12:00:00 AM
Building:	771
Location:	771/rm 114
Description:	During raschig ring removal in Room 114, pin hole leak in sleeving resulted in spread of contamination, CAM alarm. Workers were not in respiratory protection resulting in several Level 2 PIs.
RS Supervisor	Robert Kury
Immediate Corrective Action:	All personnel in Room 114 during the CAM alarm were given nasal/mouth surveys and those above Level 2 PI were sent priority. Contacted Internal Dosimetry and initiated bioassay on personnel Performed survey of raschig ring tank area and found approximately 2-5k dpm/100cm2 on sleeving. Deconned and posted room . Fact Finding meeting was set up.
Primary Event Code:	O
Secondary Event Codes:	
Apparent Cause:	PEOPLE
Facility Mgr:	Tom Hergert
DOE Categorization:	Completed
Occurrence Rpt. No.:	771OPs-2002-0014
Responsible Mgr.:	Robert Kury
Responsible Dir.:	Tom Dieter
Target Date:	11/3/2002 8:35:00 AM
Corrective Actions:	See Facti Finding minutes - 771OPS-2002-0014 - Internal Tracking # 2002-0426
PATS No.:	N/A
Comments:	All corrective actions identified in Internal Tracking #2002-0426 have been completed. Still awaiting final exposure for one individual. All others individuals are less than 25 mrem internal exposure.

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Radiological Improvement Report Details

RIR No.:	03-030
Originator:	
Project:	771/774
Date Entered:	2/7/2003 4:00:00 PM
Event Date:	2/7/2003 3:15:00 PM
Status:	CLOSED
DateClosed:	3/10/2003 12:00:00 AM
Building:	771
Location:	Room 249, FU2C Plenum
Description:	During FU2C plenum entry, one individual had approximately 1800 dpm/100cm2 on back of neck. Lapel air sample for individual resulted in level II PI (approx. 3900 DAC-hr). Potential hole in Level B Garment and/or some seepage through the zipper area.
RS Supervisor	Robert Kury
Immediate Corrective Action:	Individual was deconned with soap and warm water to remove contamination on back of neck. Nasal/mouth swabs were expedited through internal dosimetry. Individual was restricted from back area and received lung count and fecal kit. Lung Count and nasal/mouth results were less than decision level. Individual submitted fecal samples and was released back to work. Internal Dosimetry bound the internal exposure to less than 100 mrem internal exposure. The actual dose the individual received was 13 mrem internal exposure.
Primary Event Code:	H
Secondary Event Codes:	O
Apparent Cause:	EQUIPMENT
Facility Mgr:	Hergert, Thomas
DOE Categorization:	Completed
Occurrence Rpt. No.:	
Responsible Mgr.:	Robert Kury
Responsible Dir.:	Dieter, Thomas
Target Date:	3/14/2003 12:00:00 AM
Corrective Actions:	Redesigned the doffing chamber to eliminate the possiblity of cross contamination during doffing operations. Added a second layer of PPE to individuals inside the Level B garment. Provided an additional layer of duct tape of all openings of suit. Held briefing with all associated workers on the event and the corrective actions taken.
PATS No.:	
Comments:	Followup entries into FU2C plenums (approx 15 -20 entries) have not resulted in any additional personnel contaminations or high lapel air samples. The corrective

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Radiological Improvement Report Details

RIR No.:	**04-045**
Originator:	
Project:	771/774
Date Entered:	6/22/2004 3:34:00 PM
Event Date:	6/21/2004 3:00:00 PM
Status:	OPEN
DateClosed:	
Building:	771
Location:	771
Description:	Contamination of 4545 dpm detected on workers head at SOP. Contamination was easily removed with a wet Kim wipe. Worker was power washing in Infinity Room tent when splashback occured.
RS Supervisor	Walt MacMillan
Immediate Corrective Action:	Evacuate the tent and suspend work activities. Conduct managers meeting to investigate cause and implement corrective actions.
Primary Event Code:	H
Secondary Event Codes:	O
Apparent Cause:	PEOPLE
Facility Mgr:	Tom Hergert
DOE Categorization:	TBD
Occurrence Rpt. No.:	
Responsible Mgr.:	Chris Gilbreath
Responsible Dir.:	
Target Date:	7/22/2004 12:00:00 AM
Corrective Actions:	
PATS No.:	
Comments:	

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BUILDING 707
RADIOLOGICAL
INCIDENT REPORTS
(1998 – 2003)

