February 2009 Electrical Safety Occurrences

There were 4 electrical safety occurrences for February 2009:

- 1 resulted in electrical shock (welding shock)
- 3 involved lockout/tagout
- 1 involved cutting energized conductors
- 2 involved electrical workers and 2 involved non-electrical workers
- 2 occurrences involved subcontractors

February reports continue to follow the trend for the past three years by dropping significantly from the spike experienced in the previous months. In February 2008 there were 8 events, 9 fewer than January 2008. The positive momentum carried forward through March 2008, but began an adverse trend in April that carried through the spring. The 4 events in February 2009 represent a reduction of 7 from the 11 in January 2009. A seasonal review of electrical safety events has shown a favorable (decreasing) trend from the winter of 2004/2005 through the fall of 2008. A look at the distribution of events by season (2005 through 2007) shows that 17 percent of the events occurred in the fall, while 26 percent occurred in winter, 28 percent occurred in spring, and 29 percent occurred in summer. An electrical safety awareness campaign in March could pay dividends by heading off the predicted upward trend until Electrical Safety Month in May.

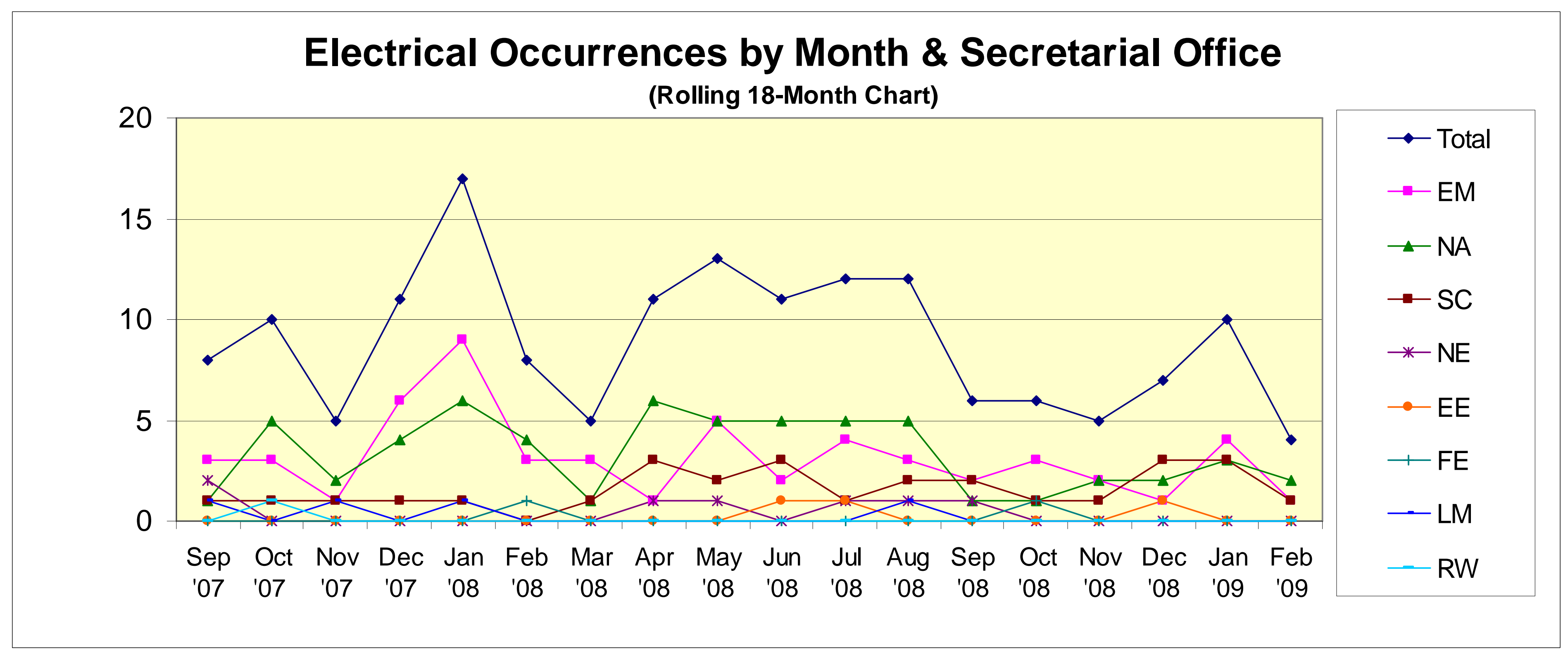
In compiling the monthly totals, the search initially looked for occurrence discovery dates in this month (excluding Significance Category R reports), and for the following ORPS "HQ keywords":
01K – Lockout/Tagout Electrical, 01M - Inadequate Job Planning (Electrical),
08A – Electrical Shock, 08J – Near Miss (Electrical), 12C – Electrical Safety

