March 2008 Electrical Safety Occurrences

There were 5 electrical safety occurrences for March 2008:

- 1 resulted in an electrical shock
- 3 involved lockout/tagout
- 1 involved a vehicle intrusion of electrical equipment
- 4 involved electrical workers and 1 involved a non-electrical worker
- 0 occurrences involved subcontractors

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":

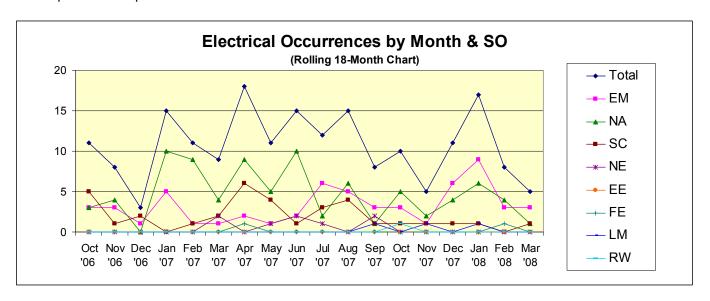
- 01K Lockout/Tagout Electrical, 01M Inadequate Job Planning (Electrical),
- 08A Electrical Shock, 08J Near Miss (Electrical), 12C Electrical Safety

The initial search yielded 5 occurrences and a review of these determined that none needed to be culled out.

Below is the current summary of 2008 electrical safety occurrences:

Period	Electrical Safety Occurrences	Shocks	Burns	Fatalities
Jan-08	17	7	0	0
Feb-08	8	3	0	0
Mar-08	5	1	0	0
2008 total	30 (avg. 10/month)	11	0	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 2008 is now 10 per month, which is less than the average rate of 11.7 per month experienced in 2007.



Electrical Safety Occurrences – March 2008

No	Report Number	Subject/Title	$\mathbf{EW}^{(1)}$	N-EW ⁽²⁾	SUB ⁽³⁾	SHOCK	BURN	ARCF ⁽⁴⁾	LOTO ⁽⁵⁾	EXCAV ⁽⁶⁾	CUT/D ⁽⁷⁾	VEH ⁽⁸⁾
1	EMPPPO-PRS-	Unexpected Discovery of										
	PGDPENVRES-	Energized 120V Heater Circuit	X						X			
	2008-0003	during Installation of Temporary	Λ						Λ			
		Power in Switchgear Cubicle										
2	EM-IDCWI-BIC-	Snow Removal Equipment										
	2008-0002	Severs 240-Volt Temporary		X								X
		Power Cable										
3	EM-RLPHMC-	LOTO Procedural Compliance	X						X			
	FSS-2008-0002	Concern	Λ						Λ			
4	NAYSO-BWXT-	Failure of LO/TO to Fully Isolate	X						X			
	Y12SITE-2008-0011	Power	Λ						Λ			
5	SCBSO-LBL-ENG-	Maintenance Technician	X			X						
	2008-0001	Sustained Electric Shock at ALS	Λ			Λ						
	TOTAL		4	1		1			3			1

<u>Key</u>

(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

ORPS Operating Experience Report 2 Production GUI - New ORPS

ORPS contains 53660 OR(s) with 56978 occurrences(s) as of 4/2/2008 11:23:12 AM Query selected 5 OR(s) with 5 occurrences(s) as of 4/2/2008 2:36:00 PM

	Dov	vnload this report in Mi	crosoft Word format. 🗐		
1)Report Number:	EMPPPO-PRS-PGDPENV	RES-2008-0003 After	2003 Redesign		
Secretarial Office:	Environmental Management				
Lab/Site/Org:	Paducah Gaseous Diffusion	Plant			
Facility Name:	Environmental Restoration				
Subject/Title:	Unexpected Discovery of En of Temporary Power in Swit		ircuit during Installation		
Date/Time Discovered:	03/25/2008 15:00 (ETZ)				
Date/Time Categorized:	03/25/2008 15:55 (ETZ)				
Report Type:	Notification				
Report Dates:	Notification	03/27/2008	18:32 (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:	2) Analyze the Hazards4) Perform Work Within Co.	ntrols			
Subcontractor Involved:	No				
Occurrence Description:	On March 20, 2008, electricians were completing installation of a new 480V 200 amp breaker for a temporary power circuit in a outdoor main power panel at the C-410 facility. Work was being performed under an approved PRS work package and the main circuit breaker for the panel was locked and tagged open using the single source exception per the approved site Lock Out/Tag Out (LO/TO)procedure. A LO/TO permit was not required. It was a cold day (less than 33 degrees F) and one of the electricians felt heat being radiated from a heater located at the bottom of the switchgear cabinet.				