SEC00030

Radiological Improvement Report Details

RIR No.:	98-005
Originator:	
Project:	SSOC
Date Entered:	1/7/1998 12:00:00 AM
Event Date:	1/6/1998 12:00:00 AM
Status:	CLOSED
DateClosed:	1/22/1998 12:00:00 AM
Building:	707
Location:	A Module
Description:	While doing bagouts from A-65 glove box, employee was putting 8801 cans into 8802 cans and got a hole in 8801 can bag. Area contaminated by A-65 glove box was 10,000 dpm/100cm2 about 3 ft square max. Had 3 positive CAM alarms and employee contaminated on anti-cs. No skin contamination.
RS Supervisor	R. Stueckrath
Immediate Corrective Action:	Evacuated area. Surveyed personnel. Removed contaminated anti-cs. Evaluated for PI. Took air samples. Surveyed area, contained source of release. No PIs taken.
Primary Event Code:	B5
Secondary Event Codes:	B7
Apparent Cause:	
Facility Mgr:	D. Ciocchetti
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	B. Fiore
Responsible Dir.:	R. Bacon
Target Date:	2/5/1998 12:00:00 AM
Corrective Actions:	See attached information and rosters.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	98-180
Originator:	
Project:	SSOC
Date Entered:	5/6/1998 12:00:00 AM
Event Date:	5/5/1998 12:00:00 AM
Status:	CLOSED
DateClosed:	5/13/1998 12:00:00 AM
Building:	707
Location:	K Module
Description:	During brushing operations in K Mod, 2 CAMs alarmed and were classified positive. DAC level mx 5.9 DAC, one area <1 ft square found 500 dpm/wipe Alpha. No apparent source of contamination. No suspension guide limits exceeded.
RS Supervisor	T. Johnston
Immediate Corrective Action:	Evacuated module. Surveyed personnel. Pulled air samples. Notified proper personnel. Surveyed area.
Primary Event Code:	B7
Secondary Event Codes:	
Apparent Cause:	EQUIPMENT
Facility Mgr:	R. Sakaguchi
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	B. Fiore
Responsible Dir.:	R. Bacon
Target Date:	6/4/1998 12:00:00 AM
Corrective Actions:	Containment houses will be erected for bag in/out operations. Also more surveys should be taken to see if a source can be found. These houses will be built as soon as possible.
PATS No.:	
Comments:	Returned by RDR Administrator 5/8/98. Memo from B. Fiore received 5/13/98: Containment house has been built with air mover attached. Ongoing surveys and studies to prevent recurrence.

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Radiological Improvement Report Details

RIR No.:	98-182
Originator:	
Project:	SSOC
Date Entered:	5/6/1998 12:00:00 AM
Event Date:	5/6/1998 12:00:00 AM
Status:	CLOSED
DateClosed:	5/27/1998 12:00:00 AM
Building:	707
Location:	A Module
Description:	Breach of liquid from organic drain hose and pump causing organic liquid to spray on two workers, Saranex Tyvek coated, coverails were 120,000 dpm/100cm2 modesty clothing was 1733 dpm on the PCM2 and 864 dpm on Electra. Scaffolding wood was also contaminated with 120,000 dpm/100cm2. Clothing contaminated at SOP.
RS Supervisor	T. Johnston
Immediate Corrective Action:	Stopped draining, removed contaminated clothing, bagged up combustibles and contained contamination
Primary Event Code:	B6
Secondary Event Codes:	B5
Apparent Cause:	EQUIPMENT
Facility Mgr:	R. L. Garcia
DOE Categorization:	Completed
Occurrence Rpt. No.:	98-0273
Responsible Mgr.:	J.E. Rice
Responsible Dir.:	R. Bacon
Target Date:	6/5/1998 12:00:00 AM
Corrective Actions:	1. Engineering, IH and RE will design a containment to prevent liquid from spaying out of pump/hose should this happen again. 2. Characteristics of hose will be looked at to verify it is the correct type for this operation. 3. Area will be deconned and wood planking and scaffolding will be replaced. 4.. When job is restarted, personnel will rotate the hose more often than every 5 min.
PATS No.:	
Comments:	Returned by RIR Administrator 5/11/98. As of 5/16/98: The new pump has been received, the correct tubing for the pump has been verified and installed, the procedure has been changed to include a tube inspection prior to each use.

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Radiation Protection
Radiological Improvement Reports (RIR)

Radiological Improvement Report Details

RIR No.:	98-356
Originator:	
Project:	SSOC
Date Entered:	9/2/1998 12:00:00 AM
Event Date:	9/1/1998 12:00:00 AM
Status:	CLOSED
DateClosed:	9/30/1998 12:00:00 AM
Building:	707
Location:	A-Module
Description:	During routine glovebox operations for salts, operator had 5000 dpm on right upper arm. Hole in glovebox glove A-110. No other contamination detected.
RS Supervisor	R. Stueckrath
Immediate Corrective Action:	PI factor was 3.125, sent operator to Internal Dosimetry, contained gloveport (suspended RWP for A-100 ops similar to what caused this hole).
Primary Event Code:	B13
Secondary Event Codes:	
Apparent Cause:	EQUIPMENT
Facility Mgr:	D. Alison
DOE Categorization:	Completed
Occurrence Rpt. No.:	98-0549
Responsible Mgr.:	R. Cantwell
Responsible Dir.:	R. Bacon
Target Date:	9/30/1998 12:00:00 AM
Corrective Actions:	Revised RWP to require additional protective gloves.
PATS No.:	
Comments:	See attached RWP.