Three of the four occurrences involved a hazardous energy control discrepancy. Only one report (NA--LASO-LANL-BOP-2009-0001) provided an Electrical Severity (ES) score. Although the use of the Electrical Severity Measurement Tool in the evaluation of electrical energy events is not required, it's use is strongly encouraged in order to provide a more consistent approach to tracking and trending electrical energy events. This month's report includes an additional column in the table that provides an estimated ES score for each of the events.

Below is the current summary of 2009 electrical safety occurrences:

Period	Electrical Safety Occurrences	Shocks	Burns	Fatalities
Feb-09	4	1	0	0
2009 total	15 (avg. 7.5/month)	3	0	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

The average rate of electrical safety occurrences in 2009 is 7.5 per month, which is less than the average rate of 9.4 per month experienced in 2008. The 2009 average rate, of course, is based on a very small set of data and is below the 2004 – 2007 average rates.



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

Electrical Safety Occurrences – February 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-IWTU-2009-0002	A Carpenter/Welder reported a tingling in his hand while performing a weld.		X	X	X							110
2	NA--LASO-LANL-BOP-2009-0001	While pulling a sealed flexible conduit, the conduit made contact with an energized computer rack and a grounded floor stringer.	X						X				110
3	NA--LSO-LLNL-LLNL-2009-0013	During concrete-cutting operation, a 110-Volt power line enclosed in PVC conduit was severed.		X	X				X		X		160
4	SC--PNSO-PNNL-PNNLBOPER-2009-0003	Electricians did not apply a personal Lock Out Tag Out (LOTO) as required by the PNNL Hazardous Energy Control Process.	X						X				0
	TOTAL		2	2	2	1			3		1		

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

ORPS Operating Experience Report

Production GUI - New ORPS

ORPS contains 54066 OR(s) with 57384 occurrences(s) as of 3/4/2009 10:14:38 AM
Query selected 4 OR(s) with 4 occurrences(s) as of 3/4/2009 11:43:41 AM

Download this report in Microsoft Word format.

1)Report Number:	EM-ID--CWI-IWTU-2009-0002 **After 2003 Redesign**
Secretarial Office:	Environmental Management
Lab/Site/Org:	Idaho National Laboratory
Facility Name:	Integrated Waste Treatment Unit
Subject/Title:	IWTU - Welder Receives Shock While Arc Welding
Date/Time Discovered:	02/11/2009 16:35 (MTZ)
Date/Time Categorized:	02/11/2009 17:25 (MTZ)
Report Type:	Notification
Report Dates:	Notification: 02/12/2009 19:25 (ETZ) Initial Update: Latest Update: Final:
Significance Category:	3
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 3 occurrence)
Cause Codes:	
ISM:	
Subcontractor Involved:	Yes URS-Washington Division
Occurrence Description:	On Wednesday, February 11, 2009 at approximately 1415 hours (MDT) a URS Carpenter/Welder reported he had felt a tingling and his hand had momentarily clenched onto the weld stinger while he was performing a weld at the Integrated Waste Treatment Unit (IWTU). The carpenter/welder was on the East wall about 15 feet off of the first scaffold platform welding a small clamp onto a piece of tube steel that serves as extra bracing for the concrete forms associated with Wall #11. At approximately 1415 hours (MDT), the surrounding area had been wetted

