

August 2009 Electrical Safety Occurrences

There were 12 electrical safety occurrences for August 2009:

- 3 resulted in shocks
- 11 involved inadequate lockout/tagout (LOTO)
- 9 involved electrical workers and 3 involved non-electrical workers
- 7 occurrences involved subcontractors
- 5 occurrences reported resulted from inadequate planning

After a significant reduction in the number of reports in July, August reports spiked to 12. Nearly all reports indicated a weakness in hazardous energy control programs or execution. Four of the events resulted when workers discovered electrical energy after the LOTO boundary had been established. In one of the four cases, the energy was discovered when a worker received a shock. For the second consecutive month, a crane pendant was the source of an electrical shock. This could be a predictive indication that pendants may be exposed to harsh environments and may need additional preventive maintenance. As we enter the final months of the calendar year, we should pay special attention to our LOTO programs. This year has provided evidence that improvement in that critical process may be warranted.

On a positive note, excavation and severed line events continue to track low through the summer season. Continued focus on prevention in these two areas is important for worker safety.

In compiling the monthly totals, the search initially looked for occurrence discovery dates in this month (excluding Significance Category R reports), and for the following ORPS "HQ keywords":

01K – Lockout/Tagout Electrical, 01M - Inadequate Job Planning (Electrical),
08A – Electrical Shock, 08J – Near Miss (Electrical), 12C – Electrical Safety

Using the key words above, 12 events were identified. Please continue to report all events and screen the events using the Electrical Severity Measurement Tool.

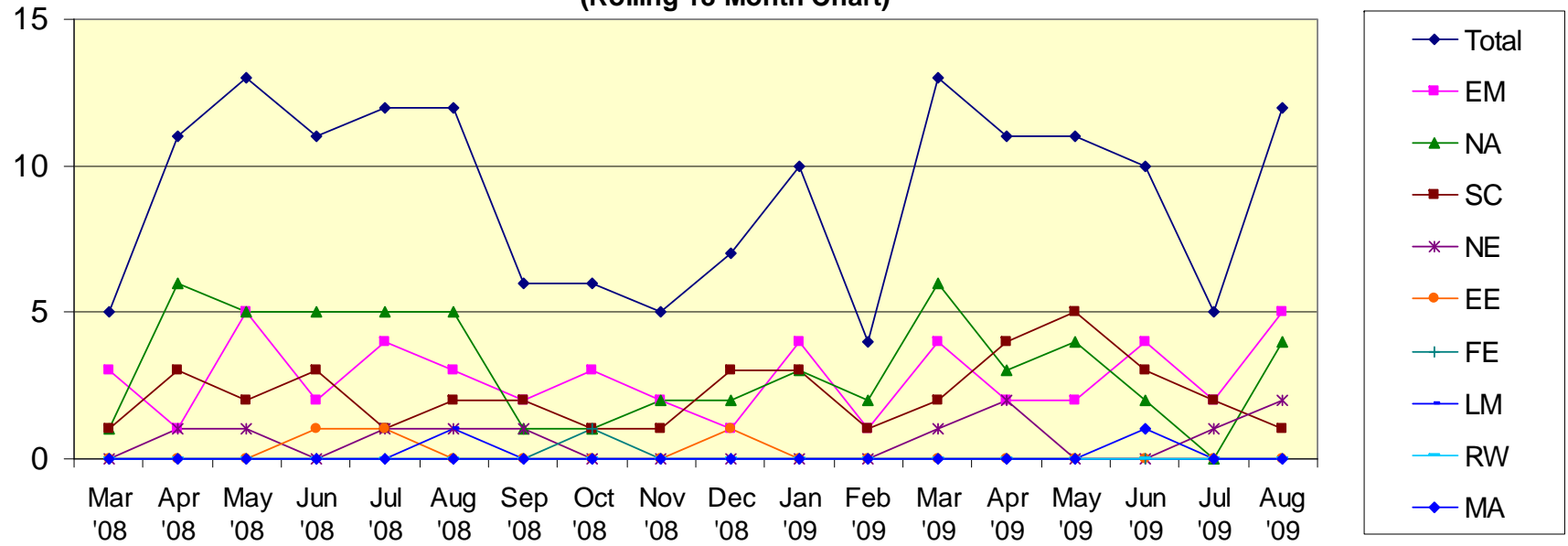
Below is the current summary of 2009 electrical safety occurrences:

Period	Electrical Safety Occurrences	Shocks	Burns	Fatalities
January-09	11	2	0	0
February-09	4	1	0	0
March-09	13	1	1	0
April-09	11	1	0	0
May-09	11	2	0	0
June-09	10	3	0	0
July-09	5	1	0	0
August-09	12	3	0	0
2009 total	77 (avg. 9.6/month)	14	1	0
2008 total	113 (avg. 9.4/month)	26	1	0
2007 total	140 (avg. 11.7/month)	25	2	0
2006 total	166 (avg. 13.8/month)	26	3	0
2005 total	165 (avg. 13.8/month)	39	5	0
2004 total	149 (avg. 12.4/month)	25	3	1

Eight months through the calendar year, the average rate of electrical safety occurrences in 2009 is 9.6 per month, which is above the average rate of 9.4 per month experienced in 2008. The 2009 average rate remains below the 2004 – 2007 average rates. Severity remains low, but the number of events continues to be a cause for concern, and should be considered a predictive indicator of more severe occurrences.

Electrical Occurrences by Month & Secretarial Office

(Rolling 18-Month Chart)



EE - Energy Efficiency and Renewable Energy, EM - Environmental Management, FE - Fossil Energy, LM - Legacy Management, MA - Management, NA - National Nuclear Security Administration, NE - Nuclear Energy, RW - Civilian Radioactive Waste Management, SC - Science

Electrical Safety Occurrences – August 2009

No	Report Number	Event Summary	EW ⁽¹⁾	N-EW ⁽²⁾	SUB ⁽³⁾	SHOCK	BURN	ARCF ⁽⁴⁾	LOTO ⁽⁵⁾	EXCAV ⁽⁶⁾	CUT/D ⁽⁷⁾	VEH ⁽⁸⁾	ES ⁽⁸⁾
1	EM-ID--CWI-BIC-2009-0004	While installing a steel pipe into a monitoring well, a worker received an electrical shock.		X		X			X				180
2	EM-ID--CWI-ICPWM-2009-0003	An operator received an electrical shock from a crane pendant.		X		X			X				330
3	EM-RL--MSC-FSS-2009-0001	Subcontractor electricians using a proximity voltage detector from outside the vault, detected energy on a bundle of 480V insulated cables after LOTO established.	X		X				X				0
4	EM--RP- WRPS - TANKFARM -2009-0009	A subcontract electrician received a 120 volt shock during startup testing.	X		X	X			X				330
5	EM--SR-PSC-SWPF-2009-0008	Electricians discovered power was supplied to open conductors.	X						X				0
6	NA--LASO-LANL-ADOADMIN-2009-0002	Access door to 480 volts was left open and unattended	X		X				X				0
7	NA--LASO-LANL-ADOADMIN-2009-0003	Electrician performed work without placing a personal locking device on the isolating device.	X		X								0
8	NA--SRSO-SRNS-TRIT-2009-0005	Construction electrician discovered electrical energy after LOTO established.	X		X				X				0
9	NA--SS-SNL-NMFAC-2009-0007	Construction electrician dropped a panel cover on an MCC buss.	X		X				X				100
10	NE--ID-BEA-MFC-2009-0002	Electrician applied LOTO device to wrong circuit.	X		X				X				0
11	NE--ID-BEA-SMC-2009-0010	Worker performed work inside relay panel without applying proper LOTO.	X						X				0

No	Report Number	Event Summary	EW⁽¹⁾	N-EW⁽²⁾	SUB⁽³⁾	SHOCK	BURN	ARCF⁽⁴⁾	LOTO⁽⁵⁾	EXCAV⁽⁶⁾	CUT/D⁽⁷⁾	VEH⁽⁸⁾	ES⁽⁸⁾
12	SC--PNSO-PNNL-PNNLNUCL-2009-0003	Worker performed work near energized receptacles with covers removed.		X					X				0
	TOTAL		9	3	7	3			11				

Key

(1)EW = electrical worker, (2)N-EW = non-electrical worker, (3)SUB = subcontractor, (4)ARCF = significant arc flash, (5)LOTO = lockout/tagout, (6)EXCAV = excavation, (7)CUT/D = cutting or drilling, (8)VEH = vehicle event, (9)ES = electrical severity

Electrical Safety Occurrences – August 2009

No	Report Number	Event Summary	NM ⁽¹⁾	PLAN ⁽²⁾	NEUT ⁽³⁾	70E ⁽⁴⁾	HV ⁽⁵⁾	LV ⁽⁶⁾	HFW ⁽⁷⁾	WFH ⁽⁸⁾	PPE ⁽⁹⁾	SC ⁽¹⁰⁾	RC ⁽⁸⁾
1	EM-ID--CWI-BIC-2009-0004	While installing a steel pipe into a monitoring well, a worker received an electrical shock.							X			3	2C(2)
2	EM-ID--CWI-ICPWM-2009-0003	An operator received an electrical shock from a crane pendant.						X	X			2	2C(1)
3	EM-RL--MSC-FSS-2009-0001	Subcontractor electricians using a proximity voltage detector from outside the vault, detected energy on a bundle of 480V insulated cables after LOTO established.						X		X		3	2C(2)
4	EM--RP-WRPS-TANKFARM-2009-0009	A subcontract electrician received a 120 volt shock during startup testing.						X	X			2	2C(1)
5	EM--SR-PSC-SWPF-2009-0008	Electricians discovered power was supplied to open conductors.						X		X		3	2C(2)
6	NA--LASO-LANL-ADOADMIN-2009-0002	Access door to 480 volts was left open and unattended		X				X		X		3	2C(2)
7	NA--LASO-LANL-ADOADMIN-2009-0003	Electrician performed work without placing a personal locking device on the isolating device.						X		X		4	10(2)
8	NA--SRSO-SRNS-TRIT-2009-0005	Construction electrician discovered electrical energy after LOTO established.		X				X		X		3	2C(2)
9	NA--SS-SNL-NMFAC-2009-0007	Construction electrician dropped a panel cover on an MCC buss.						X	X			3	2C(2)
10	NE--ID-BEA-MFC-2009-0002	Electrician applied LOTO device to wrong circuit.		X				X		X		3	2C(2)
11	NE--ID-BEA-SMC-2009-0010	Worker performed work inside relay panel without applying proper LOTO.		X				X		X		3	2C(2)

No	Report Number	Event Summary	NM ⁽¹⁾	PLAN ⁽²⁾	NEUT ⁽³⁾	70E ⁽⁴⁾	HV ⁽⁵⁾	LV ⁽⁶⁾	HFW ⁽⁷⁾	WFH ⁽⁸⁾	PPE ⁽⁹⁾	SC ⁽¹⁰⁾	RC ⁽⁸⁾
12	SC--PNSO-PNNL-PNNLNUCL-2009-0003	Worker performed work near energized receptacles with covers removed.		X				X		X		3	2C(2)
	TOTAL			5				11	4	8			

Key

(1)NM = near miss, (2)PLAN = job planning, (3)NEUT = neutral circuit, (4)70E = NFPA 70E issues, (5)HV = high voltage, (6)LV= low voltage, (7)HFW = hazard found the worker, (8)WFH = worker found the hazard, (9)PPE = inadequate or no PPE used, (10)SC = significance category, (11)RC = reporting criteria

ORPS Operating Experience Report

Production GUI - New ORPS

ORPS contains 54323 OR(s) with 57641 occurrences(s) as of 9/3/2009 1:02:58 AM

Query selected 12 OR(s) with 12 occurrences(s) as of 9/3/2009 1:03:48 AM

Download this report in Microsoft Word format. 