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Radiological Improvement Report Details

RIR No.:	98-240
Originator:	
Project:	SSOC
Date Entered:	6/16/1998 12:00.00 AM
Event Date:	6/15/1998 12:00:00 AM
Status:	CLOSED
DateClosed:	7/13/1998 12:00:00 AM
Building:	707
Location:	Storage Board Location
Description:	TLD was missing from storage board on 6/15/98. Last time TLD was worn was on 6/11/98. (Storage Board location 707)
RS Supervisor	A. D. Allshouse
Immediate Corrective Action:	Notified supervisor and Rad Safety
Primary Event Code:	C7
Secondary Event Codes:	
Apparent Cause:	OTHER
Facility Mgr:	W. Sproles
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	W. Sproles
Responsible Dir.:	R. Bacon
Target Date:	7/14/1998 12:00:00 AM
Corrective Actions:	Employee followed procedures and plant policies. No further action is required
PATS No.:	
Comments:	Per External Dosimetry, the dosimeter was never returned. The dosimeter is still lost. The individual reported it missing and never attempted to enter an area without it.

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Radiation Protection
Radiological Improvement Reports (RIR)
Welcome, Steve Trujillo

Radiological Improvement Report Details

RIR No.:	*98-467*
Originator:	
Project:	SSOC
Date Entered:	11/23/1998 12:00:00 AM
Event Date:	11/20/1998 12:00:00 AM
Status:	CLOSED
DateClosed:	12/14/1998 12:00:00 AM
Building:	707
Location:	E Module
Description:	While performing maintenance work in box E-20 a worker received 50,000 dpm on right sleeve of his Anti-Cs. There was a hole in the glove.
RS Supervisor	A. Allshouse
Immediate Corrective Action:	Stopped work. Contained contamination, posted module, performed PI evaluation, made notifications.
Primary Event Code:	A1
Secondary Event Codes:	
Apparent Cause:	EQUIPMENT
Facility Mgr:	D. Alison
DOE Categorization:	Completed
Occurrence Rpt. No.:	98-0718
Responsible Mgr.:	B. Walton/J. Rice
Responsible Dir.:	R. Bacon
Target Date:	12/19/1998 12:00:00 AM
Corrective Actions:	Corrective Actions: 1) Replaced damaged glovebox glove. 2) Repaired sharp edges of cotter pin. 3) Employee has submitted bio-assay sample. 4) See attached Nasal Smear results. 5) No further action is required at this time.
PATS No.:	*1998-001684*
Comments:	

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Radiation Protection
Radiological Improvement Reports (RIR)

Radiological Improvement Report Details

RIR No.:	98-491
Originator:	
Project:	SSOC
Date Entered:	12/17/1998 12:00:00 AM
Event Date:	12/15/1998 12:00:00 AM
Status:	CLOSED
DateClosed:	12/28/1998 12:00:00 AM
Building:	707
Location:	Module J
Description:	During bag cuts, 1st SAAM alarmed (16 cts Pu)-3 more CAMS alarmed in next 50 minutes. Total of 4 positive SAAM/CAMs.
RS Supervisor	B. L. Austin
Immediate Corrective Action:	Called supervision, Building announcement, responded to alarms.
Primary Event Code:	C7
Secondary Event Codes:	
Apparent Cause:	OTHER
Facility Mgr:	D. Alison
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	R. Fiori
Responsible Dir.:	R. Bacon
Target Date:	1/14/1999 12:00:00 AM
Corrective Actions:	This happened during normal bag out ops. No contamination found except on operators hand. No source other than normal conditions during bag out. No other out of the ordinary conditions observed.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	98-503
Originator:	
Project:	SSOC
Date Entered:	12/21/1998 12:00:00 AM
Event Date:	12/19/1998 12:00:00 AM
Status:	CLOSED
DateClosed:	2/19/1999 12:00:00 AM
Building:	707
Location:	Module A
Description:	Employee was working in GB A-110. Checked himself on the Alphamet after surveying and found 5,000 dpm on left glove and found 700 dpm on Glove 0015.
RS Supervisor	G. Osburn
Immediate Corrective Action:	Changed glove with pinhole in it. Did nasal and mouth smears.
Primary Event Code:	B13
Secondary Event Codes:	
Apparent Cause:	EQUIPMENT
Facility Mgr:	D. Alison
DOE Categorization:	Completed
Occurrence Rpt. No.:	98-0774
Responsible Mgr.:	R. Cantwell
Responsible Dir.:	R. Bacon
Target Date:	1/18/1998 12:00:00 AM
Corrective Actions:	Completed fecal samples, changed glove on GB. Checked other gloves for same problem. None found.
PATS No.:	1999-000234
Comments:	

