Summary Report of Occurrences Reviewed
From August 18 – 22, 2008

Summary: 26 occurrences at 15 sites reviewed during this period.

Significant Occurrences (3)

Near Miss – 1 occurrence at 1 site

- ***SC – Pacific Northwest National Laboratory (Significance Category 3).*** On August 15, while lifting a 1,300-pound load of reinforcing steel bars at Building 3425 (the Ultra Low Background Counting Facility), the uppermost inner tube section of the crane boom unexpectedly and instantly retracted about 6 feet, dropping the load approximately 8 to 10 feet. No workers were in the drop area or under the load, but subcontractor ironworkers were in close proximity waiting for the load of bars. The crane operator had extended the mechanical fly section but failed to lock it properly, so when the boom angle was such that gravity overcame friction, the fly section suddenly slid into the boom section. The crane operator was not familiar with the operation of this fly section. The work in this area was immediately suspended and notifications were made. The crane was placed in a safe condition and removed from service pending further investigation.

Radiological Control – 1 occurrence at 1 site

- ***NA – Los Alamos National Laboratory (Significance Category 2).*** On August 12, a metal sliver punctured the pad of a glovebox technician's right thumb while the technician was guiding a stainless steel metal piece through a fastened-in-place nibbler in Room 319 of Building PF-4. A radiological control technician did not detect any surface contamination on the technician's hand; however, a wound count taken later at Occupational Medicine was positive for radiological contamination with results greater than 5,000 dpm alpha contamination. Machining operations throughout PF-4 have been suspended pending evaluation. The technician underwent chelation and wound excision. After two excisions of the wound, the original wound count went from 79-81 nanoCi to 0.16 nanoCi.

Industrial Operations – 1 occurrence at 1 site

- ***EM – Hanford Site, Office of River Protection (Significance Category 3).*** On August 19, while placing a 6,000-pound shield window liner on its side to attach jacking bolts to aid in positioning the window liner in a wall, two eye bolts sheared, causing the window to topple approximately 6 feet to the ground. The manufacturer's instructions intended for the shield window liner to be lifted in the vertical position by the eye bolts and not side-loaded, which is what occurred when the shield window liner was placed on its side. Rigging activities were halted, notifications were made and an investigation was initiated.

Other Occurrences (23). 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	0	0	2	2	1
Near Miss	0	0	1	1	1

Occurrence Category	Number of Occurrences				Number of Sites
	E&E	NNSA	SC	DOE Total	
Authorization Basis	0	2	0	2	2
Radiological Concerns	2	2	0	4	3
Environmental	0	1	0	1	1
Fire Safety	1	1	0	2	2
Shipping/Quality Assurance	0	0	0	0	0
Criticality Concerns	0	1	0	1	1
Industrial Operations	1	0	0	1	1
Conduct of Operations	1	1	1	3	1
Electrical Safety	2	1	1	4	4
Vehicle Accident	0	1	0	1	1
Equipment Failures	1	2	0	3	3
Safeguards and Security	0	0	0	0	0
Suspect & Counterfeit Parts	1	0	0	1	1
Other	0	0	0	0	0
Total	**9**	**12**	**5**	**26**	

Secretarial Office Summary

National Nuclear Security Administration	12 occurrences	(5 sites)
Office of Environmental Management	7 occurrences	(6 sites)
Office of Nuclear Energy	2 occurrences	(1 site)
Office of Science	5 occurrences	(3 sites)