	down as required by the assigned Fire Watch in accordance with the Hot Work Permit. They had wetted the upper scaffold and lower scaffold. The carpenter/welder then climbed the side of the wall to perform the welding. The carpenter/welder noted that there were puddles of standing water on the scaffolding and the floor below, that there was water dripping onto his head from the scaffolding above him, and that the concrete forms were wet. The carpenter/welder stated that his leather welding gloves were damp after climbing to the weld location. Shortly after striking the arc, the carpenter/welder felt a tingling in the hand and arm and his hand clenched onto the stinger. The carpenter/welder immediately stopped welding, descended the wall and reported the event to line management.
Cause Description:	
Operating Conditions:	The area around for 35 feet around the welding location had been watered down as required by the hot work permit.
Activity Category:	Construction
Immediate Action(s):	Immediate Actions taken: - the carpenter/welder was sent to the Central Facilities Area (CFA) medical dispensary where he was evaluated and was released with no work restrictions. -all welding at the IWTU was suspended pending review and determination of corrective actions. - an electrical inspection of the welding unit, leads and surrounding area was performed. - the event was categorized as ORPS reportable.
FM Evaluation:	At 1736 hours (MDT) on February 11, 2009 the DOE Facility Representative was informed that the IWTU Operations Manager had categorized this event as a DOE M 231.1-2 Group 10 (Management Concerns/Issues), Sequence 2 (Any 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.), Significance Category 4. The DOE Facility Representative concurred with the contractor's event categorization. Following the Fact Finding meeting that was held on February 12, CWI re-categorized the event as Group 10, Sequence 2, Significance Category 3 at 0845 hours (MDT). The DOE Facility Representative concurs with the re-categorization. The CWI Lead Construction Engineer convened a fact finding on Thursday morning February 12, 2009. Highlights from the fact finding included: - The Hot Work Permit had been recently revised requiring wetting down of

	the area in a 35-foot sphere around the area where hot work was to be performed. - the welding machine, welding lead, welding ground and the electrical gang box were inspected by qualified Electricians and line management and no material and/or equipment deficiencies were found. - At the time of the event, the welding unit was set at 92 Amps and was grounded to a re-bar curtain on the North wall approximately 20-feet from the welding unit. The welding lead was routed to the East wall about 200-feet from the welding unit. Corrective action discussed at the Fact Finding included: - management evaluation to attempt to determine the actual amps and voltage the carpenter/welder received when he felt the tingling. - welding outside of designated shop areas is on hold pending the completion of a management review of the entire welding procedure(s) and associated controls (i.e. Hot Work Permit, Job Safety Analysis, etc.) - the carpenter/welder has a follow-on examination/evaluation scheduled with CFA Medical on February 12, 2009.
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is Required:	Yes. Before Further Operation? Yes By Whom: Scott Marhefka By When: 02/19/2009
Division or Project:	Integrated Waste Management Unit
Plant Area:	IWTU Enclosure
System/Building/Equipment:	Welding on the north east wall forms
Facility Function:	Nuclear Waste Operations/Disposal
Corrective Action:	
Lessons(s) Learned:	
HQ Keywords:	01N--Inadequate Conduct of Operations - Inadequate Job Planning (Other) 08A--OSHA Reportable/Industrial Hygiene - Electrical Shock 08H--OSHA Reportable/Industrial Hygiene - Safety Noncompliance 11G--Other - Subcontractor 12C--EH Categories - Electrical Safety 13A--Management Concerns - HQ Significant (High-lighted for Management attention) 14E--Quality Assurance - Work Process Deficiency
HQ Summary:	On February 11, 2009, shortly after striking an arc, a URS Carpenter/Welder felt a tingling and his hand momentarily clenched onto the weld stinger while he was welding at the Integrated Waste Treatment Unit (IWTU). The welder was standing on wet scaffolding and water dripped onto his head

	from the scaffolding above. His leather welding gloves were damp. At the time of the event, the welding unit was set at 92 Amps. An electrical inspection of the welding unit, leads and surrounding area was performed. The welder was examined at medical and released with no restrictions.
Similar OR Report Number:	
Facility Manager:	Name: James M White; Phone: (208) 520-4443; Title: Operations Manager
Originator:	Name: BOSLEY, JAMES B; Phone: (208) 533-3552; Title: STAFF ENGINEER - ISSUE MANAGEMENT CO
HQ OC Notification:	
Other Notifications:	
Authorized Classifier(AC):	Gene Newsome Date: 02/12/2009

Facility Manager:

Name	James M White
Phone	(208) 520-4443
Title	Operations Manager

Originator:

Name	BOSLEY, JAMES B
Phone	(208) 533-3552
Title	STAFF ENGINEER - ISSUE MANAGEMENT CO

HQ OC Notification:

Date	Time	Person Notified	Organization
NA	NA	NA	NA

Other Notifications:

Date	Time	Person Notified	Organization
02/11/2009	17:36 (MTZ)	Brad Davis	DOE-ID
02/12/2009	08:45 (MTZ)	Brad Davis	DOE-ID

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2)Report Number:	NA--LASO-LANL-BOP-2009-0001 **After 2003 Redesign**
Secretarial Office:	National Nuclear Security Administration
Lab/Site/Org:	Los Alamos National Laboratory
Facility Name:	"at large" or Balance of Plant
Subject/Title:	Unexpected Discovery of an Energized Source during Maintenance Activities
Date/Time Discovered:	02/05/2009 11:00 (MTZ)
Date/Time Categorized:	02/05/2009 11:25 (MTZ)
Report Type:	Notification
Report Dates:	
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