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Radiological Improvement Report Details

RIR No.:	98-509
Originator:	
Project:	SSOC
Date Entered:	12/22/1998 12:00:00 AM
Event Date:	12/21/1998 12:00:00 AM
Status:	CLOSED
DateClosed:	1/5/1999 12:00:00 AM
Building:	707
Location:	J Module
Description:	Opening of drum in lock resulted in a contamination release . 2 positive SAAMs and 1 individual with skin contamination. Levels of skin contamination was 1500 dpm on back of hand and 5,000 dpm on chest.
RS Supervisor	J. Mattson
Immediate Corrective Action:	Secured work, evacuated area, decon of skin in decon room, PI given, notifications made.
Primary Event Code:	B4
Secondary Event Codes:	B5, B13
Apparent Cause:	EQUIPMENT
Facility Mgr:	Sakaguchi
DOE Categorization:	Completed
Occurrence Rpt. No.:	98-0780
Responsible Mgr.:	E. J. Poling
Responsible Dir.:	R. Bacon
Target Date:	1/20/1999 12:00:00 AM
Corrective Actions:	Hired full time RCT, characterize drums, survey and decon the C-Cell & hood, re-evaluate and smoke test hood, CCA will be responsible for PA announcements, continuing training for SAAM/CAM response, improve communications from C-Cell to Mod., restock decon room, purchase baggies, stock larger size tyvex coveralls in decon room.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	98-514
Originator:	
Project:	SSOC
Date Entered:	12/29/1998 12:00:00 AM
Event Date:	12/29/1998 12:00:00 AM
Status:	CLOSED
DateClosed:	2/2/1999 12:00:00 AM
Building:	707
Location:	E Module
Description:	RCTs entered module and discovered that 3 carts with ash material were moved out of radiation areas and create a new radiation area (unposted) by ash individual without RCT support.
RS Supervisor	A. D. Allshouse
Immediate Corrective Action:	Performed Rad surveys and posted areas appropriately, notified supervision.
Primary Event Code:	A6
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	M. Harris
DOE Categorization:	Completed
Occurrence Rpt. No.:	98-0791
Responsible Mgr.:	S. Scott
Responsible Dir.:	R. Bacon
Target Date:	1/28/1999 12:00:00 AM
Corrective Actions:	All team personnel have been briefed in tool box meeting and staff meeting on requirements to have RCT approval and support prior to material movement from rad areas.
PATS No.:	1998-001789
Comments:	Returned by RIR Administrator 1/11/99. Unsatisfactory closure.

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Radiological Improvement Report Details

RIR No.:	99-050
Originator:	
Project:	SSOC
Date Entered:	2/8/1999 12:00:00 AM
Event Date:	2/4/1999 12:00:00 AM
Status:	CLOSED
DateClosed:	2/19/1999 12:00:00 AM
Building:	707
Location:	A. B. Hallway
Description:	After bagging the SOP trash, 1911 dpm/100cm2 alpha contamination was found on anti-c gloves. No respirator worn.
RS Supervisor	A. D. Allshouse
Immediate Corrective Action:	Survey of bagged area, PI calculations, nasal taken, notifications made.
Primary Event Code:	B5
Secondary Event Codes:	
Apparent Cause:	TRAINING
Facility Mgr:	J. M. Flora
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	J. E. Poling
Responsible Dir.:	R. Bacon
Target Date:	3/4/1999 12:00:00 AM
Corrective Actions:	Employee was counseled on the proper anti-c doffing procedures and to ensure he only handles the outside of the laundry bags. Nasal/mouth smears negative.
PATS No.:	
Comments:	Code changed from B13 (Potential Level I Inhalation or Ingestion) to B5 (Loss of Containment Spill Inside Radiological Area) on 3/22/99 due to results of bioassay which showed no intake. which showed no intake. BJS

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Radiological Improvement Report Details

