Occurrence Report

Waste Isolation Pilot Plant

(Name of Facility)

Nuclear Waste Operations/Disposal

(Facility Function)

Carlsbad Area Office Westinghouse Waste Isolation Div.

(Laboratory, Site, or Organization)

Name: XXXXX
Title: ASSIST MGR **Telephone No.:** XXXXX

(Facility Manager/Designee)

Name: XXXXX
Title: ASSIST MGR **Telephone No.:** XXXXX

(Originator/Transmitter)

Name: **Date:**

(Authorized Classifier (AC))

1. Occurrence Report Number: ALO--WWID-WIPP-2000-0002

SR-90 Source Not placed back in storage area

2. Report Type and Date: Final

	Date	Time
Notification:	06/19/2000	10:45 (MTZ)
Initial Update:	07/20/2000	14:52 (MTZ)
Latest Update:	07/20/2000	14:52 (MTZ)
Final:	09/05/2000	05:38 (MTZ)

3. Occurrence Category: Off-Normal

4. Number of Occurrences: 1 **Original OR:**

5. Division or Project: WID/WIPP

6. Secretarial Office: EM - Environmental Management

7. System, Bldg., or Equipment: 451 - Support Buiilding - Analytical Lab

8. UCNI?: No

9. Plant Area: Analytical Lab

10. Date and Time Discovered: 06/16/2000 07:46 (MTZ)

11. Date and Time Categorized: 06/16/2000 09:00 (MTZ)

12. DOE Notification:

13. Other Notifications:

14. Subject or Title of Occurrence:

SR-90 Source Not placed back in storage area

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15. Nature of Occurrence:

01) Facility Condition

D. Loss of Control of Radioactive Material/Spread of Radioactive Contamination

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16. Description of Occurrence:

At 0746 on June 16, 2000 the Radiological Control Manager notified the Central Monitoring Room Operator of a Sr-90 radioactive source not in the proper storage place. The source was left in the Analytical Calibration Lab from the swingshift Radiological Control Technician (RCT) and was not placed in the storage safe as required. The swingshift RCT left the site at 0130 on June 16, 2000. At 0738 on June 16, 2000 an on-coming dayshift RCT began operability checks on equipment in the Analytical Calibration Lab when she found the source. She immediately notified her manager. The manager instructed the RCT to place the source in its proper location and to document the event. The manager then notified the Central Monitoring Room Operator.

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17. Operating Conditions of Facility at Time of Occurrence:

In Waste Storage Mode. No waste stored on surface.

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18. Activity Category:

03 - Normal Operations

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19. Immediate Actions Taken and Results:

The Sr-90 source was immediately placed back in the storage room and in the safe. The RCT who found the source notified the Radiological Control Manager. The Manager discussed the event with the FMD and is going to conduct further investigation.

20. Direct Cause:

3) Personnel Error

A. Inattention to Detail

21. Contributing Cause(s):

3) Personnel Error

D. Other Human Error

22. Root Cause:

3) Personnel Error

A. Inattention to Detail

23. Description of Cause:

After review of the event and interview of the Radiological Control personnel involved the Radiological Control Manager and Team Leader it was determined that the root cause of the event was inattention to detail. The person who left the source unattended has over 20 years experience and he understood the process and procedure for source control. The direct cause was not placing the source back in the safe after use, eventhough the person knew and understood the procedure, inattention to detail. A contributing cause to the event was that the RCT was preparing to leave the next day on a two month leave of absence for medical treatment (out of the state of New Mexico). In his interview he stated that his frame of mind was not as focused on the job as it normally is.

The source is a sealed source and is in container which contains a springloaded door to allow closure after use. The room in which the source was left is limited access for authorized personnel and contains a cypher lock on the door. There was no authorized access into the room after 1600 on June 15, 2000, until 0700 on June 16, 2000. There were no radiological exposures to the workers during this time.

24. Evaluation (by Facility Manager/Designee):

Review of the event was completed on July 13, 2000. The event root cause was due to inattention to detail. The actions performed by the RCT who found the source were immediate and correct. The Radiological Controls Manager will conduct a follow up meeting with the RCTs on source control and accountability. A toolbox meeting was held after the event and personnel attention to detail, source control and accountability will be re-emphasized at the follow up meeting scheduled for July 13, 2000 to preclude a similar event from occurring. The Radiological Control Manager also briefed the RCT who left the source outside of the safe. The briefing was conducted by phone due to departure of the RCT for previously scheduled medical treatment.

This event was reported based on procedural criteria which were established at a level several orders of magnitude lower than the threshold values referenced in DOE M 232.1-1A. The WIPP Occurence Reporting procedure will be revised to reflect the threshold values required by the DOE Order.

25. Is Further Evaluation Required?: No

26. Corrective Actions

(* = Date added/revised since final report was approved.)

1.

The Radiological Control Manager will conduct a toolbox meeting with the responsible organization to re-emphasize source control and accountablity.	
Target Completion Date: 07/20/2000	**Completion Date:** 07/13/2000

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27. Impact on Environment, Safety and Health:

None

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28. Programmatic Impact:

None

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29. Impact on Codes and Standards:

None

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30. Lessons Learned:

Periodic re-emphasis of the requirements for source control, accountability, and attention to detail is necessary to ensure that those requirements are consistently met.

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31. Similar Occurrence Report Numbers:

1. None

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32. User-defined Field #1:

33. User-defined Field #2:

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34. DOE Facility Representative Input:

FR concurs with the M&OC's assessment, RCAT conclusions, and the reasonableness/timeliness of actions taken in this occurrence.

Entered by: XXXXX Date: 09/05/2000

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35. DOE Program Manager Input:

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36. Approvals:

Approved by:XXXXX Facility Manager/Designee

Date: 07/20/2000

Telephone No.: XXXXX

Approved by: XXXXX, Facility Representative/Designee
Date: 09/05/2000
Telephone No.:XXXXX

Approved by: Approval delegated to FR
Date: 09/05/2000
Telephone No.: XXXXX