Upon further investigation, the electrician concluded the heater was energized (120 VAC).

During previous work evolutions, the heater had not been energized because it was thermostatically controlled and the ambient temperature was higher than the thermostat set point when work was being performed. Therefore, previous zero energy checks on the heater terminals had indicated no voltage. No zero energy check was made on the heater terminals before the work was initiated on March 20, 2008.

The Front Line Manager (FLM) overheard an electrician discussing the discovery of the energized heater. The FLM temporarily suspended the work and gathered the electricians to discuss this changed condition. A switch (located on the switchgear panel) was identified that de-energized the heater and was turned off. Electricians performed a zero energy check on the heater and verified it was de-energized. The FLM and electricians discussed how to proceed and agreed to continue to finish the job, which consisted of connecting the wires to the new circuit breaker. A LO/TO permit was discussed but it was agreed that they had placed the equipment in a safe condition and could resume. Personnel were wearing cotton clothing, safety glasses, and leather gloves while working in the switchgear cubicle. The job was finished without further incident. None of the personnel involved came in contact with the 120v heater or terminals during the time it was energized.

On March 25, 2008, after a briefing for a revision to the site LO/TO procedure, the FLM decided to perform a thorough review of the procedure in relation to the work performed on March 20. During the review, the FLM determined the actions taken on March 20th may have resulted in a violation of the site LO/TO procedure.

The FLM immediately self-reported the event to the Superintendent, Operations Manager, and Facilities Disposition Director stating that the LO/TO procedure might have been violated. Upon conferring with the Quality Assurance, the Facilities Disposition Director determined that the event was a violation of the LO/TO procedure and ORPS reportable.

(Cause	D	es	cr	ıp	tı	on:	

Operating Conditions: Does Not Apply

Activity Category: Facility Decontamination/Decommissioning

Immediate Action(s): A critique of the event was conducted by PRS Senior Management following the event.

An Extent of Condition review was initiated for all active lockout/tagout tasks by the Manager of Projects on March 26, 2008.

Workers were reassigned to other work where LO/TO was not required

	pending completion of the extent of condition review and evaluation by management.
FM Evaluation:	A safety pause, in which this event was discussed, was conducted for all site personnel on March 26 and 27, 2008. The extent of condition review of all active LO/TO permits is continuing. Work involving LO/TO will not be reinitiated until management has been assured that all the appropriate hazard controls are in place and the work involving LO/TO can be performed safely.
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is Required:	Yes. Before Further Operation? Yes By Whom: Pete Coutts By When: 05/05/2008
Division or Project:	Paducah Environmental Restoration Project
Plant Area:	C-410/C-420 Complex
System/Building/Equipment:	C-410/C-420 Complex
Facility Function:	Category "B" Reactors
Corrective Action:	
Lessons(s) Learned:	
HQ Keywords:	01KInadequate Conduct of Operations - Lockout/Tagout Noncompliance (Electrical) 01MInadequate Conduct of Operations - Inadequate Job Planning (Electrical) 08HOSHA Reportable/Industrial Hygiene - Safety Noncompliance 12IEH Categories - Lockout/Tagout (Electrical or Mechanical) 14EQuality Assurance - Work Process Deficiency
HQ Summary:	On March 20, 2008, electricians were completing installation of a new 480V 200 amp breaker for a temporary power circuit in an outdoor main power panel at the C-410 facility. The main circuit breaker for the panel was locked and tagged open using the single source exception per the approved site Lock Out/Tag Out (LO/TO) procedure. During the work, an electrician felt heat radiating from a heater located at the bottom of the switchgear cabinet, and realized it was energized. No zero energy check was made on the heater terminals before the work was initiated. Work was suspended so the changed condition could be discussed. The heater was de-energized and the work was completed. A subsequent review of the site LO/TO procedure in relation to the work performed on March 20 determined the actions taken may have resulted in a violation of the site LO/TO procedure.
Similar OR Report Number:	•