1)Report Number:	EM-ID--CWI-BIC-2009-0004 After 2003 Redesign		
Secretarial Office:	Environmental Management		
Lab/Site/Org:	Idaho National Laboratory		
Facility Name:	ICP Demolition and Decommissioning Activities		
Subject/Title:	Worker Receives Shock While Handling Well Piping		
Date/Time Discovered:	08/24/2009 15:00 (MTZ)		
Date/Time Categorized:	08/24/2009 16:35 (MTZ)		
Report Type:	Update		
Report Dates:	Notification	08/26/2009	18:43 (ETZ)
	Initial Update	08/26/2009	18:43 (ETZ)
	Latest Update	08/31/2009	18:06 (ETZ)
	Final		
Significance Category:	3		
Reporting Criteria:	<p>2C(2) - Failure to follow a prescribed hazardous energy control process (e.g., lockout/tagout) or a site condition that results in the unexpected discovery of an uncontrolled hazardous energy source (e.g., live electrical power circuit, steam line, pressurized gas). This criterion does not include discoveries made by zero-energy checks and other precautionary investigations made before work is authorized to begin.</p> <p>10(2) - An event, condition, or series of events that does not meet any of the other reporting criteria, but is determined by the Facility Manager or line management to be of safety significance or of concern to other facilities or activities in the DOE complex. One of the four significance categories should be assigned to the occurrence, based on an evaluation of the potential risks and the corrective actions taken. (1 of 4 criteria - This is a SC 4 occurrence)</p>		
Cause Codes:			
ISM:	2) Analyze the Hazards		
Subcontractor Involved:	No		
Occurrence Description:	On August 24, 2009, at approximately 2:30 PM, a Environmental Restoration (ER) well maintenance worker received a minor electrical shock from a 42-foot section of stainless steel piping as it was being		

lowered into a monitoring well.

The work was suspended by performing a Step Back and proper notifications made.

The worker was escorted to the Central Facility Area (CFA) Medical Facility for evaluation, and was returned to work with no restrictions.

The work was being performed approximately 30-feet from a 13.8 Kilo Volt (keV) line. The safe working distance from power lines described in the work order and per the DOE-standard DOE/STD-1009 required 15-foot minimum distance from the 13.8 lines. Workers were wearing the approved personal protective equipment (PPE), as described in the approved Work Order (WO) # 625734 "Site Wide Well Maintenance", and an approved Idaho National Laboratory (INL) Power Management Permit #214 "Pit 9 High Voltage Work Authorization". INL Power Management had inspected the work area prior to the start of the work to validate the permit requirements.

The scope of the work is to remove existing well piping from monitoring well CFA-1932, repair and re-install well pipe and pump. This work had been ongoing the first half of the day with no anomalies encountered. After lunch workers began re-installation of the well piping according to the work order. Workers had successfully re-installed six (6) section of the 42-foot well piping before this event.

A boom truck was used to facilitate removing and installing the well piping. The boom truck was located 20-feet beyond the well, and perpendicular to the high power transmission line at an approximate distance of 50-feet (away from) from the transmission lines; the truck's boom, with the rigging equipment (sling and load) when the lifted load was vertical and over the well, approached 30-foot distance from the power transmission line.

INL Power Management responded to the scene. Power Management could not determine a specific cause for the shock, but believed the most likely cause was that a static charge was induced (i.e. proximity to the transmission lines, work site is located between two separate power lines, humid air, damp ground, etc.).

Step Back upgrade to a formal "Stop Work".

Corrective actions being evaluated:

- Ground the Boom truck through the well surface casing,
- Evaluate grounding well pipe,
- INL Power Management to attempt to get voltage readings on equipment

	<p>with appropriate meters, and</p> <p>--Review and revise work control documents based on Lessons Learned(LL) from this event.</p> <p>UPDATE,</p> <p>08/27/09: Performed voltage testing on the overhead Power Lines in support of the corrective actions from the worker getting shocked while performing well maintenance activities. Electricians detected 1050 volts on the pipes while the cluster was attached using the nylon sling, and only 5 volts with the steel rope rigging. ORPS categorization changed from "Management Concern" to "Personal Safety and Health 2C(2), Sig. Cat 3.</p>
Cause Description:	
Operating Conditions:	Warm moist air from recent rains, sunny skies.
Activity Category:	Maintenance
Immediate Action(s):	<p>--Performed a Step Back.</p> <p>--Notified Power Management and Management,</p> <p>--Initiated a Step Back, per MCP-553,</p> <p>--Moved from a Step Back to a Stop Work,</p> <p>--Held a Fact Finding.</p>
FM Evaluation:	<p>This incident underscores the importance of evaluating the job hazards in and around the projected job scope in the Work Packages. Even though company procedures and standards in this case gave expected safe distances for working, and were adhered to, additional hazards were encountered in the field.</p> <p>Grounding of the components is a common sense answer to an uncommon event.</p>
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is Required:	No
Division or Project:	Environmental Restoration/CERCLA
Plant Area:	field work
System/Building/Equipment:	Monitoring Well CFA-1932
Facility Function:	Environmental Restoration Operations
Corrective Action:	
Lessons(s) Learned:	
HQ Keywords:	<p>08A--OSHA Reportable/Industrial Hygiene - Electrical Shock</p> <p>12C--EH Categories - Electrical Safety</p> <p>14L--Quality Assurance - No QA Deficiency</p>
HQ Summary:	<p>On August 24, 2009, an Environmental Restoration well maintenance worker received a minor electrical shock from a 42-foot section of stainless steel piping as it was being lowered into a monitoring well. The</p>

work was suspended by performing a Step Back and management notifications were made. The worker was escorted to the Central Facility Area Medical Facility for evaluation, and was released to work with no restrictions. INL Power Management responded to the scene. They could not determine a specific cause for the shock, but believed the most likely cause an induced static charge (i.e., proximity to 13.8 kV transmission lines, humid air, damp ground, etc.). Corrective actions are being evaluated including grounding the boom truck through the well surface casing and consideration of grounding the well pipe. A fact finding meeting was held.

Similar OR Report Number:

Facility Manager:	Name	Frank Webber
	Phone	(208) 533-3562
	Title	Environmental Restoration Director

Originator:	Name	CROFTS, BRYAN P
	Phone	(208) 533-0648
	Title	ISSUES COORDINATOR

HQ OC Notification:	Date	Time	Person Notified	Organization
	NA	NA	NA	NA

Other Notifications:	Date	Time	Person Notified	Organization
	08/24/2009	16:35 (MTZ)	Brad Joseph Davis	DOEID

Authorized Classifier(AC): Randall R. Vaden Date: 08/31/2009

2)Report Number: [EM-ID--CWI-ICPWM-2009-0003](#) After 2003 Redesign

Secretarial Office: Environmental Management

Lab/Site/Org: Idaho National Laboratory

Facility Name: Waste Management Project Activities and Facilities

Subject/Title: Equipment Operator Receives Electrical Shock From Operating A Crane - (ARRA)

Date/Time Discovered: 08/11/2009 11:15 (MTZ)

Date/Time Categorized: 08/11/2009 12:18 (MTZ)

Report Type: Notification

Report Dates:	Notification	08/13/2009	15:34 (ETZ)
	Initial Update		
	Latest Update		
	Final		

Significance Category: 2

Reporting Criteria:	2C(1) - Failure to follow a prescribed hazardous energy control process (e.g., lockout/tagout) or disturbance of a previously unknown or mislocated hazardous energy source (e.g., live electrical power circuit, steam line, pressurized gas) resulting in a person contacting (burn, shock, etc.) hazardous energy.
Cause Codes:	
ISM:	2) Analyze the Hazards 3) Develop and Implement Hazard Controls
Subcontractor Involved:	No
Occurrence Description:	<p>While manipulating a crane in building CPP-666, an equipment operator working for Waste Management received an electrical shock.</p> <p>On Tuesday, August 11, 2009 at approximately 11:00 preparing to pull hatch above the FDP cell, in building CPP-666, to prepare for evolution, a Waste Management Equipment Operator was holding the pendant and received an electrical shock.</p> <p>Work involving the crane and hatch pull was immediately stopped, the pendant area roped off, and the crane was de-energized and placed out of service until a troubleshooting work package was developed.</p> <p>The equipment operator's management team -- supervisor, escorted the equipment operator the Central Facilities Area (CFA) medical office and was kept for a lengthy time under observation. After the medical staff concluded their, the equipment operator was returned to work with no restrictions.</p> <p>While developing the troubleshooting package, Waste Operations Management conducted a walkthrough where from pulling voltage readings, it was discovered a voltage reading taken on the key switch -- from the crane's control box -- read 121-volts. After opening the control box cover, a wire was noticed to have been smashed with conductors exposed.</p> <p>The wire was touching a screw on the back of the contact block, which attached to the front end of the switch.</p> <p>After this discovery, tape was placed around the smashed wire, pulled slack into the junction box, and left for further review.</p>
Cause Description:	
Operating Conditions:	Waste Management Operations; Hatch Cover Lifting via a Crane
Activity Category:	Normal Operations (other than Activities specifically listed in this Category)
Immediate Action(s):	1) Worker transported to CFA medical (no restrictions given to worker).

