

June 2009 Electrical Safety Occurrences

There were 10 electrical safety occurrences for June 2009:

- 3 resulted in shocks
- 6 involved inadequate lockout/tagout (LOTO)
- 6 involved electrical workers and 4 involved non-electrical workers
- 3 occurrences involved subcontractors
- 2 occurrences reported severed lines due to cutting or drilling
- 1 excavation event was reported

June reports continue to follow the trend of previous years in regard to number of events as the summer months begin. We continue to see a significantly high percentage of events caused by inadequate execution of LOTO. Hazardous energy control plays a critical role in ensuring a workplace free of electrical hazards. LOTO must be performed perfectly each and every time. All three shocks reported this month occurred to non-electrical workers, indicating that we still have work to do in making our non-electrical workers aware of the hazards and how to avoid exposure. One event reported this month was due to electrical workers not being aware of a major electrical system configuration change. Understanding the system configuration is critical in performing an arc flash hazard analysis, as well as ensuring the capability of installed equipment. Only one excavation event was reported in June, even though more excavation work is likely to take place as the warmer months begin. This could be a positive indicator that efforts to reduce the number of excavation events have had an impact.

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, 10 events were identified. Active reporting coupled with effective use of the Electrical

Severity Measurement Tool will provide valuable information to improve individual programs and overall electrical safety across the DOE Complex. Three of the ES values in the June report were estimated based on information in the report and assumptions for missing data. Please continue to report all events and screen the events using the Electrical Severity Measurement Tool.

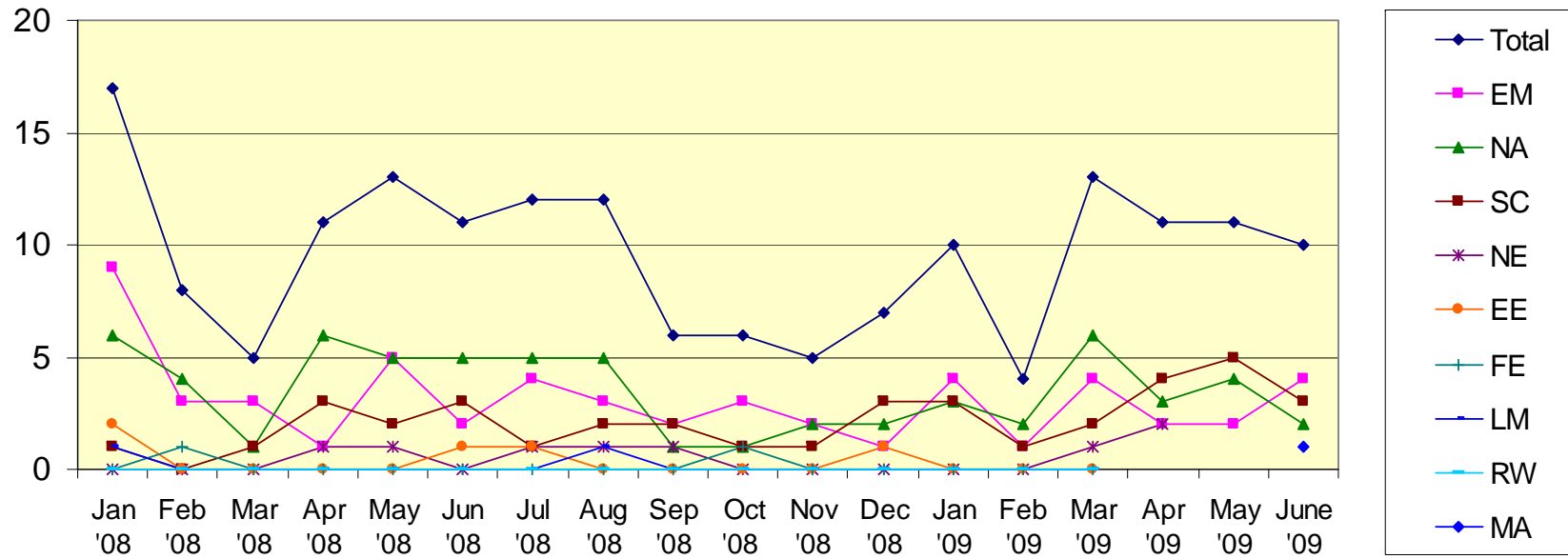
Below is the current summary of 2009 electrical safety occurrences:

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
2009 total	60 (avg. 10.0/month)	10	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

Half way through the calendar year, the average rate of electrical safety occurrences in 2009 is 10 per month, which is above the average rate of 9.4 per month experienced in 2008, and above the average number of 9.6 over the past 18 months. The 2009 average rate is below the 2004 – 2007 average rates. It will take continued diligence to reduce the number of events and reverse the trend through the last half of the year.

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 – June 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 ⁽⁹⁾
1	EM-ORO--ISOT-3019A-2009-0002	Energized 120 volt conductors discovered after LOTO established.	X		X				X				0
2	EM-RL--PHMC-FSS-2009-0004	A 120 volt conductor arcs to ground.	X						X				0
3	EM-RL--PHMC-FSS-2009-0005	A work team failed to recognize multiple energy sources while working on a UPS system, and did not use a complex LOTO method.	X						X				0
4	EM-SR--SRNS-SRNL-2009-0002	An energized conductor containing 68 volts was severed during D&D activities.	X						X		X		110
5	MA-HQ--GOHQ-DOEHQ-2009-0003	Contractor receives shock while exiting on a metal ladder, a manhole containing 480 volt energized conductors.		X	X	X							1650
6	NA--LASO- LANL-PHYSTECH-2009-0003	A near miss occurred due to failure to identify significant changes to the configuration of the electrical system.	X										0
7	NA--LSO-LLNL-LLNL-2009-0027	A de-energized 220 volt conductor was severed.	X						X		X		0
8	SC--BHSO-BNL-BNL-2009-0014	An experimenter received a shock when contacting a lab water faucet.		X		X							630
9	SC--PNSO-PNNL-PNNLBOPER-2009-0013	A backhoe operator severed a buried conduit containing conductors that were de-energized at the time.		X	X				X	X			0
10	SC--SSO-SU-SLAC-2009-0014	A lab worker received an electrical shock while touching the pendant control for a crane.		X		X							330
	TOTAL		6	4	3	3	0	0	6	1	2	0	

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 54224 OR(s) with 57542 occurrences(s) as of 7/5/2009 6:20:54 PM
Query selected 10 OR(s) with 10 occurrences(s) as of 7/5/2009 6:21:23 PM

Download this report in Microsoft Word format. 

1)Report Number:	EM-ORO--ISOT-3019A-2009-0002 After 2003 Redesign		
Secretarial Office:	Environmental Management		
Lab/Site/Org:	Oak Ridge National Laboratory		
Facility Name:	3019A Complex		
Subject/Title:	6/13/09 Discovery of Energized Circuit in MCC 1 Breaker		
Date/Time Discovered:	06/15/2009 12:45 (ETZ)		
Date/Time Categorized:	06/15/2009 13:00 (ETZ)		
Report Type:	Update		
Report Dates:	Notification	06/16/2009	17:18 (ETZ)
	Initial Update	06/17/2009	16:32 (ETZ)
	Latest Update	06/17/2009	16:32 (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 UT-B		
Occurrence Description:	Single-source LOTO was established at Substation 3000-BKR-10 on 6/13/09 while completing Annual Preventive Maintenance of Diesel Generator 3123. After establishing this LOTO, a zero energy check was completed on all three phases on switchgear 3000. No energy was found. The breakers were removed and zero energy checks were completed in the circuit breaker cubicle in order to attach UTB grounding clamps to the load side connections (while in PPE for voltages between 301 and 750). This was done to comply with UTB's power distribution work permit. UTB stop tags were placed on the ground and the 2400V fuses and		

