# Summary Report of Occurrences Reviewed
## *From January 21– 25, 2008*

**Summary:** 22 occurrences at 12 sites reviewed during this period.

**Significant Occurrences (7)**

### Fatality – 1 occurrence at 1 site

- ***SC – Oak Ridge National Laboratory (Significance Category 1).*** On January 22, a UT-Battelle employee was killed in a single-vehicle accident at approximately 7:05 AM. The employee was driving his pickup truck from the ORNL site to Commerce Park, an office park in the nearby city of Oak Ridge, when the truck hit black ice, slid off the road, and slammed sideways into a tree. The driver was wearing a seatbelt. Inclement weather conditions, including icy roads, existed at the time of the accident. The Oak Ridge Police Department is responsible for the investigation of the traffic accident.

### Injuries – 4 occurrences at 3 sites

- ***NE – Idaho National Laboratory (Significance Category 4).*** On January 16, a Specific Manufacturing Capability employee received a 3-inch long and ¼-inch deep cut on his upper right thigh when the blade guard failed to close while cutting 2x4s with a hand-held circular saw. The employee was in a kneeling position as he brought the saw back from the extended position and the spinning blade hit his coveralls, pulling the saw down onto his thigh. Further evaluation is being conducted on the saw as to why the guard failed to close and an investigation with formal cause analysis is being developed.

- ***NA – Savannah River Site (Significance Category 3).*** On January 22, an ironworker was knocked off a flatbed trailer while attempting to remove a 60-foot length of #11 (1-⅜-inch diameter) rebar from a bundle of rebar on the trailer. The rebar suddenly released from the bundle and hit the ironworker on his boot, knocking him to the ground. The ironworker was taken to the Emergency Room at Medical College of Augusta, Georgia, for evaluation and treatment, where X-Rays indicated a fracture in the right elbow. Attending physicians were forecasting surgery to assist in healing the elbow. A critique was conducted to understand the sequence of the event.

- ***NA – Y12 National Security Complex (Significance Category 3).*** On January 18, an apprentice ironworker was in the process of removing a metal shim, when the bull pin tool he was using unexpectedly released and struck him in the mouth causing the loss of eight teeth and requiring four stitches. The ironworker was working approximately 11 feet off the floor at the time of the incident and had to be safely lowered to the ground in a man lift. He was immediately transported to the hospital for evaluation and treatment and was released from the hospital the same night.

- ***NA – Y12 National Security Complex (Significance Category 3).*** On January 18, a Radiological Control Technician (RCT) fell off a metal box while attempting to hang a calendar on her office wall. The RCT was turning to step off the box, which measured 24 inches long by 16 inches wide and 5 inches tall, when she fell into a chair and then onto the floor. An ambulance transported the injured RCT to Oak Ridge Methodist Medical Center where doctors determined that she had broken 2 bones in three places in her lower leg that

required immediate surgery. A critique was held to develop a best time line. The cause of the incident could not be determined positively because the RCT was unavailable.

### Electrical Safety – 2 occurrences at 1 site

- ***EM – Hanford Site, Office of River Protection (Significance Category 4).*** On January 16, an ironworker had forgotten to unplug a drop cord from a scissors lift before he moved the lift, which pulled the female cord cap off, exposing the wires. The ironworker had moved the lift without the use of a spotter and was unaware of the situation. The damaged cord was later found by a carpenter. Work was stopped and an investigation was initiated.

- ***EM –Hanford Site, Office of River Protection (Significance Category 3).*** On January 16, a carpenter, who was using a power drill to install scaffolding straps to the export bay wall from a scissors lift, did not unplug the tool before moving the lift. The power cord became tangled in a tire on the lift and was severed into two pieces. The carpenter immediately stopped the lift and the spotter unplugged the cord from a spider box, and notified supervision. Work was stopped and an investigation was initiated.

**Other Occurrences (15).** 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 | 4 | 0 | 5 | 4 |
| Near Miss | 0 | 0 | 0 | 0 | 0 |
| Authorization Basis | 1 | 2 | 0 | 3 | 3 |
| Radiological Concerns | 0 | 0 | 1 | 1 | 1 |
| Environmental | 0 | 0 | 0 | 0 | 0 |
| Fire Safety | 0 | 3 | 0 | 3 | 3 |
| Shipping/Quality Assurance | 0 | 0 | 1 | 1 | 1 |
| Criticality Concerns | 0 | 0 | 0 | 0 | 0 |
| Industrial Operations | 0 | 0 | 0 | 0 | 0 |
| Conduct of Operations | 1 | 1 | 0 | 2 | 2 |
| Electrical Safety | 3 | 0 | 0 | 3 | 2 |
| Vehicle Accident | 0 | 0 | 1 | 1 | 1 |
| Equipment Failures | 2 | 1 | 0 | 3 | 2 |
| Safeguards and Security | 0 | 0 | 0 | 0 | 0 |
| Suspect & Counterfeit Parts | 0 | 0 | 0 | 0 | 0 |
| Other | 0 | 0 | 0 | 0 | 0 |
| **Total** | **8** | **11** | **3** | **22** | |

### Secretarial Office Summary

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|---|---|---|
| National Nuclear Security Administration | 11 occurrences | (6 sites) |
| Office of Environmental Management | 6 occurrences | (3 sites) |
| Office of Nuclear Energy, Science and Technology | 2 occurrences | (1 site) |
| Office of Science | 3 occurrences | (2 sites) |