Facility Manager: Originator:	Name Pete Coutts Phone (270) 441-5035 Title Manager of Projects Name VALENTINE, LENIS C Phone (270) 441-5161 Title SENIOR QA ENGINEER			
HQ OC Notification:	Date Time Person Notified Organization NA NA NA NA NA			
Other Notifications: Authorized Classifier(AC):	Date Time Person Notified Organization 03/25/2008 15:00 (ETZ) Don Ulrich PRS PM 03/25/2008 15:00 (ETZ) Len Valentine PRS QA 03/25/2008 15:00 (ETZ) Greg Bazzell DOE FR 03/25/2008 15:55 (ETZ) Mike Evans PRS S&H 03/25/2008 17:30 (ETZ) John Martin PRS S&H 03/25/2008 18:10 (ETZ) Bob Goldsmith DOE EM Montgomery Breneman Date: 03/27/2008			
2)Report Number:	EM-IDCWI-BIC-2008-0002 After 2003 Redesign			
Secretarial Office:	Environmental Management			
Lab/Site/Org:	Idaho National Laboratory			
Facility Name:	Demolition and Decommissioning Activities			
Subject/Title:	Snow Removal Equipment Severs 240-Volt Temporary Power Cable			
Date/Time Discovered:	03/04/2008 13:50 (MTZ)			
Date/Time Categorized: Report Type:	03/04/2008 15:35 (MTZ) Notification			
Report Dates:				
port zates:	Notification 03/06/2008 15:31 (ETZ) Initial Update			
	-			
	Latest Update Final			
Cianificance Category				
Significance Category: 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.
	investigations made before work is authorized to begin.
Cause Codes:	
ISM:	2) Analyze the Hazards4) Perform Work Within Controls
Subcontractor Involved:	No
Occurrence Description:	At about 1350 hours on Tuesday, March 4, 2008 a CH2M-WG Idaho (CWI) Voluntary Consent Order (VCO)/Deactivation and Demolition (D&D) front end loader was being operated by a heavy equipment operator (HEO). During use of this equipment in a snow removal activity, it struck and damaged a live 240-volt temporary electrical supply cable. The HEO was using the front end loader in an attempt to clear a space for relocation of a VCO storage / cargo container. The approved snow removal map that identifies interferences was not being used, nor were the requirements in the snow removal plan (MCP-6103, Appendix D) being followed. The damage from the front end loader to the cable caused the power supply breaker in the Irradiated Fuel Storage Facility, CPP-603, to trip. No personnel injuries, no visible electrical arcing and no burn marks on the loader bucket were noted. VCO and D&D personnel performed a step-back, contacted maintenance electricians to ensure the circuit was no longer energized and placed a lock out tag out (LO/TO) on the breaker. While notifications were being made and the LO/TO was being prepared, personnel were assigned to guard the area to prevent any contact with the cable. The area of cable damage was
Cause Description:	roped off and posted to limit access.
Operating Conditions:	Normal Voluntary Consent Order activities
Activity Category:	Facility Decontamination/Decommissioning
Immediate Action(s):	 Stopped the snow removal activity. Placed a LO/TO on the circuit and completed a zero energy verification. Roped off the area and limited area access. Placed a hold on all INTEC area snow removal in non-designated areas.
FM Evaluation:	
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is Required:	Yes. Before Further Operation? No By Whom: T. Reynolds By When: 04/17/2008
Division or Project:	Balance of Plant