	<p>additional grounds per UTB procedures were installed on the transformer.</p> <p>A break for lunch was then taken.</p> <p>Following the break, zero energy was re-verified on the bus voltages and also checked on the areas to be worked. At this time, an energized 120 V AC power to the load center/transformer space heaters was discovered in the cabinet.</p> <p>During the Post-Job Review which took place on 6/15/09, the participants reviewed the events that took place on 6/13/09 and discovered that the project had an occurrence under 2C(2).</p>
Cause Description:	
Operating Conditions:	Normal
Activity Category:	Maintenance
Immediate Action(s):	Maintenance work was suspended in the switchgear, transformer and motor control area in order to re-evaluate the lockout/tagout and the work package.
FM Evaluation:	To be provided later.
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is Required:	<p>Yes.</p> <p>Before Further Operation? No</p> <p>By Whom: Facility Manager</p> <p>By When: 07/15/2009</p>
Division or Project:	U233 Material Downblending and Disposition Project
Plant Area:	Building 3019A
System/Building/Equipment:	Diesel Generator 3123
Facility Function:	Special Nuclear Materials Storage
Corrective Action:	
Lessons(s) Learned:	
HQ Keywords:	<p>01M--Inadequate Conduct of Operations - Inadequate Job Planning (Electrical)</p> <p>01O--Inadequate Conduct of Operations - Inadequate Maintenance</p> <p>11G--Other - Subcontractor</p> <p>12C--EH Categories - Electrical Safety</p> <p>14E--Quality Assurance - Work Process Deficiency</p>
HQ Summary:	On June 13, 2009, an energized 120 V power to the load center transformer space heaters was discovered while completing Annual Preventive Maintenance of Diesel Generator 3123. Zero energy checks had previously been completed with no energy found. Workers had taken a

	lunch break and following the break, zero energy was re-verified on the bus voltages. Zero energy was also checked on the areas to be worked. At that time, the energized 120 V power was discovered. Maintenance work was suspended to re-evaluate the lockout/tagout and the work package.			
Similar OR Report Number:				
Facility Manager:	Name	SCHAEFER, SARAH S		
	Phone	(865) 241-1883		
	Title	FACILITY MANAGER		
Originator:	Name	GILPIN, LINDA L		
	Phone	(865) 241-8654		
	Title	NUCLEAR CRITICALITY SAFETY ENGINEER		
HQ OC Notification:	Date	Time	Person Notified	Organization
	NA	NA	NA	NA
Other Notifications:	Date	Time	Person Notified	Organization
	06/15/2009	13:20 (ETZ)	Chelsea Hubbard	DOE
	06/15/2009	13:20 (ETZ)	Jay Mullis	DOE
	06/15/2009	13:20 (ETZ)	Gary Riner	DOE
	06/15/2009	14:45 (ETZ)	OROC	DOE
Authorized Classifier(AC):	L. L. Gilpin Date: 06/15/2009			

2)Report Number:	EM-RL--PHMC-FSS-2009-0004 After 2003 Redesign		
Secretarial Office:	Environmental Management		
Lab/Site/Org:	Hanford Site		
Facility Name:	Facility & Site Services		
Subject/Title:	Electrical Conductor Grounding		
Date/Time Discovered:	06/08/2009 11:20 (PTZ)		
Date/Time Categorized:	06/09/2009 16:25 (PTZ)		
Report Type:	Notification		
Report Dates:	Notification	06/11/2009	20:07 (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:	At approximately 1115 hours on 06/08/2009, team members of the Refrigerated Equipment Services (RES) organization were performing preventive maintenance on a Computer Room Air Conditioning unit (#3) at the 1220 Building in the 3000 Area of the Hanford Site. After performing the routine filter changeout, the craftsman checked the coolant gas lines for temperature. After performing these checks, the craftsman moved his hands away from the coolant gas lines and turned to move away from the equipment. At that time, the craftsman heard a loud "pop" and noticed a section of the insulation on the 208/230v 3-phase system conductor had gone to ground resulting in 120vAC ground fault damaging the conductor insulation and leaving a burn mark on the panel.
Cause Description:	
Operating Conditions:	Normal Operations
Activity Category:	Maintenance
Immediate Action(s):	<ol style="list-style-type: none"> 1. Craftsman immediately shut down both electrical switches on the unit and performed an Absence of Voltage Check. 2. The craftsman notified his immediate RES Supervisor. 3. The craftsman identified the fault wire source went to the Crank Case Heater and placed tape on the wire and then placed an identifying tag on the specific wire to be later identified.
FM Evaluation:	
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is Required:	<p>Yes. Before Further Operation? No By Whom: R. Gonzales By When: 06/30/2009</p>
Division or Project:	Closure Services & Infrastructure
Plant Area:	3000 Area
System/Building/Equipment:	Building 1220 HVAC System
Facility Function:	Balance of Plant - Infrastructure (Other Functions not specifically listed in this Category)