	<p>2) Crane taken out of service, and area roped off.</p> <p>3) Troubleshooting maintenance package was developed to check crane's pendant; pinched wire found.</p> <p>4) Notifications made to DOE-ID and to CWI Sr. Management.</p> <p>5) Fact Finding meeting held.</p>
FM Evaluation:	<p>During the fact-finding it was determined this specific incident has not happened before, although numerous equipment problems have previously occurred with this crane. All immediate corrective actions were determined to be in compliance correctly implemented.</p> <p>This event's reporting criteria, with its significance category was derived from using the EFCOG Electrical Severity Measurement Tool:</p> <p>1) Electrical Hazard Factor - Yellow (moderate hazard - Class 1.2a) - 10</p> <p>2) Environmental Factor - Dry - 0</p> <p>3) Shock Proximity Factor - Within Prohibited Approach Boundary - 10</p> <p>4) Arc Flash Proximity Factor - No Arc Flash Exposure - 0</p> <p>5) Thermal Proximity Factor - 0</p> <p>6) PPE/Equipment Mitigation - No reduction factor</p> <p>7) Injury Factor - Shock (no fibrillation) 3</p> <p>Electrical Severity - $10 \times (1 + 0 + 10 + 0 + 0) \times 3 = 330$</p>
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is Required:	<p>Yes.</p> <p>Before Further Operation? No</p> <p>By Whom: Pat Troescher</p> <p>By When:</p>
Division or Project:	Waste Management Operations
Plant Area:	INTEC
System/Building/Equipment:	INTEC CPP-666, FDP Cell
Facility Function:	Nuclear Waste Operations/Disposal
Corrective Action:	
Lessons(s) Learned:	
HQ Keywords:	<p>07D--Electrical Systems - Electrical Wiring</p> <p>08A--OSHA Reportable/Industrial Hygiene - Electrical Shock</p>

	08G--OSHA Reportable/Industrial Hygiene - Industrial Equipment 12C--EH Categories - Electrical Safety 13H--Management Concerns - American Recovery and Reinvestment Act (ARRA) 14L--Quality Assurance - No QA Deficiency								
HQ Summary:	On August 11, 2009, while preparing to pull a hatch above the FDP cell, in building CPP-666, a Waste Management Equipment Operator was holding the crane pendant and received an electrical shock. Work was immediately stopped, the pendant area roped off, and the crane was de-energized and placed out of service until a troubleshooting work package was developed. A voltage reading taken on the key switch from the crane's control box read 121 volts. After opening the control box cover, a wire was noticed to have been smashed with conductors exposed and the wire was touching a screw on the back of the contact block, which attached to the front end of the switch. Tape was placed around the smashed wire and the slack was pulled into the junction box. A fact finding meeting was held.								
Similar OR Report Number:	1. EM-ID--CWI-LANDLORD-2008-0006 2. EM-ID--CWI-LANDLORD-2009-0004								
Facility Manager:	<table border="1"> <tr> <td>Name</td> <td>Pat Troescher</td> </tr> <tr> <td>Phone</td> <td>(208) 521-8611</td> </tr> <tr> <td>Title</td> <td>Nuclear Facility Manager, Waste Management Ops</td> </tr> </table>	Name	Pat Troescher	Phone	(208) 521-8611	Title	Nuclear Facility Manager, Waste Management Ops		
Name	Pat Troescher								
Phone	(208) 521-8611								
Title	Nuclear Facility Manager, Waste Management Ops								
Originator:	<table border="1"> <tr> <td>Name</td> <td>ALLRED, MATTHEW D</td> </tr> <tr> <td>Phone</td> <td>(208) 533-6294</td> </tr> <tr> <td>Title</td> <td>ORPS COORDINATOR</td> </tr> </table>	Name	ALLRED, MATTHEW D	Phone	(208) 533-6294	Title	ORPS COORDINATOR		
Name	ALLRED, MATTHEW D								
Phone	(208) 533-6294								
Title	ORPS COORDINATOR								
HQ OC Notification:	<table border="1"> <thead> <tr> <th>Date</th> <th>Time</th> <th>Person Notified</th> <th>Organization</th> </tr> </thead> <tbody> <tr> <td>NA</td> <td>NA</td> <td>NA</td> <td>NA</td> </tr> </tbody> </table>	Date	Time	Person Notified	Organization	NA	NA	NA	NA
Date	Time	Person Notified	Organization						
NA	NA	NA	NA						
Other Notifications:	<table border="1"> <thead> <tr> <th>Date</th> <th>Time</th> <th>Person Notified</th> <th>Organization</th> </tr> </thead> <tbody> <tr> <td>08/11/2009</td> <td>12:26 (MTZ)</td> <td>Shawn Murphy</td> <td>DOE-ID</td> </tr> </tbody> </table>	Date	Time	Person Notified	Organization	08/11/2009	12:26 (MTZ)	Shawn Murphy	DOE-ID
Date	Time	Person Notified	Organization						
08/11/2009	12:26 (MTZ)	Shawn Murphy	DOE-ID						
Authorized Classifier(AC):	M. S. Casteel Date: 08/13/2009								

3)Report Number:	EM-RL--MSC-FSS-2009-0001 After 2003 Redesign
Secretarial Office:	Environmental Management
Lab/Site/Org:	Hanford Site
Facility Name:	Facility & Site Services
Subject/Title:	Discovery of Energized Conductors
Date/Time Discovered:	08/29/2009 11:20 (PTZ)
Date/Time Categorized:	08/29/2009 12:05 (PTZ)

Report Type:	Notification		
Report Dates:	Notification	09/01/2009	17:28 (ETZ)
	Initial Update		
	Latest Update		
	Final		
Significance Category:	3		
Reporting Criteria:	2C(2) - Failure to follow a prescribed hazardous energy control process (e.g., lockout/tagout) or a site condition that results in the unexpected discovery of an uncontrolled hazardous energy source (e.g., live electrical power circuit, steam line, pressurized gas). This criterion does not include discoveries made by zero-energy checks and other precautionary investigations made before work is authorized to begin.		
Cause Codes:			
ISM:	3) Develop and Implement Hazard Controls		
Subcontractor Involved:	Yes George A. Grant Construction		
Occurrence Description:	<p>On 08/29/2009, at 1120 hours, while performing a good faith electrical check at a non-permitted electrical vault, subcontractor electricians using a proximity voltage detector from outside the vault, detected energy on a bundle of 480V insulated cables. The cables passed through the lower portion of the vault. This was discovered after the lock and tag was installed and the safe condition checks were documented as per the Tagout Authorization Form (TAF). As a final good faith electrical check, a proximity voltage detector was used on the insulated cables prior to vault entry to meet confined space requirements.</p> <p>NOTE: This event was initially categorized as Significance Category 3, 10(2c) "An event, condition, or series of events that does not meet any of the other reporting criteria, but is determined by the Facility Manager or line management to be of safety significance or of concern to other facilities or activities in the DOE complex." After further evaluation, the event was re-categorized as a Significance Category 3, 2C(2) on 08/31/2009, at 1545 hours.</p>		
Cause Description:			
Operating Conditions:	Planned Electrical Outage		
Activity Category:	Construction		
Immediate Action(s):	<ol style="list-style-type: none"> 1. Stopped work. 2. Management was notified. 3. The system and work area was returned to safe condition. 		
FM Evaluation:	The building 480V electrical service was being prepared for an upgrade to the existing electrical that would increase the primary building service		

	panel to 400 amps. The task required the removal of some existing cable and the addition of new higher service rated cable. Removal and reinstallation of the cable required the entry into a large electrical service vault that measured approximately 7' square by 12' deep. Numerous cables pass through this vault feeding multiple buildings. The cables originate in a nearby main switchgear and travel through the vault to various buildings. No service connections and/or cable splices exist in the vault.		
DOE Facility Representative Input:			
DOE Program Manager Input:			
Further Evaluation is Required:	Yes. Before Further Operation? Yes By Whom: K. A. Ekstrom By When: 09/01/2009		
Division or Project:	Site Business Management		
Plant Area:	400 Area		
System/Building/Equipment :	Secondary Electrical System		
Facility Function:	Balance of Plant - Infrastructure (Other Functions not specifically listed in this Category)		
Corrective Action:			
Lessons(s) Learned:			
HQ Keywords:	01K--Inadequate Conduct of Operations - Lockout/Tagout Noncompliance (Electrical) 11G--Other - Subcontractor 12I--EH Categories - Lockout/Tagout (Electrical or Mechanical) 14E--Quality Assurance - Work Process Deficiency 14G--Quality Assurance - Procurement Deficiency		
HQ Summary:	On August 29, 2009, while performing a good faith electrical check at a non-permitted electrical vault, subcontractor electricians using a proximity voltage detector from outside the vault, detected energy on a bundle of 480-volt insulated cables. The cables passed through the lower portion of the vault. This was discovered after the lock and tag was installed and the safe condition checks were documented as per the Tagout Authorization Form. As a final good faith electrical check, a proximity voltage detector was used on the insulated cables prior to vault entry to meet confined space requirements. Work was stopped and management was notified. The system and work area were returned to safe condition.		
Similar OR Report Number:			
Facility Manager:	<table border="1"> <tr> <td>Name</td> <td>C. W. Stolle</td> </tr> </table>	Name	C. W. Stolle
Name	C. W. Stolle		

	Title	Manager, Facilities & Land Management		
Originator:	Name	DAVIS, KENNETH W		
	Phone	(509) 376-3030		
	Title	OCCURRENCE NOTIFICATION CENTER		
HQ OC Notification:	Date	Time	Person Notified	Organization
	NA	NA	NA	NA
Other Notifications:	Date	Time	Person Notified	Organization
	08/29/2009	12:25 (PTZ)	C. W. Stolle	MSA
	08/29/2009	12:25 (PTZ)	L. W. Earley	DOE-RL
Authorized Classifier(AC):				