Report Dates:

Notification	02/09/2009	19:28 (ETZ)
Initial Update		
Latest Update		
Final		

	discoveries made by zero-energy checks and other precautionary investigations made before work is authorized to begin. 10(3) - A near miss, where no barrier or only one barrier prevented an event from having a reportable consequence. One of the four significance categories should be assigned to the near miss, based on an evaluation of the potential risks and the corrective actions taken. (1 of 4 criteria - This is a SC 3 occurrence)
Cause Codes:	
ISM:	
Subcontractor Involved:	No
Occurrence Description:	MANAGEMENT SYNOPSIS: On February 5, 2009, at Technical Area 3, Building 132, Room 270, at 1105, while an electrician (E1) was pulling a sealed flexible conduit, the conduit made contact with an energized computer rack and a grounded floor stringer resulting in an electrical arc. Using a voltage meter, E1 and another electrician (E2) identified the source as the computer rack. They unplugged the twist-lock cord cap from the receptacle. The electricians immediately barricaded the area and notified the Institutional Facilities and Central Services (IFCS) operations personnel. Subsequent inspection found the computer rack's cord cap, which was designed for 120 volts, had been plugged into a 208 volts receptacle thereby energizing the computer rack cabinet. No personnel injuries resulted. The Computing Operations and Support Group (HPC-2) management locked and tagged out the computer rack pending further evaluation. Because of the inappropriate power configuration of the computer rack and the potential impact it could have posed to the safety of personnel, operations, and the facility, the IFCS Facility Operations Director also categorized the event as a near miss. BACKGROUND: The HPC-2 had a project to remove circuits from power distribution units (PDUs) and install new circuits in Room 270 which is a computer room. The electricians had been tasked to remove unused circuits and the associated flexible conduits. Subsequent discussion with a Systems Integration Group (HPC-5) worker (W1) found he had been tasked by his line management to move the computer rack from one section of the computer room to another section where other HPC-5 computer racks were located. W1 indicated he had worked with the HPC-5 research and development (R&D) manager who normally moves computer racks in the room. On or around January 26, 2009, W1 and the R&D manager moved the computer rack. They initially moved the rack to one section of the room, but did not find the appropriate receptacle (110V). They moved the computer rack to another section where the R&D manager identified what he thought was the appropriate receptacle. The R&D manager ran the cord under the sub-flooring and told W1 to plug

	the 120V twist-lock cord cap into the 208V twist-lock floor receptacle. W1 stated the plug did not initially plug into the receptacle. W1 turned the plug a few degrees before it fit into the receptacle. W1 indicated he had not turned on the power to the computer rack because it still required a network connection. W1 and the R&D manager then left the computer room not knowing the incorrect configuration of the plug-in. According to HPC-2 management, any time the tenants need to have their computer racks moved, they are to complete and submit a request to HPC-2. Upon receipt, HPC-2 personnel review and approve the request. Following approval, a work ticket is generated for the electricians to move and install the computer racks. As part of the installation process, the computer rack is bonded and grounded before it is energized. In this instance, the movement of the computer rack did not follow this process; therefore, the computer rack had not been bonded or grounded. Following the event, a Division Electrical Safety Officer (DESO) evaluated the event using the electrical severity tool. The evaluation resulted in a score of 110 for an electrical severity significance of "Medium" because of the presence of a moderate electrical hazard factor of 120V and the shock proximity was within the prohibited approach boundary when the equipment inadvertently made contact with an uncontrolled, hazardous electrical energy source.
Cause Description:	
Operating Conditions:	Maintenance Activities
Activity Category:	Maintenance
Immediate Action(s):	1. The electricians unplugged the computer rack cord cap from the floor receptacle. They barricaded the area and notified their supervision and the IFCS operations personnel. 2. The HPC-2 management locked and tagged out the computer rack pending further evaluation. 3. The HPC-2 management will inspect and verify the plug-ins are in the correct configuration. In addition, they will also inspect and verify the computer racks are bonded. 4. The HPC Division management will share the event lessons learned with personnel.
FM Evaluation:	
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is	Yes.