RIR No.:	99-062
Originator:	
Project:	SSOC
Date Entered:	2/12/1999 12:00:00 AM
Event Date:	2/11/1999 12:00:00 AM
Status:	CLOSED
DateClosed:	2/19/1999 12:00:00 AM
Building:	707
Location:	SOP
Description:	5,000 dpm on the right arm of PPE Anti-Cs. 600 dpm skin (same). Dosimeter initially 576 dpm and security badge 192 dpm. Deconned < MDA.
RS Supervisor	Mattson
Immediate Corrective Action:	RIR written and PI issued. Sent to medical for PI kit determination. A module posted respiratory protection @ 2300 hours, foreman and 3 RCTs responded. Deconned to
Primary Event Code:	B4
Secondary Event Codes:	B15
Apparent Cause:	EQUIPMENT
Facility Mgr:	D. Alison
DOE Categorization:	Completed
Occurrence Rpt. No.:	99-0087
Responsible Mgr.:	R. Cantwell
Responsible Dir.:	C. Cox
Target Date:	3/11/1999 12:00:00 AM
Corrective Actions:	1. Placed Velcro as padding over the sharp edge of shield door. 2. Hard card submitted to have other shield door evaluated by MTCE and cover other sharp edges. 3. Hard card submitted to have shield doors on chainveyor replaced with smaller shields as used on other GBs.
PATS No.:	
Comments:	Secondary event code changed from B13 (Potential Level I Inhalation or Ingestion) to B15 (Confirmed Inhalation or Ingestion <100 mrem) on 2/17/00. Confirmed <100 mrem CEDE. (das)

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Radiation Protection
Radiological Improvement Reports (RIR)

Welcome, **Steve Trujillo**

Radiological Improvement Report Details

RIR No.:	99-063
Originator:	
Project:	SSOC
Date Entered:	2/12/1999 12:00:00 AM
Event Date:	2/12/1999 12:00:00 AM
Status:	CLOSED
DateClosed:	3/11/1999 12:00:00 AM
Building:	707
Location:	D95 GB
Description:	Holes in two separate Gloves during GB activities. Individual #1 had 2000 dpm/100cm2 on anti-c glove. PI factor 1.25. Individual #2 had 30,000 dpm/100cm2 on anti-c gloves. PI factor 18.75.
RS Supervisor	A. D. Allshouse
Immediate Corrective Action:	Notifications made, PIs taken, TLD on #2 pulled, surveys of area
Primary Event Code:	B15
Secondary Event Codes:	B5
Apparent Cause:	EQUIPMENT
Facility Mgr:	R. L. Garcia
DOE Categorization:	Completed
Occurrence Rpt. No.:	99-0088
Responsible Mgr.:	J. VanDuzer
Responsible Dir.:	C. Cox
Target Date:	3/12/1999 12:00:00 AM
Corrective Actions:	Change gloves- Introduce leather gloves to use inside box- Inspect suspect gloves in box 95 and other boxes with similar activities.
PATS No.:	
Comments:	Event code changed from B13 (Potential Level I Inhalation or Ingestion) to B15 (Confirmed Inhalation or Ingestion <100 mrem) on 2/17/00 due to bioassay results. (das)

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Radiation Protection
Radiological Improvement Reports (RIR)

Welcome,
Steve Trujillo

Radiological Improvement Report Details

RIR No.:	99-070
Originator:	
Project:	SSOC
Date Entered:	2/18/1999 12:00:00 AM
Event Date:	2/18/1999 12:00:00 AM
Status:	CLOSED
DateClosed:	3/1/1999 12:00:00 AM
Building:	707
Location:	A Module
Description:	During routine salt glovebox ops, employee had 4,000 dpm on back of thumb of anti-c glove (very small spot 1cm2) Hole in glovebox glove-cause unknown. No other contamination detected outside of glovebox. GB glove 40,000 dpm.
RS Supervisor	R. Stueckrath
Immediate Corrective Action:	Glove contained. Sent individual to Internal Dosimetry. PI factor 2.5 surveyed.
Primary Event Code:	B5
Secondary Event Codes:	
Apparent Cause:	EQUIPMENT
Facility Mgr:	D. Alison
DOE Categorization:	Completed
Occurrence Rpt. No.:	99-0102
Responsible Mgr.:	R. Cantwell
Responsible Dir.:	C. Cox
Target Date:	3/20/1999 12:00:00 AM
Corrective Actions:	Had several operators evaluate glove. Determined to be caused by normal wear. Evaluated other gloves for excessive wear. Changed 3 other gloves.
PATS No.:	
Comments:	0 CEDE assigned

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Radiological Improvement Report Details