Plant Area:	INTEC				
System/Building/Equipment:	Temporary power /Temporary building/Snow removal				
Facility Function:	Balance-of-Plant - Site/outside utilities				
Corrective Action:					
Lessons(s) Learned:					
HQ Keywords:	01NInadequate Conduct of Operations - Inadequate Job Planning (Other) 07DElectrical Systems - Electrical Wiring 08FOSHA Reportable/Industrial Hygiene - Industrial Operations Issues 12CEH Categories - Electrical Safety 14EQuality Assurance - Work Process Deficiency				
HQ Summary:	During snow removal, a front end loader struck and damaged an energized 240-volt temporary electrical supply cable and tripped a power supply breaker in the Irradiated Fuel Storage Facility, CPP-603. No personnel injuries, no visible electrical arcing and no burn marks on the loader bucket were noted. The circuit breaker was locked and tagged out and snow removal was suspended.				
Similar OR Report Number:					
Facility Manager:	Name T. Reynolds Phone (208) 526-8005 Title INTEC Operations Manager				
Originator:	Name GERDES, ANNETTE W Phone (208) 526-3100 Title PLANT SHIFT SUPERVISOR				
HQ OC Notification:	Date Time Person Notified Organization NA NA NA				
Other Notifications:	DateTimePerson NotifiedOrganization03/04/200815:35 (MTZ)Rodger ClaycombDOE-ID				
Authorized Classifier(AC):	Annette W. Gerdes Date: 03/06/2008				
3)Report Number:	EM-RLPHMC-FSS-2008-0002 After 2003 Redesign				
Secretarial Office:	Environmental Management				
Lab/Site/Org:	Hanford Site				
Facility Name:	Facility & Site Services				
Subject/Title:	LOTO Procedural Compliance Concern				
Date/Time Discovered:	03/14/2008 09:45 (PTZ)				
Date/Time Categorized:	03/14/2008 10:20 (PTZ)				
Report Type:	Notification				

Report Dates:	Natification	02/10/2000	16.22 (ETZ)			
	Notification	03/18/2008	16:33 (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:	No					
Occurrence Description:	On 03/12/2008 at approximately 1600 hours, craft personnel reported a concern to management relative to compliance with hazardous energy control procedure HNF-PRO-081. a review of the activity was performed. It was determined that inconsistencies existed in compliance with prescribed procedures for the isolation of the utilities for a modular office. The inconsistencies were both technical and administrative in nature. At no time during the performance of this work were any workers exposed to hazardous energy. The task at hand was to remove all utilities from MO-251 to prepare the modular for relocation to another location on the Hanford Site. On-Site Fluor Hanford Construction Services (FHCS) were tasked with the work scope and started the dismantling process on 03/12/2008 beginning with the removal of modular skirting followed by isolation of the water and sewer utilities. On the morning of 03/12/2008, FH Electrical Utilities (EU) received written authorization from FH Facilities & Land Management (F&LM) to remove electrical service to MO-251. The authorization was granted for the period of 03/12/2008 through 03/20/2008, at which time the electrical power was to be restored to provide electrical service to two remaining modular offices and parking lot lighting. This effort required the opening of switches on the utility pole which in turn removed electrical power to a pedestal mounted transformer. Since electrical power was to be restored, EU was also requested to lift all electrical cables from the transformer that fed the MO-251 local disconnect.					

