Summary Report of Occurrences Reviewed
From September 29 – October 3, 2008

Summary: 31 occurrences at 20 sites reviewed during this period.

Significant Occurrences (2)

Near Miss – 1 occurrence at 1 site

- ***EM – Carlsbad Field Office, Waste Isolation Pilot Plant (Significance Category 3).*** On September 24, after loading an empty cask on a trailer, Remote Handling personnel were installing the upper canister impact limiter when two synthetic lifting slings failed and struck a Waste Handling Technician across the hand, forearm and chest. The incident scene was secured with barrier tape and a nurse evaluated the technician, noticing redness of the skin. The technician was taken to a local hospital for X-rays, seen by a Company physician, and released to work with no restrictions. After the impact limiter had been bolted in place, the spotter signaled the crane operator to lower the hoist on the 25-ton crane to allow the slings to be removed; however, the operator accidentally raised the hoist and overloaded the slings to failure. Each synthetic sling was rated at 3,200 pounds and had satisfactorily passed all pre-use inspection requirements before the evolution.

Radiological Exposure – 1 occurrence at 1 site

- ***NA – Los Alamos National Laboratory (Significance Category 4).*** On September 10, the official Dose Assessment Report on a worker exposed to airborne contamination on January 22, 2008 was released and critiqued. On the day of the event, Actinide Process Chemistry Group personnel performed a radiological "hot" job (spool replacement) in Room 409 of Building PF-4 at Technical Area 55. After the job was complete and post-job radiological surveys showed no elevated contamination levels, the room was released for normal operations. A Pit Disposition and Technology Group worker entered the room to perform minor administrative duties and was only in the room for a short amount of time. The following day, the room fixed-head air samplers were changed out and the results showed 76 DAC-hr, indicating that an airborne release had occurred during the spool replacement. As a precaution, the worker and other personnel who had entered the room following completion of the hot job were placed on diagnostic bioassay analysis. Only the worker, who performed administrative duties, had a measurable dose of 44 mrem, which is well below reportable limits.

Other Occurrences (29). 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	2	0	2	2
Near Miss	1	0	1	2	2
Authorization Basis	0	0	0	0	0
Radiological Concerns	3	1	1	5	5
Environmental	1	0	2	3	3
Fire Safety	0	2	2	4	3
Shipping/Quality Assurance	0	1	1	2	2

Occurrence Category	Number of Occurrences				Number of Sites
	E&E	NNSA	SC	DOE Total	
Criticality Concerns	0	0	0	0	0
Industrial Operations	0	0	0	0	0
Conduct of Operations	0	3	0	3	3
Electrical Safety	1	0	0	1	1
Vehicle Accident	0	0	0	0	0
Equipment Failures	4	1	0	5	4
Safeguards and Security	0	0	0	0	0
Suspect & Counterfeit Parts	2	0	1	3	3
Other	1	0	0	1	1
Total	**13**	**10**	**8**	**31**	

Secretarial Office Summary

National Nuclear Security Administration	10 occurrences	(7 sites)
Office of Environmental Management	10 occurrences	(6 sites)
Office of Fossil Energy	1 occurrence	(1 site)
Office of Nuclear Energy	2 occurrences	(1 site)
Office of Science	8 occurrences	(5 sites)