4)Report Number:	EM-RP--WRPS-TANKFARM-2009-0009 After 2003 Redesign		
Secretarial Office:	Environmental Management		
Lab/Site/Org:	Hanford Site		
Facility Name:	Tank Farms		
Subject/Title:	Construction Electrician Receives Electrical Shock While Performing Construction Acceptance Testing		
Date/Time Discovered:	08/10/2009 10:15 (PTZ)		
Date/Time Categorized:	08/10/2009 15:10 (PTZ)		
Report Type:	Update		
Report Dates:	Notification	08/11/2009	18:25 (ETZ)
	Initial Update	08/13/2009	17:05 (ETZ)
	Latest Update	08/13/2009	17:05 (ETZ)
	Final		
Significance Category:	2		
Reporting Criteria:	2C(1) - Failure to follow a prescribed hazardous energy control process (e.g., lockout/tagout) or disturbance of a previously unknown or mislocated hazardous energy source (e.g., live electrical power circuit, steam line, pressurized gas) resulting in a person contacting (burn, shock, etc.) hazardous energy.		
Cause Codes:			
ISM:	2) Analyze the Hazards 3) Develop and Implement Hazard Controls		
Subcontractor Involved:	Yes American Electric		
Occurrence Description:	On 08/10/2009 at 1015 hours, a construction electrician received an		

	<p>electrical shock while performing Construction Acceptance Testing (CAT) on tank C-104 retrieval equipment in the 156-AZ building. New electrical equipment had been installed for tank C-104 retrieval in panel 106 in the 156-AZ building in the 200 East Area. Installation of the new equipment had been completed and the lock and tag was removed for CAT. All wires in the 106 panel had been "safed off," meaning that they were pulled away from the panel and taped, with the exception of one wire. While preparing to check voltage on equipment near the bare wire, the electrician brushed against the bare wire, and at the same time his arm touched the door of the panel. The electrician felt a small shock. The bare wire was 120 volts and by all indications in the work package was de-terminated at both ends. Why the wire was not safed off is unknown.</p> <p>At 1510, following the critique, facility management categorized this event as a 2C(1) SC-2 occurrence.</p>
Cause Description:	
Operating Conditions:	Does not apply.
Activity Category:	Construction
Immediate Action(s):	<p>The electrician was evaluated by AdvancedMed Hanford and returned to work with no restrictions.</p> <p>The work was stopped and immediate area around panel was barricaded. A lock and tag was installed to isolate electrical power to the 156-AZ building 106 panel.</p> <p>A critique was held.</p>
FM Evaluation:	<p>Following categorization, the WRPS Project Operations manager requested this event be evaluated against EFCOG's Electrical Severity Measurement Tool [Revision 1, April 16, 2007]. Using the below formula, the Electrical Severity value was 330 resulting in a significance of "Medium" and a recommended ORPS Group 2 Significance Category (SC) of 4.</p> $ES \text{ (Electrical Severity)} = (EHF) * [(1 + EF + SPF + AFPF + TPF) * IF]$ <p>EHF (Electrical Hazard Factor) = 10 EF (Environmental Factor) = 0 SPF (Shock Proximity Factor) = 10 AFPF (Arc Flash Proximity Factor) = 0 TPF (Thermal Proximity Factor) = 0 IF (Injury Factor) = 3</p> <p>UPDATE 8/13/2009 This update is being submitted to correct two typos. 1) The event date in the Description of Occurrence was 8/10/2009 (not 8/9/2009), and 2) The EF (Environmental Factor) should have been 0, not 5.</p>

DOE Facility Representative Input:							
DOE Program Manager Input:							
Further Evaluation is Required:	Yes. Before Further Operation? No By Whom: Peggy Hamilton By When:						
Division or Project:	Washington River Protection Solutions, LLC (WRPS)						
Plant Area:	200 East						
System/Building/Equipment :	241-C-104 Retrieval/156-AZ/Electrical Panel 106						
Facility Function:	Nuclear Waste Operations/Disposal						
Corrective Action:							
Lessons(s) Learned:							
HQ Keywords:	08A--OSHA Reportable/Industrial Hygiene - Electrical Shock 08H--OSHA Reportable/Industrial Hygiene - Safety Noncompliance 11G--Other - Subcontractor 12C--EH Categories - Electrical Safety 14E--Quality Assurance - Work Process Deficiency						
HQ Summary:	On August 10, 2009, a construction electrician received an electrical shock while performing Construction Acceptance Testing (CAT) on tank C-104 retrieval equipment in the 156-AZ building. New electrical equipment had been installed for tank C-104 retrieval in panel 106 in the 156-AZ building in the 200 East Area. Installation of the new equipment had been completed and the lock and tag was removed for CAT. All wires in the 106 panel had been "safed off," meaning that they were pulled away from the panel and taped, with the exception of one wire. While preparing to check voltage on equipment near the bare wire, the electrician brushed against the bare wire, and at the same time his arm touched the door of the panel. The bare wire was 120 volts and by all indications in the work package was de-termed at both ends. Why the wire was not safed off is unknown. The electrician was evaluated by AdvanceMed Hanford and returned to work with no restrictions. A critique was held.						
Similar OR Report Number:							
Facility Manager:	<table border="1"> <tr> <td>Name</td> <td>Hamilton, Helen (Peggy) M</td> </tr> <tr> <td>Phone</td> <td>(509) 372-9945</td> </tr> <tr> <td>Title</td> <td>Manager, Construction</td> </tr> </table>	Name	Hamilton, Helen (Peggy) M	Phone	(509) 372-9945	Title	Manager, Construction
Name	Hamilton, Helen (Peggy) M						
Phone	(509) 372-9945						
Title	Manager, Construction						
Originator:	<table border="1"> <tr> <td>Name</td> <td>WATERS, SHAUN F</td> </tr> <tr> <td>Phone</td> <td>(509) 373-3457</td> </tr> <tr> <td>Title</td> <td>OPERATIONS SPECIALIST</td> </tr> </table>	Name	WATERS, SHAUN F	Phone	(509) 373-3457	Title	OPERATIONS SPECIALIST
Name	WATERS, SHAUN F						
Phone	(509) 373-3457						
Title	OPERATIONS SPECIALIST						

HQ OC Notification:	Date	Time	Person Notified	Organization
	NA	NA	NA	NA
Other Notifications:	Date	Time	Person Notified	Organization
	08/10/2009	15:40 (PTZ)	Trump, G. D.	ONC
	08/10/2009	15:51 (PTZ)	Blanchard, C. A.	DOE-ORP
	08/10/2009	15:54 (PTZ)	Reynolds, T. R.	WRPS
Authorized Classifier(AC):				

5)Report Number:	EM-SR--PSC-SWPF-2009-0008 After 2003 Redesign		
Secretarial Office:	Environmental Management		
Lab/Site/Org:	Savannah River Site		
Facility Name:	Salt Waste Processing Facility		
Subject/Title:	Temporary Electrical System Ballast Event		
Date/Time Discovered:	08/28/2009 13:30 (ETZ)		
Date/Time Categorized:	08/28/2009 14:56 (ETZ)		
Report Type:	Notification		
Report Dates:	Notification	09/01/2009	13:41 (ETZ)
	Initial Update		
	Latest Update		
	Final		
Significance Category:	3		
Reporting Criteria:	2C(2) - Failure to follow a prescribed hazardous energy control process (e.g., lockout/tagout) or a site condition that results in the unexpected discovery of an uncontrolled hazardous energy source (e.g., live electrical power circuit, steam line, pressurized gas). This criterion does not include discoveries made by zero-energy checks and other precautionary investigations made before work is authorized to begin.		
Cause Codes:			
ISM:	3) Develop and Implement Hazard Controls 4) Perform Work Within Controls		
Subcontractor Involved:	No		
Occurrence Description:	On 08/28/2009, while energizing a temporary electrical system for the first time in the SWPF Construction Site's Cylinder Storage structure, an electrical worker discovered an uncontrolled hazardous energy source. Earlier that day electrical workers ran wiring from a breaker panel to a junction box to feed three previously installed fluorescent lighting fixtures. They also ran wiring from the junction box to an on/off switch in the Cylinder Storage building.		

	<p>When the wiring and subsequent walkdown were complete at approximately 1300 hours, the breaker was energized and the light switch was turned to the ON position. When the lights did not come on, the light switch was returned to the OFF position and a lockout was reinstalled. The electrical workers began troubleshooting the first light. After disassembling the light, workers noticed a ballast had been removed and the wires that had been disconnected from the ballast were left with bare copper wire exposed (not insulated). They immediately stopped work at approximately 1330 hours and contacted their foreman. A critique was held.</p>
Cause Description:	
Operating Conditions:	SWPF Construction
Activity Category:	Construction
Immediate Action(s):	<ol style="list-style-type: none"> 1. Stopped temporary Electrical work for the Cylinder Storage structure. 2. A lock and tag was placed on the electrical panel located in the Ice House. 3. Following the critique, selected temporary electrical work was allowed to proceed provided involved personnel receive a briefing on management's expectation for wire protection/termination or correct identification for all situations when securing temporary electrical work.
FM Evaluation:	While there were no impacts to the facility, the event had potential to impact the safety of the Individuals working on the Cylinder Storage structures electrical system. The management expectation briefings provided adequate assurance of proper wire terminations for allowing continuation of SWPF construction temporary electrical work.
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is Required:	<p>Yes. Before Further Operation? No By Whom: Const. Safety-Mike Quattro By When:</p>
Division or Project:	SWPF
Plant Area:	SWPF J-Area
System/Building/Equipment :	Cylinder Storage structure
Facility Function:	Nuclear Waste Operations/Disposal
Corrective Action:	
Lessons(s) Learned:	
HQ Keywords:	01A--Inadequate Conduct of Operations - Inadequate Conduct of Operations (miscellaneous)

01Q--Inadequate Conduct of Operations - Personnel error
 07D--Electrical Systems - Electrical Wiring
 08H--OSHA Reportable/Industrial Hygiene - Safety Noncompliance
 12C--EH Categories - Electrical Safety
 14E--Quality Assurance - Work Process Deficiency

HQ Summary: On August 28, 2009, while energizing a temporary electrical system for the first time in the Salt Waste Processing Facility Construction Site's Cylinder Storage structure, an electrical worker discovered an uncontrolled hazardous energy source. Earlier that day electrical workers ran wiring from a breaker panel to a junction box to feed three previously installed fluorescent lighting fixtures. They also ran wiring from the junction box to an on/off switch in the Cylinder Storage building. When the wiring and subsequent walkdown were complete, the breaker was energized and the light switch was turned to the ON position. When the lights did not come on, the light switch was returned to the OFF position and a lockout was reinstalled. The electrical workers began troubleshooting the first light and noticed a ballast had been removed and the wires that had been disconnected from the ballast were left with bare copper wire exposed (not insulated). They immediately stopped work and contacted their foreman. A critique was held.

