Stanford Linear Accelerator Center

Quarterly Performance Analysis for the Occurrence Reporting and Processing System (ORPS)

Reportable and Non-Reportable Incidents

For period ending 12/31/04

As required by the DOE ORPS Order, an analysis was performed for the previous twelve months of both ORPS reportable and non-reportable events transmitted through the SLAC Facility Manager's Office for the period January 2004 through December 2004.

In October 2004, a SLAC contractor was injured as a result of an electrical arc flash that occurred during the installation of a circuit breaker in an energized 480-volt electrical panel. As a result, DOE appointed a Type A Accident Investigation Board to conduct an investigation. The Corrective Action Plan subsequently approved by DOE focuses on strengthening line and project management accountability for safety at SLAC; ensuring verification of the implementation and effectiveness of ES&H policies, training and procedures; strengthening control and oversight of safety in the workplace and changing the overall safety climate at SLAC.

Another ORPS reportable event involved a hoisting and rigging "near miss" which led to revised hoisting/rigging procedures, more rigorous refresher training, and the use of special lifting devices.

An analysis of the remaining occurrences in 2004 shows that most are related to either procedural deficiencies or trip/slip/fall accidents due to human error. With regard to the procedurally-related events, the resulting investigative reports and corrective actions focused on improving existing SLAC policies, guidelines or procedures after a thorough needs assessment. In response to the trip/slip/fall accidents, employees were given additional training and/or guidance, and in one case, engineering controls were put in place to remediate the tripping hazard. In addition, the entire accelerator tunnel floor was inspected for trip/fall hazards.

For events with similar contributing causes, the practice of notifying line managers of events and corrective actions in a timely manner via monthly occurrence logs and posted investigative reports heightened site awareness of these issues and facilitated the sharing of lessons learned throughout the Laboratory.