Summary Report of Occurrences Reviewed
From October 15 – 19, 2007

Summary: 23 occurrences at 14 sites reviewed during this period.

Significant Occurrences (3)

Equipment Failure – 1 occurrence at 1 site

- ***EM – Idaho National Laboratory (Significance Category 4).*** On October 12, 2007, during a loss of commercial power from the Antelope Sub Station to the Idaho National Laboratory, the Idaho Nuclear Technology and Engineering Center (INTEC) stand-by generators did not start. Pumps were not working and the service waste buildings began filling with waste water. Management was notified and the sources of water to the service waste systems were isolated. Some electrical panels suffered water intrusion and had to be dried out. While restoring electrical power, it was realized that the technical procedure for recovering from a loss of commercial power was predicated on startup of the stand-by generators. As such, there was no procedure in place for recovery. INTEC Power Operations put together a plan and restored commercial power and started all systems that had shut down.

Injuries – 1 occurrence at 1 site

- ***NE – Idaho National Laboratory (Significance Category 3).*** On October 11, 2007, a Nuclear Operations Maintenance Pipefitter received a hand injury while repairing fire hydrant (FH)-33. He was assisting with this repair when the hydrant operating rod that extends approximately 15 feet down to the valve located below the frost line slipped down and pinched his left middle finger. The finger was severed at the top of the finger nail. Work was stopped and the pipefitter was transported by private vehicle to the Eastern Idaho Regional Medical Center where he received sutures to seal the wound. He was released to return to work with some medical restrictions on the use of his hand.

Environmental Compliance – 1 occurrence at 1 site

- ***NA – Sandia National Laboratory (Significance Category 4).*** On October 16, 2007, while replacing a 20-year old Nitrogen Plant owned and maintained by a subcontractor, Center 1700 Facilities personnel discovered oil staining the ground under the compressor skid. The SNL Environmental Coordinator notified the SNL Spill Prevention Controls and Countermeasure Coordinator, who directed that the area be covered with plastic sheeting to prevent further leaching of oil into the soil in case there was rain. An official notification of the spill was made to the New Mexico Environmental Department. The depth the oil extends into the ground cannot be determined until the subcontractor digs down into the dirt to obtain soil samples. When the depth is known and when sample analyses results are obtained, the quantity of the leaked oil can be better estimated. The contaminated soil will be excavated and placed in a roll-off trailer for proper disposal.

Other Occurrences (20). See Table (Note: The Table includes the occurrences listed above).

Occurrence Category	Number of Occurrences				Number of Sites
	E&E	NNSA	SC	DOE Total	
Injury - Industrial Hygiene/Occupational Safety	1	1	1	3	3
Near Miss	1	0	0	1	1
Authorization Basis	2	0	0	2	2
Radiological Concerns	0	0	0	0	0
Environmental	0	1	0	1	1
Fire Safety	0	1	1	2	2
Shipping/Quality Assurance	1	0	0	1	1
Criticality Concerns	0	0	0	0	0
Industrial Operations	0	0	0	0	0
Conduct of Operations	3	2	0	5	4
Electrical Safety	1	1	0	2	2
Vehicle Accident	0	0	0	0	0
Equipment Failures	2	1	0	3	2
Safeguards and Security	0	0	0	0	0
Suspect & Counterfeit Parts	0	2	1	3	3
Other	0	0	0	0	0
Total	**11**	**9**	**3**	**23**	

Secretarial Office Summary

National Nuclear Security Administration	9 occurrences	(6 sites)
Office of Environmental Management	8 occurrences	(4 sites)
Office of Nuclear Energy, Science and Technology	3 occurrences	(1 site)
Office of Science	3 occurrences	(3 sites)