Corrective Action:													
Lessons(s) Learned:													
HQ Keywords:	07D--Electrical Systems - Electrical Wiring 12C--EH Categories - Electrical Safety 14L--Quality Assurance - No QA Deficiency												
HQ Summary:	On June 8, 2009, while team members of the Refrigerated Equipment Services organization were performing preventive maintenance on a Computer Room Air Conditioning unit (#3) at the 1220 Building in the 3000 Area of the Hanford Site, a craftsman heard a loud "pop" and noticed a section of the insulation on the 208/230-volt, 3-phase system conductor had gone to ground resulting in 120-volt AC ground fault damaging the conductor insulation and leaving a burn mark on the panel. The craftsman immediately shut down both electrical switches on the unit and performed an absence of voltage check. The craftsman notified his immediate supervisor. The craftsman then identified the fault wire source and placed tape on the wire and an identifying tag on the specific wire.												
Similar OR Report Number:													
Facility Manager:	<table border="1"> <tr> <td>Name</td> <td>C.W. Stolle</td> </tr> <tr> <td>Phone</td> <td>(509) 376-9080</td> </tr> <tr> <td>Title</td> <td>Manager, Facilities and Land Management</td> </tr> </table>	Name	C.W. Stolle	Phone	(509) 376-9080	Title	Manager, Facilities and Land Management						
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Originator:	<table border="1"> <tr> <td>Name</td> <td>BAKER, SAMUEL G</td> </tr> <tr> <td>Phone</td> <td>(509) 376-3030</td> </tr> <tr> <td>Title</td> <td></td> </tr> </table>	Name	BAKER, SAMUEL G	Phone	(509) 376-3030	Title							
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06/08/2009	15:00 (PTZ)	R. Redekopp	FH/CS&I										
06/08/2009	16:15 (PTZ)	R. Gordon	DOERL										
Authorized Classifier(AC):													

3)Report Number:	EM-RL--PHMC-FSS-2009-0005 After 2003 Redesign
Secretarial Office:	Environmental Management
Lab/Site/Org:	Hanford Site
Facility Name:	Facility & Site Services
Subject/Title:	Failure to Properly Isolate DC Power
Date/Time Discovered:	06/23/2009 15:00 (PTZ)
Date/Time Categorized:	06/24/2009 07:15 (PTZ)
Report Type:	Notification

Report Dates:	Notification	06/24/2009	17:14 (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>During post-review of a completed work package, it was determined that an energy source was not properly isolated prior to conduct of the work. The work package repaired a failed Uninterruptible Power Supply (UPS) in the 3506C building. The UPS has two sources of electrical power: an external AC power source and an internal DC power source. The FHI electricians found the UPS DC power circuit breaker tripped open, however, the batteries could have had residual electrical energy. A facility controlling organization lockout/tagout should have been used to properly isolate the AC and DC power sources prior to entry into the UPS cabinet. AC power was properly isolated, however the DC power was not isolated. Fortunately the UPS batteries were fully discharged and no exposure to hazardous energy actually occurred.</p>		
Cause Description:			
Operating Conditions:	The facility was in operation on main power. A work task was being conducted to repair a failed Uninterruptable Power Supply.		
Activity Category:	Maintenance		
Immediate Action(s):	<ol style="list-style-type: none"> 1. No actions were taken as the failure was not discovered until during the post-review of that work package. 2. A critique is planned 		
FM Evaluation:			
DOE Facility Representative Input:			
DOE Program Manager Input:			
Further Evaluation is Required:	Yes. Before Further Operation? No		