Required:	Before Further Operation? No By Whom: HPC-DO, IFCS-DO & ESH-IO By When: 03/20/2009
Division or Project:	High Performance Computing Division
Plant Area:	TA3-132-270
System/Building/Equipment:	Dell Computer Rack
Facility Function:	Laboratory - Analytical
Corrective Action:	
Lessons(s) Learned:	
HQ Keywords:	01A--Inadequate Conduct of Operations - Inadequate Conduct of Operations (miscellaneous) 01E--Inadequate Conduct of Operations - Operations Procedure Noncompliance 01M--Inadequate Conduct of Operations - Inadequate Job Planning (Electrical) 01R--Inadequate Conduct of Operations - Management issues 08J--OSHA Reportable/Industrial Hygiene - Near Miss (Electrical) 12K--EH Categories - Near Miss (Could have been a serious injury or fatality) 14E--Quality Assurance - Work Process Deficiency
HQ Summary:	On February 5, 2009, while an electrician was pulling a sealed flexible conduit in Building 132, Room 270, the conduit touched an energized computer rack and a grounded floor stringer resulting in an electrical arc. Subsequent inspection found that the computer rack's cord cap (designed for 120 volts) had been plugged into a 208-volt receptacle, which energized the computer rack cabinet. No personnel injuries resulted. The Computing Operations and Support Group management locked and tagged out the computer rack pending further evaluation.
Similar OR Report Number:	
Facility Manager:	Name: Judith Huchton Phone: (505) 665-2272 Title: IFCS Facility Operations Director
Originator:	Name: YAZZIE, ALVA M Phone: (505) 664-0666 Title: OCCURRENCE INVESTIGATOR
HQ OC Notification:	Date: NA; Time: NA; Person Notified: NA; Organization: NA
Other Notifications:	Date: 02/05/2009; Time: 11:57 (MTZ); Person Notified: Ed Christie; Organization: NNSA

	02/06/2009	13:30 (MTZ)	Notification Line	NNSA
Authorized Classifier(AC):	Antonia Tallarico Date: 02/09/2009			

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3)Report Number:	NA--LSO-LLNL-LLNL-2009-0013 **After 2003 Redesign**
Secretarial Office:	National Nuclear Security Administration
Lab/Site/Org:	Lawrence Livermore National Lab.
Facility Name:	Lawrence Livermore Nat. Lab. (BOP)
Subject/Title:	110-Volt Power Line Severed During Concrete Cutting Activity in Building 481
Date/Time Discovered:	02/26/2009 14:00 (PTZ)
Date/Time Categorized:	02/26/2009 14:30 (PTZ)
Report Type:	Notification
Report Dates:	Notification 02/27/2009 17:20 (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 Gowan Construction
Occurrence Description:	On February 25, 2009, a power outage to the Building 481 CAIN booth was received by Security Alarms Group. At the same time, a saw cutting operation of the paver inside the building was occurring. The saw cutting operation was stopped to determine the cause of the power outage. On February 26, 2009 it was determined that during the cutting operation a 110-Volt power line enclosed in PVC conduit supplying power to the CAIN booth was severed. The area was surveyed and plans reviewed prior to initiating the cutting activity. Work remains stopped and an investigation is ongoing.
Cause Description:	
Operating Conditions:	Does not apply
Activity Category:	Construction

<table>
<tr><td>Immediate Action(s):</td><td>Construction work was stopped and an investigation initiated.</td></tr>
<tr><td>FM Evaluation:</td><td>The Final Report is due to the ORO by 4/9/2009.