Similar OR Report Number:

Facility Manager:

Name	FRENCH, ROBERT F
Phone	(803) 643-1663
Title	PLANT MANAGER

Originator:

Name	DUKES, HEATHERLY H
Phone	(803) 617-9439
Title	OPERATIONS MANAGER

HQ OC Notification:

Date	Time	Person Notified	Organization
NA	NA	NA	NA

Other Notifications:

Date	Time	Person Notified	Organization
08/28/2009	15:15 (ETZ)	Scott McMullin	DOE-FR

Authorized Classifier(AC):

6)Report Number:	NA--LASO-LANL-ADOADMIN-2009-0002 After 2003 Redesign
Secretarial Office:	National Nuclear Security Administration
Lab/Site/Org:	Los Alamos National Laboratory
Facility Name:	ADO Administration
Subject/Title:	Subcontractor Performs Unauthorized Energized Electrical Work
Date/Time Discovered:	08/26/2009 08:26 (MTZ)

Date/Time Categorized:	08/26/2009 13:00 (MTZ)		
Report Type:	Notification		
Report Dates:	Notification	08/28/2009	16:12 (ETZ)
	Initial Update		
	Latest Update		
	Final		
Significance Category:	3		
Reporting Criteria:	2C(2) - Failure to follow a prescribed hazardous energy control process (e.g., lockout/tagout) or a site condition that results in the unexpected discovery of an uncontrolled hazardous energy source (e.g., live electrical power circuit, steam line, pressurized gas). This criterion does not include discoveries made by zero-energy checks and other precautionary investigations made before work is authorized to begin.		
Cause Codes:			
ISM:	4) Perform Work Within Controls		
Subcontractor Involved:	Yes Otis Elevator		
Occurrence Description:	Management Synopsis: At 0826 on August 26, 2009, LANL Safety Oversight discovered an open energized 480 door at the Radiological Laboratory Utility Office Building (RLUOB), which is currently under construction. The panel door had been opened by an Otis Elevator Operator, a subcontractor to Austin Commercial Contractors, LP, who was looking for blown fuses. The work had not been evaluated and hazard controls were not in place. The Chemistry Metallurgy Research Replacement (CMRR) Facility Operations Director (FOD) was notified at 1000. An Austin Commercial Contractors, LP, Root Cause Analysis Meeting was held. Based on information gathered in that meeting, the CMRR FOD determined the event was ORPS reportable.		
Cause Description:			
Operating Conditions:	Normal		
Activity Category:	Construction		
Immediate Action(s):	1) The panel was immediately barricaded until it could be recovered. 2) An energy control refresher training was conducted with Supervision (to the Foreman level) and the craft.		
FM Evaluation:			
DOE Facility Representative Input:			
DOE Program Manager Input:			
Further Evaluation is	Yes.		

Required:	Before Further Operation? No By Whom: CAO-PF & FOD By When: 10/09/2009															
Division or Project:	CMRR RULOB															
Plant Area:	TA-505-400															
System/Building/Equipment :	RULOB electrical system															
Facility Function:	Balance of Plant - Infrastructure (Other Functions not specifically listed in this Category)															
Corrective Action:																
Lessons(s) Learned:																
HQ Keywords:	01M--Inadequate Conduct of Operations - Inadequate Job Planning (Electrical) 11G--Other - Subcontractor 12C--EH Categories - Electrical Safety 14E--Quality Assurance - Work Process Deficiency 14G--Quality Assurance - Procurement Deficiency															
HQ Summary:	On August 26, 2009, LANL Safety Oversight discovered an open door to an energized 480-volt panel at the Radiological Laboratory Utility Office Building (RLUOB), which is currently under construction. The panel door had been opened by an Otis Elevator Operator, a subcontractor to Austin Commercial Contractors, LP, who was looking for blown fuses. The work had not been evaluated and hazard controls were not in place. The Chemistry Metallurgy Research Replacement Facility Operations Director was notified. The panel was immediately barricaded until it could be covered. An Austin Commercial Contractors Root Cause Analysis Meeting was held. An energy control refresher training was conducted with Supervision (to the Foreman level) and the craft.															
Similar OR Report Number:																
Facility Manager:	<table border="1"> <tr> <td>Name</td> <td colspan="3">Richard Holmes</td> </tr> <tr> <td>Phone</td> <td colspan="3">(505) 606-2389</td> </tr> <tr> <td>Title</td> <td colspan="3">CMRR Facility Operations Director</td> </tr> </table>				Name	Richard Holmes			Phone	(505) 606-2389			Title	CMRR Facility Operations Director		
Name	Richard Holmes															
Phone	(505) 606-2389															
Title	CMRR Facility Operations Director															
Originator:	<table border="1"> <tr> <td>Name</td> <td colspan="3">TALLARICO, ANTONIA</td> </tr> <tr> <td>Phone</td> <td colspan="3">(505) 665-6988</td> </tr> <tr> <td>Title</td> <td colspan="3">OCCURRENCE INVESTIGATOR</td> </tr> </table>				Name	TALLARICO, ANTONIA			Phone	(505) 665-6988			Title	OCCURRENCE INVESTIGATOR		
Name	TALLARICO, ANTONIA															
Phone	(505) 665-6988															
Title	OCCURRENCE INVESTIGATOR															
HQ OC Notification:	<table border="1"> <tr> <td>Date</td> <td>Time</td> <td>Person Notified</td> <td>Organization</td> </tr> <tr> <td>NA</td> <td>NA</td> <td>NA</td> <td>NA</td> </tr> </table>				Date	Time	Person Notified	Organization	NA	NA	NA	NA				
Date	Time	Person Notified	Organization													
NA	NA	NA	NA													
Other Notifications:	<table border="1"> <tr> <td>Date</td> <td>Time</td> <td>Person Notified</td> <td>Organization</td> </tr> <tr> <td>08/26/2009</td> <td>15:19 (MTZ)</td> <td>Geraldine Vigil</td> <td>NNSA</td> </tr> </table>				Date	Time	Person Notified	Organization	08/26/2009	15:19 (MTZ)	Geraldine Vigil	NNSA				
Date	Time	Person Notified	Organization													
08/26/2009	15:19 (MTZ)	Geraldine Vigil	NNSA													

Authorized Classifier(AC): Antonia Tallarico **Date:** 08/28/2009

7)Report Number: [NA--LASO-LANL-ADOADMIN-2009-0003](#) **After 2003 Redesign**

Secretarial Office: National Nuclear Security Administration

Lab/Site/Org: Los Alamos National Laboratory

Facility Name: ADO Administration

Subject/Title: Management Concern: Subcontractor LO/TO Noncompliance

Date/Time Discovered: 08/26/2009 08:55 (MTZ)

Date/Time Categorized: 08/26/2009 13:00 (MTZ)

Report Type: Notification/Final

Report Dates:	Notification	08/28/2009	16:22 (ETZ)
	Initial Update	08/28/2009	16:22 (ETZ)
	Latest Update	08/28/2009	16:22 (ETZ)
	Final	08/28/2009	16:22 (ETZ)

Significance Category: 4

Reporting Criteria: 10(2) - An event, condition, or series of events that does not meet any of the other reporting criteria, but is determined by the Facility Manager or line management to be of safety significance or of concern to other facilities or activities in the DOE complex. One of the four significance categories should be assigned to the occurrence, based on an evaluation of the potential risks and the corrective actions taken. (1 of 4 criteria - This is a SC 4 occurrence)

Cause Codes:

ISM: 4) Perform Work Within Controls

Subcontractor Involved: Yes
Rosendin

Occurrence Description: Management Synopsis: At 1300 on August 26, 2009, the Chemistry Metallurgy Research Replacement (CMRR) Project Facility Operations Director (FOD) determine he had a management concern related to the discovery of a noncompliance with the LANL LO/TO procedure (P 101-3). A Rosendin employee, performed work on a piece of equipment that was LO/TO without placing his own lock and tag on the equipment. An Austin Commercial Contractors, LP, root cause meeting was held. Based on information from that meeting, the CMRR FOD determined the event was a management concern.

Background: Rosendin is a subcontractor to Austin Commercial Contractors, LP.

Cause Description:

Operating Conditions: Normal

Activity Category:	Construction							
Immediate Action(s):	1) A peer check of lock placement, documented by the peer checker, to ensure proper LO/TO.							
FM Evaluation:								
DOE Facility Representative Input:								
DOE Program Manager Input:								
Further Evaluation is Required:	No							
Division or Project:	CMRR RLUOB							
Plant Area:	RLUOB							
System/Building/Equipment :	RLUOB equipment							
Facility Function:	Balance of Plant - Infrastructure (Other Functions not specifically listed in this Category)							
Corrective Action:								
Lessons(s) Learned:								
HQ Keywords:	01K--Inadequate Conduct of Operations - Lockout/Tagout Noncompliance (Electrical) 11G--Other - Subcontractor 12I--EH Categories - Lockout/Tagout (Electrical or Mechanical) 14E--Quality Assurance - Work Process Deficiency 14G--Quality Assurance - Procurement Deficiency							
HQ Summary:	On August 26, 2009, the Chemistry Metallurgy Research Replacement Project Facility Operations Director identified a management concern related to the discovery of a noncompliance with the LANL LO/TO procedure. A Rosendin employee, a subcontractor to Austin Commercial Contractors, LP, performed work on a piece of equipment that was under a LO/TO without placing his own lock and tag on the equipment. An Austin Commercial Contractors Root Cause meeting was held. A peer check of lock placement, documented by the peer checker, was performed to ensure proper LO/TO.							
Similar OR Report Number:								
Facility Manager:	<table border="1"> <tr> <td>Name</td> <td>Richard Holmes</td> </tr> <tr> <td>Phone</td> <td>(505) 606-2389</td> </tr> <tr> <td>Title</td> <td>CMRR Facility Operations Director</td> </tr> </table>		Name	Richard Holmes	Phone	(505) 606-2389	Title	CMRR Facility Operations Director
Name	Richard Holmes							
Phone	(505) 606-2389							
Title	CMRR Facility Operations Director							
Originator:	<table border="1"> <tr> <td>Name</td> <td>TALLARICO, ANTONIA</td> </tr> <tr> <td>Phone</td> <td>(505) 665-6988</td> </tr> <tr> <td>Title</td> <td>OCCURRENCE INVESTIGATOR</td> </tr> </table>		Name	TALLARICO, ANTONIA	Phone	(505) 665-6988	Title	OCCURRENCE INVESTIGATOR
Name	TALLARICO, ANTONIA							
Phone	(505) 665-6988							
Title	OCCURRENCE INVESTIGATOR							