	By Whom: R R Grantham By When:															
Division or Project:	Closuere Sevices and Infrastructure															
Plant Area:	300															
System/Building/Equipment:	3506C/3506C1 UPS															
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) 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 June 23, 2009, during post-review of a completed work package, it was determined that an energy source was not properly isolated prior to conduct of the work. The work package repaired a failed Uninterruptible Power Supply (UPS). The UPS has two sources of electrical power: an external AC power source and an internal DC power source. The electricians found the UPS DC power circuit breaker tripped open; however, the batteries could have had residual electrical energy. A facility controlling organization lockout/tagout should have been used to properly isolate the AC and DC power sources prior to entry into the UPS cabinet. AC power was properly isolated; however, the DC power was not isolated. The UPS batteries were fully discharged and no exposure to hazardous energy actually occurred. A critique is planned.															
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Phone	(509) 376-3030															
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06/24/2009	07:10 (PTZ)	D G Ruscitto	FH													
06/24/2009	09:05 (PTZ)	ONC	FH													

	06/24/2009	09:21 (PTZ)	L D Earley	DOE-RL
Authorized Classifier(AC):				

4)Report Number:	EM-SR--SRNS-SRNL-2009-0002 After 2003 Redesign		
Secretarial Office:	Environmental Management		
Lab/Site/Org:	Savannah River Site		
Facility Name:	Savannah River National Laboratory		
Subject/Title:	Low Voltage Discovery During D&R Activitites		
Date/Time Discovered:	06/09/2009 15:00 (ETZ)		
Date/Time Categorized:	06/10/2009 07:25 (ETZ)		
Report Type:	Notification		
Report Dates:	Notification	06/12/2009	09:25 (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>A Construction electrician cut a wire and noted a small spark while performing D&R activities in the 773-A, F-Wing REEF project. A timeout was initiated and 68 volts were found on two electrical conductors. All affected circuits in room had been previously de-terminated by "cold and dark" isolation in accordance with the electrical isolation plan # GESR-A-00022 and a verification of hazardous energy isolation package SRNL-L8200-2009-00001, R1. Workers had performed routine absence of voltage checks and had not found any voltage prior to the initiation of the D&R work. The voltage is presumed to be from a common neutral or induced voltage. All electrical activities for REEF project have been suspended pending the outcome of the investigation.</p> <p>The SRS Electrical Review Board determined this event to have a severity value of 110.</p>		

Cause Description:	Pending a full investigation, the voltage is presumed to have come from a common neutral. Investigation of the cause is underway.
Operating Conditions:	Normal
Activity Category:	Construction
Immediate Action(s):	Work was stopped and a time out was initiated for all electrical work within F-Wing REEF area until a determination of the source is made and resolution of the incident can be identified. The affected area was barricaded by the Shift Operations Manager. Appropriate construction and facility operations personnel were notified of the incident.
FM Evaluation:	ISM review of potential hazards in affected work area.
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is Required:	Yes. Before Further Operation? No By Whom: Facility Maint. Manager By When:
Division or Project:	SRNL
Plant Area:	A-Area
System/Building/Equipment:	773-A
Facility Function:	Laboratory - Research & Development
Corrective Action:	
Lessons(s) Learned:	
HQ Keywords:	01M--Inadequate Conduct of Operations - Inadequate Job Planning (Electrical) 12C--EH Categories - Electrical Safety 14E--Quality Assurance - Work Process Deficiency
HQ Summary:	On June 9, 2009, an electrician noticed a small spark while performing decommissioning activities. A timeout was initiated and 68 V were found on two electrical conductors. All affected circuits in the room had been previously de-terminated by "cold and dark" isolation and workers had performed routine absence of voltage checks and not found any voltage prior to the initiation of the D&R work. The voltage is presumed to be from a common neutral or induced voltage. All electrical activities for this project have been suspended pending the outcome of the investigation. The SRS Electrical Review Board determined this event had a DOE electrical safety severity value of 110.
Similar OR Report Number:	
Facility Manager:	Name FRANKLIN, KENNETH A