The Final Report is due for entry into ORPS by 4/12/2009.</td></tr>
<tr><td>DOE Facility Representative Input:</td><td></td></tr>
<tr><td>DOE Program Manager Input:</td><td></td></tr>
<tr><td>Further Evaluation is Required:</td><td>Yes.
Before Further Operation? Yes
By Whom: Lee Kapit
By When: 04/09/2009</td></tr>
<tr><td>Division or Project:</td><td>NIF</td></tr>
<tr><td>Plant Area:</td><td>Site 200</td></tr>
<tr><td>System/Building/Equipment:</td><td>Building 481</td></tr>
<tr><td>Facility Function:</td><td>Laboratory - Research & Development</td></tr>
<tr><td>Corrective Action:</td><td></td></tr>
<tr><td>Lessons(s) Learned:</td><td></td></tr>
<tr><td>HQ Keywords:</td><td>07C--Electrical Systems - Power Outage
07D--Electrical Systems - Electrical Wiring
08F--OSHA Reportable/Industrial Hygiene - Industrial Operations Issues
11G--Other - Subcontractor
12C--EH Categories - Electrical Safety
14E--Quality Assurance - Work Process Deficiency</td></tr>
<tr><td>HQ Summary:</td><td>On February 25, 2009, while cutting concrete in Building 481, the cutting saw cut an energized 110-volt power line resulting in a power outage to the Building 481CAIN booth. The area had been surveyed and plans were reviewed before starting the cutting activity. Work remains stopped and an investigation is ongoing.</td></tr>
<tr><td>Similar OR Report Number:</td><td></td></tr>
<tr><td>Facility Manager:</td><td><table><tr><td>Name</td><td>Valerie Roberts</td></tr><tr><td>Phone</td><td>(925) 424-3662</td></tr><tr><td>Title</td><td>NIF Asst. Principal Associate Director for Ops</td></tr></table></td></tr>
<tr><td>Originator:</td><td><table><tr><td>Name</td><td>FREEMAN, JEFFREY W</td></tr><tr><td>Phone</td><td>(925) 424-6787</td></tr><tr><td>Title</td><td>OCCURRENCE REPORTING</td></tr></table></td></tr>
<tr><td>HQ OC Notification:</td><td><table><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></td></tr>
<tr><td>Other Notifications:</td><td><table><tr><td>Date</td><td>Time</td><td>Person Notified</td><td>Organization</td></tr></table></td></tr>
</table>

	02/26/2009	15:00 (PTZ)	David Corporandy	NNSA/LSO
	02/26/2009	15:30 (PTZ)	Joel Bowers	LEDO
	02/26/2009	16:30 (PTZ)	Steven Lee	ESH TL
Authorized Classifier(AC):				

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4)Report Number:	SC--PNSO-PNNL-PNNLBOPER-2009-0003 **After 2003 Redesign**
Secretarial Office:	Science
Lab/Site/Org:	Pacific Northwest National Laboratory
Facility Name:	Energy Research Programs (PNNL)
Subject/Title:	Noncompliance with Hazardous Energy Control Process
Date/Time Discovered:	02/25/2009 12:30 (PTZ)
Date/Time Categorized:	02/25/2009 13:44 (PTZ)
Report Type:	Notification

Report Dates:

Notification	02/27/2009	14:22 (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:	On February 24, 2009, PNNL electricians performing work on a Radiation Generating Device (RGD) in 331 Building, Room 148, de-energized electrical power by disconnecting a power cord (source 1) and opening a breaker (source 2). They did not apply a personal Lock Out Tag Out (LOTO) as required by the PNNL Hazardous Energy Control Process. Building management became aware of and reported the non compliance on February 25, 2009. The electricians did not come into contact with hazardous energy and were not injured as both sources of power to the RGD were de-energized.
Cause Description:	
Operating Conditions:	Indoors - dry conditions

Activity Category:	Maintenance
Immediate Action(s):	The electricians LOTO Authorized Worker Qualifications are suspended pending further review. No further work on the RGD is pending. A critique is being scheduled.
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 Systems / Facilities & Operations
Plant Area:	300 Area
System/Building/Equipment:	331 Bldg / Room 148
Facility Function:	Laboratory - Research & Development
Corrective Action:	
Lessons(s) Learned:	
HQ Keywords:	01K--Inadequate Conduct of Operations - Lockout/Tagout Noncompliance (Electrical) 12I--EH Categories - Lockout/Tagout (Electrical or Mechanical) 14E--Quality Assurance - Work Process Deficiency
HQ Summary:	On February 24, 2009, PNNL electricians performing work on a Radiation Generating Device (RGD) in 331 Building, Room 148, de-energized electrical power by disconnecting a power cord and opening a breaker; however, they did not apply a personal Lock Out Tag Out (LOTO) as required by the PNNL Hazardous Energy Control Process. The electricians did not come into contact with hazardous energy and were not injured as both sources of power to the RGD were de-energized. The electricians LOTO Authorized Worker Qualifications were suspended pending further review. A critique is being scheduled.
Similar OR Report Number:	
Facility Manager:	Name: Berger, J. E. Phone: (509) 371-7959 Title: Manager, Maintenance & Fabrication Services
Originator:	Name: POLLARI, ROGER A Phone: (509) 371-7700 Title:
HQ OC Notification:	Date | Time | Person Notified | Organization

	NA | NA | NA | NA

Other Notifications:

Date	Time	Person Notified	Organization
02/25/2009	13:45 (PTZ)	Christ, J.	PNSO

Authorized Classifier(AC): Pollari, R. A. Date: 02/27/2009