HQ OC Notification:	Date	Time	Person Notified	Organization
	NA	NA	NA	NA
Other Notifications:	Date	Time	Person Notified	Organization
	08/26/2009	15:19 (MTZ)	Geraldine Vigil	NNSA
Authorized Classifier(AC):	Antonia Tallarico Date: 08/28/2009			

8)Report Number:	NA--SRSO-SRNS-TRIT-2009-0005 After 2003 Redesign		
Secretarial Office:	National Nuclear Security Administration		
Lab/Site/Org:	Savannah River Site		
Facility Name:	Tritium Facilities		
Subject/Title:	HEC - Hazardous Energy Found on Pre-determined Point		
Date/Time Discovered:	08/14/2009 11:56 (ETZ)		
Date/Time Categorized:	08/14/2009 12:30 (ETZ)		
Report Type:	Notification		
Report Dates:	Notification	08/17/2009	17:13 (ETZ)
	Initial Update		
	Latest Update		
	Final		
Significance Category:	3		
Reporting Criteria:	2C(2) - Failure to follow a prescribed hazardous energy control process (e.g., lockout/tagout) or a site condition that results in the unexpected discovery of an uncontrolled hazardous energy source (e.g., live electrical power circuit, steam line, pressurized gas). This criterion does not include discoveries made by zero-energy checks and other precautionary investigations made before work is authorized to begin.		
Cause Codes:	A3B3C05 - Human Performance Less Than Adequate (LTA); Knowledge Based Error; Incorrect assumption that a correlation exists between two or more facts -->couplet - A4B4C06 - Management Problem; Supervisory Methods LTA; Job performance and self-checking standards not properly communicated A5B2C07 - Communications Less Than Adequate (LTA); Written Communication Content LTA; Facts wrong / requirements not correct		
ISM:	3) Develop and Implement Hazard Controls		
Subcontractor Involved:	No		
Occurrence Description:	Construction Electrical removed a PANALARM relay can as part of the air monitoring upgrade to the facility from the HAOM control room monitor panel. The electrician rechecked work area for voltage and found 120 volts on a circuit that had been safe determined during the installation		

	of L/T 234-H-09-19. The PANALARM relay was placed back in the monitor panel and voltage was checked again and none was found. Construction personnel immediately notified the HAOM Shift Manager and the Facility Manager who was present in the control room at the time.
Cause Description:	
Operating Conditions:	The facility was performing normal operations as air monitoring upgrades (Y430 Project) to the facility were in-progress by Construction.
Activity Category:	Maintenance
Immediate Action(s):	Stopped work immediately and notified HAOM Shift Manager/Facility Manager.
FM Evaluation:	Work stopped and preliminary evaluation of events conducted.
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is Required:	Yes. Before Further Operation? No By Whom: Tritium Programs Operation By When:
Division or Project:	SR - WSRC - TRIT
Plant Area:	H-Area / Tritium Fac
System/Building/Equipment :	Air Monitoring Electrical / H-Area Old Manufacturing (HAOM)
Facility Function:	Tritium Activities
Corrective Action:	
Lessons(s) Learned:	
HQ Keywords:	01K--Inadequate Conduct of Operations - Lockout/Tagout Noncompliance (Electrical) 01M--Inadequate Conduct of Operations - Inadequate Job Planning (Electrical) 12I--EH Categories - Lockout/Tagout (Electrical or Mechanical) 14E--Quality Assurance - Work Process Deficiency
HQ Summary:	On August 14, 2009, a Construction Electrical electrician removed a PANALARM relay can as part of the air monitoring upgrade to the facility from the H-Area Old Manufacturing (HAOM) control room monitor panel. The electrician rechecked the work area for voltage and found 120 volts on a circuit that had been safe determined during the installation of L/T 234-H-09-19. The PANALARM relay was placed back in the monitor panel and voltage was checked again and none was found. Construction personnel immediately notified the HAOM Shift Manager and the Facility Manager who was present in the control room at the time. The work was stopped and a preliminary evaluation of the event was conducted.

Similar OR Report Number:	1. None			
Facility Manager:	Name	Arnold, Jeffery C.		
	Phone	(803) 208-8493		
	Title	H-Area Old Manufacturing (HAOM) Shift Ops Mgr		
Originator:	Name	HALL, WILLIAM R		
	Phone	(803) 208-8558		
	Title	PRINCIPLE ENGINEER & TECHNICAL SUPPO		
HQ OC Notification:	Date	Time	Person Notified	Organization
	08/14/2009	12:35 (ETZ)	Kuo, Andrew	NNSA FR
Other Notifications:	Date	Time	Person Notified	Organization
	08/14/2009	11:56 (ETZ)	Westergreen, Jeffery	Fac Mgr
	08/14/2009	12:40 (ETZ)	Utley, Debra	Eng Mgr
	08/14/2009	12:40 (ETZ)	Price, Crawford	AOM Dep
	08/14/2009	12:40 (ETZ)	Schifer, Lee	AOM
	08/14/2009	12:40 (ETZ)	Gentile, Chris	VP TP
	08/14/2009	13:03 (ETZ)	Morgan, Roy	SRSOC
	Authorized Classifier(AC):	Campfield, Kenneth Date: 08/17/2009		

9)Report Number:	NA--SS-SNL-NMFAC-2009-0007 After 2003 Redesign		
Secretarial Office:	National Nuclear Security Administration		
Lab/Site/Org:	Sandia National Laboratories - SS		
Facility Name:	SNL NM Site-wide F & M		
Subject/Title:	Phase to Ground Fault Results when Metal Gutter Cover is dropped between gap in MCC Cover Plates in Bldg. 870		
Date/Time Discovered:	08/03/2009 08:00 (MTZ)		
Date/Time Categorized:	08/03/2009 10:00 (MTZ)		
Report Type:	Update		
Report Dates:	Notification	08/05/2009	18:36 (ETZ)
	Initial Update	08/05/2009	19:04 (ETZ)
	Latest Update	08/05/2009	19:04 (ETZ)
	Final		
Significance Category:	3		
Reporting Criteria:	2C(2) - Failure to follow a prescribed hazardous energy control process (e.g., lockout/tagout) or a site condition that results in the unexpected discovery of an uncontrolled hazardous energy source (e.g., live electrical		

	power circuit, steam line, pressurized gas). This criterion does not include discoveries made by zero-energy checks and other precautionary investigations made before work is authorized to begin.
Cause Codes:	
ISM:	
Subcontractor Involved:	Yes B&D Electric
Occurrence Description:	<p>On 8/3/09, at approximately 7:30 am, at Building 870, a construction electrician was working on a low-voltage fire protection instrument control system and accidentally dropped a 1/8 inch thick metal cover to an 8X40 inch electrical gutter into a 3/16 inch gap located in the top of a 480 volt motor control center (MCC) BBH1 cabinet. The gutter cover came in contact with the Phase C bus bar coupling located at the top of the MCC and the grounded MCC metal exterior resulting in a phase to ground short. The resulting current damaged the copper bus bar coupling and discolored the gutter cover. The subcontractor electrician performing the work reported only a small arc that did not leave the MMC enclosure. The 480 V, 800 amp MCC main breaker tripped followed by the 1200 amp switchboard breaker feeding the building lighting, convenience receptacles, and HVAC systems.</p> <p>The electrician who was performing scoping activities had removed the gutter cover to identify possible routing paths for new conduit and conductors that would be installed as part of the Fire Alarm Upgrade Project. The electrician was replacing the gutter cover when the cover slipped, falling through the gap into the MCC. The electrician was wearing a hard hat, safety glasses, safety gloves, and using an 8' step ladder, when the 1/8" cover slipped out of his hands, falling between a 3/16" gap located at the top of the MCC cabinet, where the different sections of the cabinet are bolted together, contacting a bus bar.</p> <p>There was no impact to safety systems in the building and no shock or burn to the electrician performing the work activity as a result of this incident.</p> <p>Response:</p> <p>An FMOC Electrical Engineer and Maintenance Team Lead responded to the event at approximate 7:55 a.m. followed by two Maintenance Electricians at 8:00.</p> <p>The Maintenance Electricians performed LOTO on Switchboard B and MCC BBH1; the breakers in MCC BBHI were placed in open position and the electrical system was meggered back to the Main Switchboard Breaker - no problems identified.</p>

The Electricians switched Main Breaker in Switchboard B to the on position at approximately 8:30 a.m.

The bus bar coupling in MCC BBH1 had some damage and was inspected, cleaned and re-installed

There was no impact to MCC BBH1 cover plates or any internal parts other than minor damage to the bus coupling and scorching of the gutter cover.

The Electricians switched the breaker in MCC BBH1 to the on position at approximately 11:30 a.m., which brought all building systems impacted by the incident back on line.

Analysis:

Arc Flash analysis had been performed on the MCC (NFPA 70E 130.3). The MCC was labeled identifying the available incident energy, the hazard/risk category, Arc Flash Boundary, and Approach Boundary as required by NFPA 70E130.3. The Arc Flash Analysis identified that the MCC has a 1.2 cal/cm² Hazard Category 1 when performing energized work on the system.

The electrician was not performing work on the MCC, no MCC covers had been removed, and no bolts on the cover had been loosened. The MCC assembly is rated for a fault of 65 kA.

In June of 2008, a building PM was performed which included PM of MCC BBH1. The PM would include visual inspection of MCC and operation of the MCC breakers, as identified in FMOC OP-301 Standard Preventive Maintenance Guidelines for Low Voltage Electrical Equipment. This PM helps ensure that engineered controls (e.g., grounds and breakers) MCC operate correctly.

The manufacturer's instructions direct the installer to install gasket material up the sides of the MCC between the MCC sections and cut the material off at the top. The installation instructions do not direct the installation of gasket material between the cover plates located on top of the MCC.

