



Department of Energy
Richland Operations Office
P.O. Box 550
Richland, Washington 99352

10-EMD-0074

APR 27 2010

Ms. J. A. Hedges, Director
Nuclear Waste Program
State of Washington
Department of Ecology
3100 Port of Benton Boulevard, Mail Stop H0-57
Richland, Washington 99354

Dear Ms. Hedges:

**15-DAY REPORT TO STATE OF WASHINGTON DEPARTMENT OF ECOLOGY
(ECOLOGY) CONCERNING FIRE ALARM AT RADIOCHEMICAL PROCESSING
LABORATORY (RPL), 325 BUILDING**

The Hanford Resource Conservation and Recovery Act Permit, Condition II.A.1, and Washington Administrative Code 173-303-360(2)(k) require that a report be filed with Ecology within 15 days of any incident that requires implementation of the contingency plan at a treatment, storage, or disposal facility. The fire alarm and subsequent evacuation of the RPL, 325 Building, on April 13, 2010, required actions that constitute an implementation of the contingency plan, even though the waste management operations in the facility were not directly involved. A 15-day report that meets the requirements for such reports is enclosed.

If you have any questions, please contact me, or your staff may contact Tony McKarns, of my staff, on (509) 376-8981.

Sincerely,

A handwritten signature in cursive script, appearing to read "Stephen R. Weil".

Stephen R. Weil, Director
Environmental Management Division

EMD: ACM

Enclosure

cc w/encl:
C. M. Andersen, PNNL
F. W. Bond, Ecology
Administrative Record (325 Hazardous Waste Treatment Units, T-3-4)
Environmental Portal, LMSI

**15-DAY REPORT FOR IMPLEMENTATION OF THE HANFORD SITE
RESOURCE CONSERVATION AND RECOVERY ACT CONTINGENCY PLAN**

The following 15-day report is prepared in compliance with Washington Administrative Code (WAC), Chapter 173-303-360(2)(k).

(i) Name, address, and telephone number of the owner or operator

U.S. Department of Energy
P.O. Box 550
Richland, Washington 99352
Telephone: (509) 376-7395

(ii) Name, address, and telephone number of the facility

Hanford Facility, 325 Building (Radiochemical Processing Laboratory)
P.O. Box 550
Richland, Washington 99352
Telephone: (509) 376-7395

(iii) Date, time, and type of incident (e.g., fire, explosion):

On Tuesday, April 13, 2010 at approximately 3:20 PM, Pacific Northwest National Laboratory (PNNL) staff observed smoke in the 325 Building basement. A fire alarm pull box was actuated due to the presence of smoke. The Hanford Fire Department responded and could not positively identify the source of the smoke. There was on-going permitted hot work (welding) in the vicinity of the smoke, but it could not be determined to be the source of the smoke. The accumulated smoke dissipated within a short time and the facility was cleared for re-entry by the Hanford Fire Department at 4:35 PM. A fire watch was established, and management initiated an investigation of potential causes.

PNNL staff discontinued work in the facility (including the 90-day accumulation areas and the permitted treatment and storage activities) in accordance with the Contingency Plan. No dangerous waste or hazardous substances were involved in the incident.

The incident met all three of the criteria given in the Hanford Emergency Management Plan, Section 4.2, and thus is considered an "activation" of the RCRA contingency plan requiring reporting pursuant to Washington Administrative Code 173-303-360.

(iv) Name and quantity of material(s) involved:

Smoke resulting from unknown causes. No hazardous materials were involved.

(v) The extent of injuries, if any:

No injuries occurred as a result of this incident.

(vi) An assessment of actual or potential hazards to human health or the environment, where this is applicable:

There was no known hazard. The fire department was summoned to determine the source of the smoke observed, but it could not be readily determined.

(vii) Estimated quantity and disposition of recovered material that resulted from the incident:

None.

(viii) Cause of the incident:

Investigation revealed a burned area of a filter associated with a portable exhaust unit used to provide additional ventilation for the welding operation.

(ix) Description of corrective action taken to prevent reoccurrence of the incident:

Hot work was suspended and a fire watch was posted in the affected area of the facility. Other corrective actions may be determined as the result of the management review of the incident; if so, they will be tracked to completion via the Laboratory's Assessment Tracking System.

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