RIR No.:	99-067
Originator:	
Project:	SSOC
Date Entered:	2/17/1999 12:00:00 AM
Event Date:	2/16/1999 12:00:00 AM
Status:	CLOSED
DateClosed:	2/19/1999 12:00:00 AM
Building:	707
Location:	E Module
Description:	During routine ash ops, 1 employee had 10,000 dpm on anti-c glove (hole in GB glove). 2 employee had 1,000 dpm on anti-c glove. Positive CAM alarm. 20,000 dpm on GB glove. No other contamination.
RS Supervisor	R. Stueckrath
Immediate Corrective Action:	PI Factor- 1 employee was 6.25, 2nd employee .625. Sent to Internal Dosimetry. Changed GB glove.
Primary Event Code:	A1
Secondary Event Codes:	B5, B7, B15
Apparent Cause:	EQUIPMENT
Facility Mgr:	D. Alison
DOE Categorization:	Completed
Occurrence Rpt. No.:	99-0093
Responsible Mgr.:	P. Horning
Responsible Dir.:	C. Cox
Target Date:	3/18/1999 12:00:00 AM
Corrective Actions:	Raise worker awareness, purchase can opener that doesn't leave sharp edges, use leather gloves when appropriate.
PATS No.:	
Comments:	Event code changed from B13 (Potential Level I Inhalation or Ingestion) to A1 (Potential Level II or Confirmed Inhalation or Ingestion) on 3/22/99 due to bioassay results. Two confirmed CEDEs, one >100 mrem and one < 100 mrem. Secondary code changed to include B5. BJS

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Radiological Improvement Report Details

RIR No.:	99-118
Originator:	
Project:	SSOC
Date Entered:	3/16/1999 12:00:00 AM
Event Date:	3/15/1999 12:00:00 AM
Status:	CLOSED
DateClosed:	3/29/1999 12:00:00 AM
Building:	707
Location:	D Module
Description:	RWP 99-707-5410. While doing routine GB ops for dry repack, dry supervisor had 500 dpm on front of anti-C glove. Small hole in GB glove. Suspect prick from debris in box. No other contamination detected.
RS Supervisor	R. Stueckrath
Immediate Corrective Action:	Contained gloveport. Surveyed area. PI Factor .31. No nasal required. Cause unknown.
Primary Event Code:	B5
Secondary Event Codes:	
Apparent Cause:	EQUIPMENT
Facility Mgr:	R. Salingell
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	M. Swartz
Responsible Dir.:	C. Cox
Target Date:	4/14/1999 12:00:00 AM
Corrective Actions:	Gloves that are deemed "high use" are being placed on a 60 day change out schedule. Glove was changed, no further action required.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	**99-092**
Originator:	
Project:	SSOC
Date Entered:	3/1/1999 12:00:00 AM
Event Date:	2/27/1999 12:00:00 AM
Status:	CLOSED
DateClosed:	3/12/1999 12:00:00 AM
Building:	707
Location:	A Module
Description:	Hole in glove 0004 on A-120. Worker had 50,000 dpm alpha on palm of surgeons glove.
RS Supervisor	J. Stewart
Immediate Corrective Action:	Notify CCA on call, Rad Ops Forman, remove contamination glove from worker, whole body frisk, escort To SOP for PI evaluation, changed glove on box.
Primary Event Code:	B5
Secondary Event Codes:	
Apparent Cause:	EQUIPMENT
Facility Mgr:	D. Alison
DOE Categorization:	Completed
Occurrence Rpt. No.:	
Responsible Mgr.:	R. Cantwell
Responsible Dir.:	A. Crawford
Target Date:	3/29/1999 12:00:00 AM
Corrective Actions:	Changed glove, checked other operator in gloves, hole in glove was small and caused could not be identified. Operations now wear leather gloves while performing similar operations.
PATS No.:	
Comments:	No CEDE assigned

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Radiological Improvement Report Details

RIR No.:	99-285
Originator:	
Project:	SSOC
Date Entered:	6/17/1999 12:00:00 AM
Event Date:	6/16/1999 12:00:00 AM
Status:	CLOSED
DateClosed:	7/12/1999 12:00:00 AM
Building:	707
Location:	J Module
Description:	During material move, RWP 99-707-1257 requires a lead apron for material handlers for interaction with material outside of GB. An employee did not wear his while in training on move with supervisor.
RS Supervisor	R. Stueckrath
Immediate Corrective Action:	Pulled both employees TLDs. Evaluating RWP requirements. Was covered at pre-evolution.
Primary Event Code:	B1
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	T. Morgan
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	M. J. Landsers
Responsible Dir.:	C. Cox
Target Date:	7/15/1999 12:00:00 AM
Corrective Actions:	Both employees habe been counseled on this matter. Letter of reprimand have been issued.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	99-332
Originator:	
Project:	SSOC
Date Entered:	7/21/1999 12:00:00 AM
Event Date:	7/21/1999 12:00:00 AM
Status:	CLOSED
DateClosed:	8/23/1999 12:00:00 AM
Building:	707
Location:	A Module
Description:	Hole in GB glove. 10,200 dpm on right fingers.
RS Supervisor	T. Johnston
Immediate Corrective Action:	PI eval done, nasal mouth done, CCA notified, glove sealed off and changing it. 6.25 level I.
Primary Event Code:	B15
Secondary Event Codes:	B5
Apparent Cause:	EQUIPMENT
Facility Mgr:	R. L. Garcia
DOE Categorization:	Completed
Occurrence Rpt. No.:	99-0474
Responsible Mgr.:	J. Swartz
Responsible Dir.:	C. Cox
Target Date:	8/20/1999 12:00:00 AM
Corrective Actions:	Managers meeting held to identify better methods to identify glove failures. Stressed importance of glove check with employees.
PATS No.:	
Comments:	Returned to Resp. Mgr. for supporting closure documentation. 8/9/99 DAS. Confirmed CEDE <100 mrem 8/25/99. Event code change to B15 on 2/17/00. (das)