The electrician is a nine year Journeyman, with 14 years total experience in construction and has been with the electrical subcontract company for 2 years.

The Electrical Safety Subject Matter Expert scored the event a 100 based

	on the following data. Hazard Factor (energy): 50 - Environmental factor (dry): 0 - Shock proximity (within the LAB): 1 - Arc proximity (outside the calculated FPB): 0 - Thermal proximity: 0 - Injury (no injury): 1.
Cause Description:	Critique/Fact Finding Performed 8/4/09
Operating Conditions:	Normal
Activity Category:	Construction
Immediate Action(s):	FMOC Maintenance and Electrical Engineering responded Initiated investigation Installed a sheet metal cover over the 3/16 inch gap on top of the MCC An extent of condition survey was performed inspecting MCCs in the equipment room for gaps between MCC top cover plates that could potentially result in a similar incident.
FM Evaluation:	EOC #12426
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is Required:	Yes. Before Further Operation? No By Whom: Causal Analysis Team By When: 09/17/2009
Division or Project:	4000/Fire Alarm Upgrade
Plant Area:	Tech Area I
System/Building/Equipment :	480 Volt Electrical Distribution System/Bldg 870/Mech. Rm
Facility Function:	Balance of Plant - Infrastructure (Other Functions not specifically listed in this Category)
Corrective Action:	
Lessons(s) Learned:	
HQ Keywords:	01A--Inadequate Conduct of Operations - Inadequate Conduct of Operations (miscellaneous) 01Q--Inadequate Conduct of Operations - Personnel error 07B--Electrical Systems - Electrical Distribution 07C--Electrical Systems - Power Outage 11G--Other - Subcontractor 12C--EH Categories - Electrical Safety 14E--Quality Assurance - Work Process Deficiency
HQ Summary:	On August 3, 2009, at Building 870, a construction electrician dropped a 1/8-inch thick metal cover to an 8X40-inch electrical gutter into a 3/16-inch gap located in the top of a motor control center (MCC) BBH1. The

gutter cover came in touched the Phase C bus bar coupling located at the top of the MCC and the grounded MCC metal exterior resulting in a phase to ground short. The resulting current slightly damaged the copper bus bar coupling and discolored the gutter cover. The subcontractor electrician performing the work reported only a small arc that did not leave the MMC enclosure. The 480 Volt, 800 amp MCC main breaker tripped followed by the 1200 amp switchboard breaker feeding the building lighting, convenience receptacles, and HVAC systems. The electrician, who was performing scoping activities, had removed the gutter cover to identify possible routing paths for new conduit and conductors that would be installed as part of the Fire Alarm Upgrade Project. There was no impact to safety systems in the building and no shock or burn to the electrician performing the work activity as a result of this incident.

Similar OR Report Number:

Facility Manager:

Name	Carla Lamb
Phone	(505) 844-1753
Title	ES&H Coordinator - Facilities Management & Ops Ctr

Originator:

Name	LUCERO, JEWELLEE A
Phone	(505) 845-4727
Title	REPORTING ADMINISTRATOR

HQ OC Notification:

Date	Time	Person Notified	Organization
NA	NA	NA	NA

Other Notifications:

Date	Time	Person Notified	Organization
08/03/2009	08:00 (MTZ)	John Norwalk	4827
08/03/2009	08:06 (MTZ)	Debbie Garcia-Sanchez, FR	DOE/SSO
08/03/2009	08:24 (MTZ)	Lynnwood Dukes	4820
08/03/2009	08:30 (MTZ)	EOC	4136
08/03/2009	10:30 (MTZ)	Lynnwood Dukes	4820
08/03/2009	10:30 (MTZ)	Debbie Garcia-Sanchez, FR	DOE/SSO
08/03/2009	08:15 (MTZ)	Jeff Quintenz	4800
08/03/2009	10:30 (MTZ)	Jeff Quintenz	4800

Authorized Classifier(AC):

John Zavadil Date: 08/05/2009

10)Report Number:

[NE-ID--BEA-MFC-2009-0002](#) After 2003 Redesign

Secretarial Office:

Nuclear Energy, Science and Technology

Lab/Site/Org:

Idaho National Laboratory

Facility Name:

Materials and Fuels Complex

Subject/Title:	LO\TO Violation While Working MFC-768 Lighting Upgrade		
Date/Time Discovered:	08/25/2009 07:00 (MTZ)		
Date/Time Categorized:	08/25/2009 07:30 (MTZ)		
Report Type:	Notification		
Report Dates:	Notification	08/26/2009	15:59 (ETZ)
	Initial Update		
	Latest Update		
	Final		
Significance Category:	3		
Reporting Criteria:	2C(2) - Failure to follow a prescribed hazardous energy control process (e.g., lockout/tagout) or a site condition that results in the unexpected discovery of an uncontrolled hazardous energy source (e.g., live electrical power circuit, steam line, pressurized gas). This criterion does not include discoveries made by zero-energy checks and other precautionary investigations made before work is authorized to begin.		
Cause Codes:			
ISM:			
Subcontractor Involved:	Yes Nash Electric		
Occurrence Description:	<p>On 08/25/2009 it was discovered that a light fixture had been replaced by a subcontractor in Materials and Fuels Complex (MFC) building MFC-768 on the Idaho National Laboratory (INL), that was not isolated under the Lockout/Tagout (LO/TO) for the work being performed. The light fixture was de-energized and there was no exposure to hazardous energy. It had been de-energized under another LO/TO by a different subcontractor, who was performing a different scope of work in another part of MFC-768.</p> <p>Light fixtures were being replaced throughout MFC with more energy efficient lights under an Energy Savings Performance Contract (ESPC). The work scope for 08/24/2009 included replacing a bank of 9 emergency lights in the switchgear area of MFC-768. The work crew involved in this event was working the night shift from 1600 to 0200. An MFC plant electrician was assigned to perform LO/TOs for the subcontractor using a minor maintenance work order, or green sheet. The work planned for the shift required four separate simple LO/TOs. When performing the LO/TO on the 9 emergency lights the MFC Electrician identified the panel and circuit (ckt) in the electrical shop's book of panel directories as panel LP-349 ckt 4. He went to LP-349 and the directories in the book and panel matched. He then walked down the switch gear area where the lights are located and identified a fixture that was out. He turned the breaker off and on to identify the lights on that circuit. He assumed the light that was off during his area walkdown was burned out and was on ckt 4 because it was</p>		

	<p>in line with the other lights on the circuit, and he had encountered numerous burned out lights during the project. He applied a simple LO/TO to the LP-349 ckt 4 breaker and then performed a zero energy check at the burned out light, since he wanted to verify it was de-energized when he opened the breaker. The subcontractor Electricians were with the MFC Electrician during this process to verify their isolation boundary and apply their locks and tags over the MFC Electrician LO/TO. The Subcontractor Electricians verified zero energy at each fixture prior to working on the fixture.</p> <p>After the Subcontractor Electricians completed replacing the lights the LO/TO was cleared and ckt 4 breaker was closed. The light which had been out prior to performing the work was still out. Troubleshooting indicated that the light was de-energized by means other than the ckt 4 in LP-349.</p> <p>The light was de-energized by a different LO/TO on ckt 8 in LP-349. There were no injuries or equipment damage as a result of this event, no personnel were exposed to a hazardous energy source.</p>
Cause Description:	
Operating Conditions:	Normal Operations
Activity Category:	Construction
Immediate Action(s):	<p>1- Did trouble shooting, verified no energy to the light that was out.</p> <p>2- Ckt 4 was left in an energized condition.</p> <p>3- Subcontractor and Construction management were notified.</p> <p>4- Work was stopped for a Timeout for the Electricians and CFR to discuss the event and continuing work.</p> <p>5- Construction Management issued a formal stop work on the subcontractor after a critique was held on this event which affects the Lighting Upgrade portion of the ESPC contract.</p>
FM Evaluation:	There were no injuries or exposure to hazardous energy as a result of this event but there may be vulnerabilities which need to be evaluated and addressed prior to continuing work on the Lighting Upgrade.
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is Required:	<p>Yes.</p> <p>Before Further Operation? Yes</p> <p>By Whom: F&SS</p> <p>By When: 09/14/2009</p>
Division or Project:	Facility Management
Plant Area:	Utilities
System/Building/Equipment :	MFC 768
Facility Function:	Balance-of-Plant - Site/outside utilities

Corrective Action:																	
Lessons(s) Learned:																	
HQ Keywords:	01K--Inadequate Conduct of Operations - Lockout/Tagout Noncompliance (Electrical) 01M--Inadequate Conduct of Operations - Inadequate Job Planning (Electrical) 11G--Other - Subcontractor 12I--EH Categories - Lockout/Tagout (Electrical or Mechanical) 14E--Quality Assurance - Work Process Deficiency 14G--Quality Assurance - Procurement Deficiency																
HQ Summary:	On August 25, 2009, it was discovered that a light fixture had been replaced by a subcontractor in the Materials and Fuels Complex (MFC) Building MFC-768, which was not isolated under the Lockout/Tagout (LO/TO) for the work being performed. The light fixture was de-energized and there was no exposure to hazardous energy. The light fixture had been de-energized under another LO/TO by a different subcontractor, who was performing a different scope of work in another part of MFC-768. There were no injuries or equipment damage as a result of this event and no personnel were exposed to a hazardous energy source.																
Similar OR Report Number:																	
Facility Manager:	<table border="1"> <tr> <td>Name</td> <td>Lively, David B.</td> </tr> <tr> <td>Phone</td> <td>(208) 533-7438</td> </tr> <tr> <td>Title</td> <td>Facility Complex Manager</td> </tr> </table>	Name	Lively, David B.	Phone	(208) 533-7438	Title	Facility Complex Manager										
Name	Lively, David B.																
Phone	(208) 533-7438																
Title	Facility Complex Manager																
Originator:	<table border="1"> <tr> <td>Name</td> <td>ALLEN, JEFFREY K</td> </tr> <tr> <td>Phone</td> <td>(208) 526-5320</td> </tr> <tr> <td>Title</td> <td>OPERATIONS ASSISTANT</td> </tr> </table>	Name	ALLEN, JEFFREY K	Phone	(208) 526-5320	Title	OPERATIONS ASSISTANT										
Name	ALLEN, JEFFREY K																
Phone	(208) 526-5320																
Title	OPERATIONS ASSISTANT																
HQ OC Notification:	<table border="1"> <thead> <tr> <th>Date</th> <th>Time</th> <th>Person Notified</th> <th>Organization</th> </tr> </thead> <tbody> <tr> <td>NA</td> <td>NA</td> <td>NA</td> <td>NA</td> </tr> </tbody> </table>	Date	Time	Person Notified	Organization	NA	NA	NA	NA								
Date	Time	Person Notified	Organization														
NA	NA	NA	NA														
Other Notifications:	<table border="1"> <thead> <tr> <th>Date</th> <th>Time</th> <th>Person Notified</th> <th>Organization</th> </tr> </thead> <tbody> <tr> <td>08/25/2009</td> <td>07:00 (MTZ)</td> <td>David Lively</td> <td>F&SS</td> </tr> <tr> <td>08/25/2009</td> <td>07:10 (MTZ)</td> <td>Scott D McBride</td> <td>F&SS</td> </tr> <tr> <td>08/25/2009</td> <td>07:30 (MTZ)</td> <td>Scott E. Ferrara</td> <td>DOE-ID</td> </tr> </tbody> </table>	Date	Time	Person Notified	Organization	08/25/2009	07:00 (MTZ)	David Lively	F&SS	08/25/2009	07:10 (MTZ)	Scott D McBride	F&SS	08/25/2009	07:30 (MTZ)	Scott E. Ferrara	DOE-ID
Date	Time	Person Notified	Organization														
08/25/2009	07:00 (MTZ)	David Lively	F&SS														
08/25/2009	07:10 (MTZ)	Scott D McBride	F&SS														
08/25/2009	07:30 (MTZ)	Scott E. Ferrara	DOE-ID														
Authorized Classifier(AC):																	