	personnel then applied Authorized Worker (AW) danger tags over the EU Hold-Off tag and EU proceeded to perform their authorized tasks. Following completion of the EU work tasks (opening of switches and lifting of MO-251 feeder cabling), FHCS electrical personnel performed the required zero energy check and performed the dismantling and removal of the electrical service at the MO-251 local disconnect. A review of the process identified that FHCS electrical personnel and the work task Field Work Supervisor (FWS) failed to gain preliminary review of the work task by the Controlling Organization. It was also determined that the FHCS electrical personnel errorred by over-tagging the EU Hold-Off tag when using an AW tag. In this process, a Danger Do Not Operate (DDNO) should have been used.
Cause Description:	
Operating Conditions:	The facility was in a transitional mode and to be relocated.
Activity Category:	Construction
Immediate Action(s):	1. All work activity was immediately stopped on 03/12/2008.
	2. Critique meeting was held on 03/14/2008 to determine facts.3. Maintenance Services performed CO review and all pertinent tagging was performed on 03/17/2008.
FM Evaluation:	FH Facilities & Land Management (F&LM) manages both FH general purpose facilities and on-Site FHCS on the Hanford Site. In adherence to Site labor contracts and for ease of operations, F&LM delegates Controlling Organization (CO) responsibilities to multiple support organizations. During the review of this incident, it was determined that confusion existed in the initial review of the work task by the CO. The job site FHCS FWS did not contact the FHCS delegated CO as required. The FHCS CO is required to perform the initial review of the work task and determine criteria to perform the utility removal in compliance with Hanford Site energy control procedures. It was also determined in the critique review of this incident that the Controlling Organization (F&LM) delegations to supporting expenientions.
	Controlling Organization (F&LM) delegations to supporting organizations was confusing and may need some refinement and/or rewrite.
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is Required:	No
Division or Project:	Fluor Hanford Closure Services & Infrastructure

Plant Area:	200 East Area					
	stem/Building/Equipment: Modular Office Building					
Facility Function:	Balance-of-Plant - Offices					
Corrective Action:						
Lessons(s) Learned:						
HQ Keywords:	01AInadequate Conduct of Operations - Inadequate Conduct of Operations (miscellaneous) 01KInadequate Conduct of Operations - Lockout/Tagout Noncompliance (Electrical) 01MInadequate Conduct of Operations - Inadequate Job Planning (Electrical) 01PInadequate Conduct of Operations - Inadequate Oral Communication 01RInadequate Conduct of Operations - Management issues 12IEH Categories - Lockout/Tagout (Electrical or Mechanical) 14EQuality Assurance - Work Process Deficiency					
HQ Summary:	Craft personnel reported a concern to management relative to compliance with a hazardous energy control procedure during relocation of a modular office building. A review of the activity determined that inconsistencies existed in compliance with prescribed procedures, namely, that a required approval was not obtained, and that an Authorized Worker danger tag was placed over a Hold-Off tag rather than the required Danger Do Not Operate tag. At no time during the performance of this work were any workers exposed to hazardous energy. Work was stopped, a critique was held and tagging was corrected.					
Similar OR Report Number:						
Facility Manager:	Name C. W. Stolle Phone (509) 376-9080 Title Manager, Facilities & Land Management					
Originator:	Name BOYCE, MICHAEL L Phone (509) 376-3030 Title OCCURRENCE REPORTING SPEC.					
HQ OC Notification:	DateTimePerson NotifiedOrganizationNANANANA					
Other Notifications:	Date Time Person Notified Organization 03/14/2008 10:20 (PTZ) R. Gentry FH CS&I 03/14/2008 10:22 (PTZ) C. W. Stolle FH CS&I 03/14/2008 10:25 (PTZ) D. C. Humphreys DOE/RL					
Authorized Classifier(AC):						

4)Report Number:	NAYSO-BWXT-Y12SITE	C-2008-0011 After 2003	Redesign		
Secretarial Office:	NAYSO-BWXT-Y12SITE-2008-0011 After 2003 Redesign National Nuclear Security Administration				
Lab/Site/Org:	Y12 National Security Complex				
Facility Name:	Y-12 Site	JIOA			
Subject/Title:	Failure of LO/TO to Fully Is	olate Power			
Date/Time Discovered:	03/15/2008 10:20 (ETZ)				
Date/Time Categorized:	03/15/2008 12:37 (ETZ)				
Report Type:	Notification				
Report Dates:	Notification	03/18/2008	16:42 (ETZ)		
•	Initial Update	03/10/2000	10.42 (L1Z)		
	-				
	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:	1) Define the Scope of Work				
Subcontractor Involved:	No				
Occurrence Description:	On March 15, 2008, a work activity had been planned and scheduled to perform a preventive maintenance (PM) activity on a motor control center (MCC) in a process area. The PM involved removing electrical power from the breaker that was feeding the MCC using a single source lockout/tagout (LO/TO) isolation. The isolation breaker was identified in the approved outage plan. Once the breaker was turned off and locked-out, the absence of voltage was verified using a contact voltage meter on the input terminals of the MCC. As the PM work began, the electricians performing the work heard a clicking noise that sounded like an electric relay activating in an adjacent section of the MCC which had not yet been opened. The electricians stopped work, opened the adjacent panel and identified the presence of voltage using a proximity meter. They immediately closed the panel and contacted their supervisor to report conditions were not as expected and the LO/TO did not fully isolate the MCC as expected. The supervisor suspended the job and contacted the LO/TO Issuing Authority (IA) to determine the origin of second power source. After initial discussion with the IA, the supervisor contacted the maintenance Section Manager who came to the work site and evaluated the situation with the supervisor and IA. The area was flagged off and the Maintenance Execution Director was				