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Radiological Improvement Report Details

RIR No.:	99-181
Originator:	
Project:	SSOC
Date Entered:	4/14/1999 12:00:00 AM
Event Date:	4/14/1999 12:00:00 AM
Status:	CLOSED
DateClosed:	5/19/1999 12:00:00 AM
Building:	707
Location:	A Mod
Description:	During routine salt ops in A-mod, centerline had hole in glove. Only contamination out of glove on 2 employees. 10,000 dpm on left upper arm of anti-cs. PI factor 6.25 each. No other contamination. One other glove 10,000 dpm.
RS Supervisor	R. Stueckrath
Immediate Corrective Action:	Contained glove. Did nasals. Preparing for glove change.
Primary Event Code:	B5
Secondary Event Codes:	B11, B13
Apparent Cause:	EQUIPMENT
Facility Mgr:	D. Alison
DOE Categorization:	Completed
Occurrence Rpt. No.:	99-0238
Responsible Mgr.:	R. Cantwell
Responsible Dir.:	C. Cox
Target Date:	5/13/1999 12:00:00 AM
Corrective Actions:	Hole was caused from normal wear, operators were briefed on more diligent glove inspections and continued checks on self monitoring instrumentation.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	99-277
Originator:	
Project:	SSOC
Date Entered:	6/14/1999 12:00:00 AM
Event Date:	6/9/1999 12:00:00 AM
Status:	CLOSED
DateClosed:	6/22/1999 12:00:00 AM
Building:	707
Location:	D Module
Description:	Elevated air head in work area. Notified 2/18/99 by Thermal NuTech. Confirmed intake of 24 mrem 6/8/99
RS Supervisor	A. D. Allshouse
Immediate Corrective Action:	Requested voluntary bioassay.
Primary Event Code:	A1
Secondary Event Codes:	
Apparent Cause:	EQUIPMENT
Facility Mgr:	R. L. Garcia
DOE Categorization:	Completed
Occurrence Rpt. No.:	99-0360
Responsible Mgr.:	J. E. Van Duzer
Responsible Dir.:	C. Cox
Target Date:	7/8/1999 12:00:00 AM
Corrective Actions:	Resealed a window that was suspect. Dry Repack has implemented a glove change schedule for all GBs in module D. Had utilities increase flow in the appropriate GBs. Leather gloves are being used.
PATS No.:	1999-000903
Comments:	

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Radiological Improvement Report Details

RIR No.:	99-443
Originator:	
Project:	SSOC
Date Entered:	9/30/1999 12:00:00 AM
Event Date:	9/29/1999 12:00:00 AM
Status:	CLOSED
DateClosed:	10/26/1999 12:00:00 AM
Building:	707
Location:	J Module
Description:	Hole in a glove on box J-25 resulted in anti-c clothing contamination. Highest level was 50,000 dpm on right sleeve. There was skin contamination as well. 3120 dpm was detected on individual right thumb.
RS Supervisor	J. Mattson
Immediate Corrective Action:	Put operation in a safe configuration and contained glove. Deconned the thumb in the decon room. Changed hot glove and did follow up surveys. PI sampling performed and notifications made. PI factor 31.25.
Primary Event Code:	B4
Secondary Event Codes:	B5, B15
Apparent Cause:	EQUIPMENT
Facility Mgr:	T. Morgan
DOE Categorization:	Completed
Occurrence Rpt. No.:	99-0678
Responsible Mgr.:	J. Polling
Responsible Dir.:	C. Cox
Target Date:	10/29/1999 12:00:00 AM
Corrective Actions:	The GB gloves were changed. The operator was working according to procedures and within limits. Other follow up actions per attached fact finding summary sheet.
PATS No.:	
Comments:	B13 event code changed to B15 after confirmed intake of <100 mrem CEDE was reported on 11/29/99 (das).