11)Report Number:	NE-ID--BEA-SMC-2009-0010 After 2003 Redesign
Secretarial Office:	Nuclear Energy, Science and Technology
Lab/Site/Org:	Idaho National Laboratory
Facility Name:	Specific Manufacturing Capability

Subject/Title:	Failure to Follow Prescribed Work Control Process		
Date/Time Discovered:	08/27/2009 08:12 (MTZ)		
Date/Time Categorized:	08/27/2009 10:20 (MTZ)		
Report Type:	Notification		
Report Dates:	Notification	09/01/2009	18:53 (ETZ)
	Initial Update		
	Latest Update		
	Final		
Significance Category:	3		
Reporting Criteria:	2C(2) - Failure to follow a prescribed hazardous energy control process (e.g., lockout/tagout) or a site condition that results in the unexpected discovery of an uncontrolled hazardous energy source (e.g., live electrical power circuit, steam line, pressurized gas). This criterion does not include discoveries made by zero-energy checks and other precautionary investigations made before work is authorized to begin.		
Cause Codes:			
ISM:			
Subcontractor Involved:	No		
Occurrence Description:	<p>On Thursday, August 27, 2009, at approximately 7:00 a.m., a Specific Manufacturing Capability (SMC) employee applied a temporary modification on a piece of equipment that was already under a non-electrical LO/TO. This was accomplished by placing a jumper around a relay in an electrical control cabinet. The relay was located in a control cabinet where 480 volts was still present at the line side of the disconnect. The disconnect to the control panel had been isolated for mechanical work only and no zero energy verification had been done to perform electrical work.</p> <p>This modification was made without following the appropriate work control process. In addition, the individual's LO/TO Qualification had expired in March, 2009.</p> <p>Action Taken: At approximately 0845 hours, all activity on the equipment was stopped and equipment was placed in a safe condition. Maintenance personnel were instructed to stop work, release their personal locks, and leave the work area. A critique of this event was conducted at 1200 hours.</p>		
Cause Description:			
Operating Conditions:	Routine Maintenance		
Activity Category:	Maintenance		
Immediate Action(s):	All maintenance activities on the equipment was stopped and equipment		

	was placed in a safe condition. Maintenance personnel were instructed to stop work, release their locks, and leave the work area. Critique was conducted at 1200 hours.
FM Evaluation:	To be determined
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is Required:	Yes. Before Further Operation? No By Whom: M. Park By When: 09/30/2009
Division or Project:	Idaho National Laboratory (INL)
Plant Area:	SMC
System/Building/Equipment :	Lockout/TAN-629/Line 10
Facility Function:	Uranium Conversion/Processing and Handling
Corrective Action:	
Lessons(s) Learned:	
HQ Keywords:	01F--Inadequate Conduct of Operations - Training Deficiency 01K--Inadequate Conduct of Operations - Lockout/Tagout Noncompliance (Electrical) 01M--Inadequate Conduct of Operations - Inadequate Job Planning (Electrical) 01O--Inadequate Conduct of Operations - Inadequate Maintenance 12I--EH Categories - Lockout/Tagout (Electrical or Mechanical) 14B--Quality Assurance - Training and Qualification Deficiency 14E--Quality Assurance - Work Process Deficiency
HQ Summary:	On August 27, 2009, a Specific Manufacturing Capability (SMC) employee applied a temporary modification on a piece of equipment that was already under a non-electrical LO/TO. This was accomplished by placing a jumper around a relay in an electrical control cabinet. The relay was located in a control cabinet where 480 volts was still present at the line side of a disconnect switch. The disconnect to the control panel had been isolated for mechanical work only and no zero energy verification had been done to perform electrical work. This modification was made without following the appropriate work control process. In addition, the individual's LO/TO Qualification had expired in March, 2009. All activity on the equipment was stopped and equipment was placed in a safe condition. A critique was conducted.
Similar OR Report Number:	
Facility Manager:	Name Park Michael D

	Phone	(208) 526-6555		
Originator:	Name	GERDES, ANNETTE W		
	Phone	(208) 526-6355		
	Title	OPERATIONS SUPPORT		
HQ OC Notification:	Date	Time	Person Notified	Organization
	NA	NA	NA	NA
Other Notifications:	Date	Time	Person Notified	Organization
	08/27/2009	09:15 (MTZ)	Goriup Michael R	DOE-ID
Authorized Classifier(AC):	Del DeCoria		Date: 09/01/2009	

12)Report Number:	SC--PNSO-PNNL-PNNLNUCL-2009-0003 After 2003 Redesign		
Secretarial Office:	Science		
Lab/Site/Org:	Pacific Northwest National Laboratory		
Facility Name:	PNNL Nuclear Facilities		
Subject/Title:	Noncompliance with Hazardous Energy Control Requirements		
Date/Time Discovered:	08/27/2009 11:43 (PTZ)		
Date/Time Categorized:	08/27/2009 13:21 (PTZ)		
Report Type:	Notification		
Report Dates:	Notification	08/31/2009	21:37 (ETZ)
	Initial Update		
	Latest Update		
	Final		
Significance Category:	3		
Reporting Criteria:	2C(2) - Failure to follow a prescribed hazardous energy control process (e.g., lockout/tagout) or a site condition that results in the unexpected discovery of an uncontrolled hazardous energy source (e.g., live electrical power circuit, steam line, pressurized gas). This criterion does not include discoveries made by zero-energy checks and other precautionary investigations made before work is authorized to begin.		
Cause Codes:			
ISM:	4) Perform Work Within Controls		
Subcontractor Involved:	No		
Occurrence Description:	During preparation of room 118 in Building 325 for painting and carpeting, a craftsman (electrician) removed the receptacle covers and switch plates.		

	After the plates were removed and some amount of painting had been performed, it was identified that the electrical conductors that supply the receptacles were energized. Removal of the receptacle covers without de-energizing the circuit(s) or working under an energized electrical work permit is being reviewed to verify consistency and applicability to national codes/standards and requirements of the Standards-Based Management System procedure, "Electrical Equipment and Systems, Working on or Near." No staff received an electrical shock or came in contact with any electrical component.
Cause Description:	
Operating Conditions:	Dry
Activity Category:	Maintenance
Immediate Action(s):	Switch plate and receptacles covers were reinstalled. A critique was held Friday, August 28, 2009.
FM Evaluation:	
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is Required:	Yes. Before Further Operation? No By Whom: By When:
Division or Project:	Operational Services Directorate / Nuclear Operati
Plant Area:	300 Area
System/Building/Equipment :	RPL (325 Bldg) / Room 118
Facility Function:	Laboratory - Research & Development
Corrective Action:	
Lessons(s) Learned:	
HQ Keywords:	01M--Inadequate Conduct of Operations - Inadequate Job Planning (Electrical) 08H--OSHA Reportable/Industrial Hygiene - Safety Noncompliance 12C--EH Categories - Electrical Safety 14E--Quality Assurance - Work Process Deficiency
HQ Summary:	On August 27, 2009, during preparation of room 118 in Building 325 for painting and carpeting, a craftsman (electrician) removed the receptacle covers and switch plates. After the plates were removed and some amount of painting had been performed, it was identified that the electrical conductors that supply the receptacles were energized. Removal of the receptacle covers without de-energizing the circuits or working under an energized electrical work permit is being reviewed to verify consistency

and applicability to national codes/standards and requirements of the Standards-Based Management System procedure, "Electrical Equipment and Systems, Working on or Near." No staff received an electrical shock or came in contact with any electrical component. The switch plate and receptacles covers were reinstalled. A critique was held on August 28, 2009.

Similar OR Report Number:

Facility Manager:

Name	Kooiker, C. A.
Phone	(509) 376-5746
Title	Bldg Manager, Radiochemical Processing Laboratory

Originator:

Name	SMITH, KARLA J
Phone	(509) 373-6481
Title	TECH. OPS AND ASSURANCE OFFICE, SPEC

HQ OC Notification:

Date	Time	Person Notified	Organization
NA	NA	NA	NA

Other Notifications:

Date	Time	Person Notified	Organization
08/27/2009	13:21 (PTZ)	Davies, T.	PNSO

Authorized Classifier(AC): Pollari, R. A. Date: 08/31/2009

| [ORPS HOME](#) | [Search & Reports](#) | [Authorities](#) | [Help](#) | [Security/Privacy Notice](#) |
Please send comments or questions to orpssupport@hq.doe.gov or call the Helpline
at (800) 473-4375. Hours: 7:30 a.m. - 5:00 p.m., Mon - Fri (ETZ).
Please include [detailed information](#) when reporting problems.