Summary Report of Occurrences Reviewed
From November 5 – 9, 2007

Summary: 30 occurrences at 14 sites reviewed during this period.

Significant Occurrences (6)

Injury – 1 occurrence at 1 site

- ***NA – Sandia National Laboratory - Livermore (Significance Category 3).*** On November 1, a contractor, reporting to work on a personal bicycle, fell when the bicycle wheel caught on the edge of a driveway. Security Police Officers responded to assist, but the contractor initially refused medical attention and requested a wheelchair to attend a scheduled meeting. At the meeting, a Senior Manager insisted that the contractor go to medical. The contractor went to medical and was then taken to Kaiser Hospital where a fractured hip was diagnosed.

Industrial Hygiene Exposure – 1 occurrence at 1 site

- ***NA – Lawrence Livermore National Laboratory (Significance Category 3).*** On November 5, during the demolition of a CO_2 fire suppression system, a subcontractor discovered pressure at the manual actuation panel, alerted facility personnel and stopped work. The facility contact confirmed the work stoppage while the fire suppression technician tried to locate the pressure. Despite verbal instructions to stop work, the subcontractor cut a small, pressurized pilot line. A loud compressed air type sound was heard when the line was cut and a small amount of CO_2 gas was released into Building 451. The subcontractor stopped work and alerted operations personnel and the security escorts to vacate. A total of six people left the area. Facility personnel contacted the Hazards Control Department for an evaluation of gas in the room. Air monitoring was conducted and found to be negative for CO_2.

Near Miss – 2 occurrences at 2 sites

- ***EM – Idaho National Laboratory (Significance Category 3).*** On October 19, while delivering six new empty waste boxes from an off-site warehouse to the Advanced Mixed Waste Treatment Project (AMWTP), one of the boxes fell from the flatbed truck when the driver turned a corner. The driver had previously delivered two of six waste boxes to another building and forgot to re-secure the tie-down straps when delivering the other four boxes to another building. Shift Operations and other AMWTP management were notified. There were no injuries and no people were in the vicinity when the event happened.

- ***EM – Hanford Site, Richland Operations Office (Significance Category 3).*** On November 5, while positioning a tractor trailer loaded with three pallets of 4ft x 8ft sheet metal and various types of piping up to a loading dock, the driver made a right turn of approximately 270 degrees and the unsecured load shifted. The sheet metal load slid into the wooden racks on the left side of the tractor trailer and broke three racks off where the stakes go into the stake pockets. The top two pallets of sheet metal spilled out of the trailer and onto the ground. No personnel were injured; however, the two pallets of sheet metal were deemed unusable.

Conduct of Operations – 2 occurrences at 2 sites

- ***NE – Idaho National Laboratory (Significance Category 3).*** On November 1, a Radiological Control Technician (RCT) injured her shoulder while assisting a Plant Operator and a Heavy Equipment Operator in opening a jammed sliding exterior door at the Advanced Test Reactor. When the door jammed, the employees first tried pushing it, to assist the motor in opening the door, and then applied force using a forklift to aid the motor. This caused the motor overload feature to actuate and stop the motor. Finally, electricians reset the thermal overloads to re-energize the motor and allow the door to the fully open. The RCT then complained of shoulder pain and was taken to medical for evaluation, and released with work restrictions. The Shift Supervisor was not informed of the problems with opening the door, that a protective device had actuated on the motor, or that an injury was associated with this effort.

- ***EM – Carlsbad Field Office (Significance Category 3).*** On November 6, a lockout/tagout was applied on two circuit breakers as an administrative control to prevent movement of an overhead bridge crane to support an engineering evaluation of the crane rails. The lockout/tagout specified that the two circuit breakers be in the Off/Open position. However, the lockout/tagout was applied with the circuit breakers in the On/Closed position, thus allowing crane movement. There were no injuries or equipment damage.

Other Occurrences (24). 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	3	0	4	3
Near Miss	2	0	0	2	2
Authorization Basis	2	2	0	4	4
Radiological Concerns	0	1	0	1	1
Environmental	1	0	0	1	1
Fire Safety	0	1	0	1	1
Shipping/Quality Assurance	0	0	0	0	0
Criticality Concerns	0	1	0	1	1
Industrial Operations	1	2	0	3	3
Conduct of Operations	5	1	0	6	6
Electrical Safety	1	1	0	2	2
Vehicle Accident	0	0	0	0	0
Equipment Failures	1	2	0	3	2
Safeguards and Security	0	0	0	0	0
Suspect & Counterfeit Parts	1	1	0	2	2
Other	0	0	0	0	0
Total	**15**	**15**	**0**	**30**	

Secretarial Office Summary

National Nuclear Security Administration	15 occurrences	(5 sites)
Office of Environmental Management	10 occurrences	(5 sites)
Office of Nuclear Energy, Science and Technology	2 occurrences	(1 site)
Office of Management	1 occurrence	(1 site)
Office of Legacy Management	1 occurrence	(1 site)
Office of Civilian Radioactive Waste Management	1 occurrence	(1 site)