	notified of the discovery. When the Y-12 Electrical Authority Having Jurisdiction (AHJ) was notified of the discovery, it was confirmed to be a reportable occurrence event under criteria 2_C2 because the LO/TO did not isolate all power to the MCC and there was an unexpected discovery of an uncontrolled hazardous energy source (second voltage source). A preliminary investigation has identified a 110-volt control relay for another piece of process support equipment was located in the second compartment of the MCC and it was fed power from a source outside of the MCC. A critique was held on the same day as the event to collect the event facts. The PM activity was cancelled and the system returned to pre-PM status.
	The PM will not resume until effective energy isolation can be performed.
Cause Description:	
Operating Conditions:	The process had been taken out of service for the PM activity
Activity Category:	Maintenance
Immediate Action(s):	 Electrical personnel were briefed before the PM job began A LO/TO was performed per the approved outage plan Absence of voltage was verified at the MCC main power terminals The electricians heard what appeared to be electrical relay activity in an adjacent MCC compartment The electricians stopped work and opened the adjacent panel When the presence of electrical potential was identified, the panel was closed and supervision notified Supervision contacted the LO/TO IA Supervision contacted the maintenance Section Manager who contacted the Maintenance Execution Division Manager The Electrical AHJ was contacted and a CAT 3 Occurrence event was declared The area was controlled with flagging and a critique was held The MCC was returned to pre-PM status and turned over to operations personnel
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:	FI&S
Plant Area:	Protected Area

System/Building/Equipment:	MCC
Facility Function:	Balance-of-Plant - Site/outside utilities
Corrective Action:	
Lessons(s) Learned:	
HQ Keywords:	01BInadequate Conduct of Operations - Loss of Configuration Management/Control 01KInadequate Conduct of Operations - Lockout/Tagout Noncompliance (Electrical) 01MInadequate Conduct of Operations - Inadequate Job Planning (Electrical) 12IEH Categories - Lockout/Tagout (Electrical or Mechanical) 14DQuality Assurance - Documents and Records Deficiency 14EQuality Assurance - Work Process Deficiency
HQ Summary:	While performing preventive maintenance (PM) on a motor control center (MCC) that was isolated by a single source lockout/tagout (LO/TO), electricians heard a clicking noise that sounded like an electric relay activating in an adjacent section of the MCC. The electricians stopped work, opened the adjacent panel and found voltage using a proximity meter. They immediately closed the panel and contacted their supervisor to report that the LO/TO did not fully isolate the MCC. A preliminary investigation identified a 110-volt control relay in the second compartment of the MCC that received power from a source outside of the MCC. A critique was held and the PM was cancelled until effective energy isolation can be performed.
Similar OR Report Number:	
Facility Manager:	Name Ray, Floyd Phone (865) 576-8287 Title Maintenance Section Manager
Originator:	Name JONES, CARLA M Phone (865) 576-3949 Title
HQ OC Notification:	Date Time Person Notified Organization
	NA NA NA NA
Other Notifications:	Date Time Person Notified Organization
	03/15/2008 12:37 (ETZ) Hughes, Robert PSS 03/15/2008 12:53 (ETZ) Klemm, William B&W 03/15/2008 13:00 (ETZ) Lipsky, Jerold NNSA
Authorized Classifier(AC):	Schermerhorn, C Date: 03/18/2008
5)Report Number:	SCBSO-LBL-ENG-2008-0001 After 2003 Redesign

