Summary Report of Occurrences Reviewed

From April 23 – 27, 2007

Summary: 28 occurrences at 12 sites reviewed during this period.

Significant Occurrences (6)

Near Misses – 4 occurrences at 4 sites

- *RW Yucca Mountain Project (Significance Category 3).* On April 20, 2007, a drill core barrel on the Sonic Drill Rig operating at a borehole drilling pad broke and fell. One end of the core barrel stuck the deck of the drill platform and the other end came to rest on the mast of the drill rig. Workers were on the drill platform near the core barrel at the time of the break, but were not injured.
- <u>NA Lawrence Livermore National Laboratory (Significance Category 3).</u> On April 23, 2007, a construction worker drilled into an embedded electrical conduit containing an energized 277 volt lighting circuit. Scans of the concrete floor missed the circuit. The worker was wearing the appropriate PPE and was not injured.
- <u>SC Stanford Linear Accelerator Center (Significance Category 3).</u> On April 17, 2007, workers penetrated into a concrete tunnel used to house electrical utilities while installing a grounding rod for the Beam Transfer Hall construction project. The construction manager stopped all penetration activity pending the outcome of an investigation.
- <u>NE Idaho National Laboratory (Significance Category 3).</u> On April 23, 2007, during demolition using a mechanical hydraulic hammer attachment, a 1 by 3-inch piece of steel apparently traveled 250 feet and penetrated a window in a nearby building. The site standard exclusion area for hammering activities has been 75 feet for many years. Hammering of metallic objects will be suspended until this distance is reevaluated.

Occupational Safety/Industrial Hygiene – 1 occurrence at 1 site

• NE – United States Enrichment Corporation – K1600 Facility (Significance Category 3). On April 24, 2007, a welder experienced symptoms of respiratory exposure (coughing, fatigue, and slight nausea) while cutting a ¼" thick, painted metal plate covering a Teflon strip with a plasma torch. The welder was medically evaluated at a local hospital and returned to work the following day with no restrictions.

Safeguards and Security/Radiological Control – 1 occurrence at 1 site

• NA – Los Alamos National Laboratory (Significance Category 2). On March 26, 2007, a campaign to process and dispose of legacy radioactive waste stored since 1995 in a locked storage cage within TA-55 Room 201B discovered that radioactive material ash was missing. The tamper indicating device on the package was intact, but the package was empty. Material control and accountability personnel will determine if the ash had been combined with one of the other waste items stored in the cage area.

Other Occurrences (22). See Table (Note: The Table includes the occurrences listed above).

Occurrence Category	Number of Occurrences				Number
	E&E	NNSA	SC	DOE Total	of Sites
Injury – Industrial	3	0	1	4	4
Hygiene/Occupational Safety					
Near Miss	2	2	1	5	5
Authorization Basis	0	2	1	3	3
Radiological Concerns	1	1	0	2	2
Environmental	0	0	0	0	0
Fire Safety	0	0	0	0	0
Shipping/Quality Assurance	0	0	0	0	0
Criticality Safety	0	2	0	2	2
Industrial Operations	0	0	0	0	0
Conduct of Operations	1	0	0	1	1
Electrical Safety	1	2	0	3	2
Vehicle Accidents	0	0	0	0	0
Equipment Failures	0	2	0	2	1
Safeguards and Security	0	1	0	1	1
Suspect & Counterfeit Parts	2	2	0	4	3
Other	1	0	0	1	1
Total	11	14	3	28	

Secretarial Office Summary

National Nuclear Security Administration	14 occurrences	(5 sites)
Office of Environmental Management	7 occurrences	(4 sites)
Office of Science	3 occurrences	(3 sites)
Office of Civilian Radioactive Waste Management	2 occurrences	(1 site)
Office of Nuclear Energy	2 occurrences	(2 sites)