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Radiological Improvement Report Details

RIR No.:	99-291
Originator:	
Project:	K-H
Date Entered:	6/21/1999 12:00:00 AM
Event Date:	4/27/1999 12:00:00 AM
Status:	CLOSED
DateClosed:	7/7/1999 12:00:00 AM
Building:	707
Location:	
Description:	Individual failed to return expired dosimetry and continued using the dosimetry. Individual stated she had used the TLD twice since expiration. Visitor Indoctrination training may have been expired on those entries
RS Supervisor	R. Stueckrath
Immediate Corrective Action:	TLD was removed from storage board 6/15/99 and supervision was notified.
Primary Event Code:	C7
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	T. D. Harney
DOE Categorization:	Completed
Occurrence Rpt. No.:	99-0394
Responsible Mgr.:	D. C. Shelton
Responsible Dir.:	J. Hill
Target Date:	7/20/1999 12:00:00 AM
Corrective Actions:	Spoke to supervisor, employee has been counseled. Do not expect a reoccurrence.
PATS No.:	
Comments:	

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Radiological Improvement Report Details

RIR No.:	99-318
Originator:	
Project:	SSOC
Date Entered:	7/7/1999 12:00:00 AM
Event Date:	7/7/1999 12:00:00 AM
Status:	CLOSED
DateClosed:	7/14/1999 12:00:00 AM
Building:	707
Location:	H Module
Description:	Three drums were discovered in H-Module with Gamma Neutron Readings >5mrem/hr@30cm and not in a posted rad area.
RS Supervisor	A. D. Allshouse
Immediate Corrective Action:	Area posted RA. Supervisor notified.
Primary Event Code:	A6
Secondary Event Codes:	
Apparent Cause:	PERSONNEL
Facility Mgr:	R. Sakaguchi
DOE Categorization:	Not Applicable
Occurrence Rpt. No.:	
Responsible Mgr.:	D. Davidson
Responsible Dir.:	C. Cox
Target Date:	8/6/1999 12:00:00 AM
Corrective Actions:	Investigations were done to identify who had placed the drums in this location. No individual person was identified. Building personnel will be briefed on movement of drums and RAs.
PATS No.:	1999-001084
Comments:	

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Database Links

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

Contact

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Radiological Improvement Report Details

RIR No.:	99-383
Originator:	
Project:	SSOC
Date Entered:	8/23/1999 12:00:00 AM
Event Date:	8/19/1999 12:00:00 AM
Status:	CLOSED
DateClosed:	9/7/1999 12:00:00 AM
Building:	707
Location:	A Module
Description:	Process Specialist had 150,00 dpm on Anti-C gloves during drum unpacking operations.
RS Supervisor	J. Mattson
Immediate Corrective Action:	PI Factor taken, gloves removed, drum sealed u and marked.
Primary Event Code:	B15
Secondary Event Codes:	
Apparent Cause:	EQUIPMENT
Facility Mgr:	T. L. Larabe
DOE Categorization:	Completed
Occurrence Rpt. No.:	99-0582
Responsible Mgr.:	M. Swartz
Responsible Dir.:	C. Cox
Target Date:	9/18/1999 12:00:00 AM
Corrective Actions:	Discussed with Operations/RCTs the use of tongs to remove items from contaminated drums in the future.
PATS No.:	
Comments:	Bioassay results confirm an intake of <100 mrem CEDE on 10/18/99. Event codes changed from B13 to A1. (kks) A1 event code replaced with B15 2/17/00. (das)

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Radiological Improvement Report Details

RIR No.:	99-393
Originator:	
Project:	SSOC
Date Entered:	8/31/1999 12:00:00 AM
Event Date:	8/31/1999 12:00:00 AM
Status:	CLOSED
DateClosed:	9/7/1999 12:00:00 AM
Building:	707
Location:	E Module
Description:	Under RWP 5412, cutting items from containment bags inside GB E-20. Upon checking hands on Alpha Met discovered contamination. RCT responded and was found to have 50,000 dpm/100cm2 on left anti-c glove.
RS Supervisor	A. D. Allshouse
Immediate Corrective Action:	Notifications made, contained glove, PI factor level 2, TLD pulled.
Primary Event Code:	B15
Secondary Event Codes:	B5
Apparent Cause:	PERSONNEL
Facility Mgr:	T. Harney
DOE Categorization:	Completed
Occurrence Rpt. No.:	99-0602
Responsible Mgr.:	P. Horning
Responsible Dir.:	C. Cox
Target Date:	9/30/1999 12:00:00 AM
Corrective Actions:	Additional reinforcement training to re-emphasize need to monitor hands after pulling out of gloves. GB team will inspect glove for failure mode. Employee will have nasal smear and fecal analysis.
PATS No.:	1999-001453
Comments:	<100 mrem CEDE confirmed intake reported 10/22/99 (kks). A1 event code changed to B15 on 2/17/00. (das)

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