Secretarial Office:	Science							
Lab/Site/Org:	Lawrence Berkeley Laborato	ory						
Facility Name:	Engineering Division							
Subject/Title:	Maintenance Technician Sus	stained Electric Shock at	t ALS					
Date/Time Discovered:	03/10/2008 10:00 (PTZ)							
Date/Time Categorized:	03/10/2008 12:00 (PTZ)							
Report Type:	Notification							
Report Dates:	Notification	03/12/2008	20:13 (ETZ)					
	Initial Update							
	Latest Update							
	Final							
Significance Category:	3	3						
Reporting Criteria:	2C(2) - Failure to follow a pro- (e.g., lockout/tagout) or a sitt discovery of an uncontrolled power circuit, steam line, pro- discoveries made by zero-en investigations made before v	e condition that results in hazardous energy sourcessurized gas). This critering checks and other parts of the conditions of the condition	n the unexpected ce (e.g., live electrical erion does not include recautionary					
Cause Codes:								
ISM:	3) Develop and Implement F4) Perform Work Within Co.							
Subcontractor Involved:	No							
Occurrence Description:	On 03/08/2008 at about 1030 maintenance technician receipment opened chassis of a Granville Controller at Advanced Light re-energizing the unit for test bench power strip. After sever grasped the then inadvertent it from being flat on the worth the top and bottom of the chassis, the technician felt a finger came in contact with the power supply side of the	ived an electric shock we-Phillips model 303 Value Source (ALS). He had ting by unplugging and eral iterations of this problem of the problem of the standing on it assis for further diagnost shock sensation when the solder points on a price.	hile troubleshooting an acuum Process been de-energizing and plugging it into the ocess, the technician with both hands to pivot is right edge to expose tics. While lifting the ne pad of his left middle					
Cause Description:								
Operating Conditions:	Indoors, well lit, dry, dedicate	ted testing bench						
Activity Category:	Normal Operations (other the	an Activities specifically	y listed in this Category)					
Immediate Action(s):	The technician shut off the c strip. He then informed a fel	-						

	they informed the ALS control room operator in charge. The operator summoned the LBNL's Alameda County Fire Department (ACFD). Upon arrival, the ACFD paramedic evaluated the condition of the technician and released him to regular duties. The technician called and left messages for his direct supervisor as well as the ALS Safety Coordinator. He also contacted a backup supervisor who asked him to preserve the workbench/scene for further investigation.
FM Evaluation:	The electronic maintenance technician is qualified and authorized to perform the task.
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is Required:	Yes. Before Further Operation? No By Whom: Engineering, ALS, and EH&S By When:
Division or Project:	Engineering
Plant Area:	Bldg 80 Rm 137
System/Building/Equipment:	ALS Electronics Maintenance Shop
Facility Function:	Accelerators
Corrective Action:	
Lessons(s) Learned:	
HQ Keywords:	01OInadequate Conduct of Operations - Inadequate Maintenance 08AOSHA Reportable/Industrial Hygiene - Electrical Shock 08HOSHA Reportable/Industrial Hygiene - Safety Noncompliance 12CEH Categories - Electrical Safety 13EManagement Concerns - Facility Call Sheet 14EQuality Assurance - Work Process Deficiency
HQ Summary:	An electronics maintenance technician received an electric shock while troubleshooting an opened chassis of a Granville-Phillips model 303 Vacuum Process Controller at Advanced Light Source (ALS). He had been de-energizing and re-energizing the unit for testing by unplugging and plugging it into the bench power strip. While the chassis was still energized, the technician grasped it with both hands to pivot it to a standing position on its right edge to expose the top and bottom for further diagnostics. While lifting it, the technician felt a shock sensation when the pad of his left middle finger came in contact with the solder points on a printed circuit board on the power supply side of the controller.
Similar OR Report Number:	
Facility Manager:	Name Kem Robinson Phone (510) 486-6327

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