	Title	OPERATION MANAGER		
Originator:	Name	DERMODY, RICHARD J		
	Phone	(803) 725-3113		
	Title	LEAD ADMIN. SPECIALIST-A		
HQ OC Notification:	Date	Time	Person Notified	Organization
	NA	NA	NA	NA
Other Notifications:	Date	Time	Person Notified	Organization
	06/10/2009	07:25 (ETZ)	M. Smith	SRNL
	06/10/2009	07:25 (ETZ)	M. Swain	SRNL
	06/10/2009	07:25 (ETZ)	F. Grimm	SRNL
	06/10/2009	07:25 (ETZ)	N. Dicks	SRNL
	06/10/2009	07:25 (ETZ)	K. Franklin	SRNL
	06/10/2009	08:00 (ETZ)	Fritz Roemer	DOE-FR
	06/10/2009	10:30 (ETZ)	Matt Duncan	DOE-VIS
Authorized Classifier(AC):	Craig Baptiste Date: 06/11/2009			

5)Report Number:	MA-HQ--GOHQ-DOEHQ-2009-0003 After 2003 Redesign		
Secretarial Office:	Office of Management		
Lab/Site/Org:	DOE Headquarters		
Facility Name:	DOE Headquarters		
Subject/Title:	Near Miss - Electrical Incident		
Date/Time Discovered:	06/09/2009 10:00 (ETZ)		
Date/Time Categorized:	06/09/2009 16:00 (ETZ)		
Report Type:	Notification		
Report Dates:	Notification	06/09/2009	17:38 (ETZ)
	Initial Update		
	Latest Update		
	Final		
Significance Category:	3		
Reporting Criteria:	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:	2) Analyze the Hazards
Subcontractor Involved:	Yes IST
Occurrence Description:	On 6/9/09, a contractor working at the Germantown Main Building was shocked when exiting a manhole on an aluminum ladder. The contractor had just finished pulling fiber optic cable in a manhole containing electrical wiring including 480v lines. A ladder had been extended into the manhole to allow the individual to climb out. As the individual stepped on the first or second rung of the ladder and began climbing up the ladder, he received an electrical shock to his hand. The individual continued to ascend the ladder and was taken by coworkers to the local hospital. The individual was treated and released with no physical injuries. All work has been stopped, the manhole has been restricted for further entry, and the cause of the accident is under investigation.
Cause Description:	Under investigation.
Operating Conditions:	Normal
Activity Category:	Construction
Immediate Action(s):	Work was stopped. Manhole was closed. Individual was taken by coworkers to local hospital. Investigation was initiated.
FM Evaluation:	Under investigation.
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is Required:	Yes. Before Further Operation? Yes By Whom: HS & MA By When: 06/19/2009
Division or Project:	HS Contractor
Plant Area:	Outside GTN Main Bld
System/Building/Equipment:	GTN manhole
Facility Function:	Balance-of-Plant - Site/outside utilities
Corrective Action:	
Lessons(s) Learned:	TBD
HQ Keywords:	01M--Inadequate Conduct of Operations - Inadequate Job Planning (Electrical) 08A--OSHA Reportable/Industrial Hygiene - Electrical Shock 08H--OSHA Reportable/Industrial Hygiene - Safety Noncompliance 08J--OSHA Reportable/Industrial Hygiene - Near Miss (Electrical) 11G--Other - Subcontractor 12C--EH Categories - Electrical Safety 13A--Management Concerns - HQ Significant (High-lighted for Management attention)

	14E--Quality Assurance - Work Process Deficiency 14G--Quality Assurance - Procurement Deficiency															
HQ Summary:	On June 9, 2009, while exiting a manhole on an aluminum ladder, a contractor working at the Germantown Main Building received an electrical shock. The contractor had just finished pulling fiber optic cable in a manhole containing electrical wiring including 480-volt lines. The ladder had been extended into the manhole to allow the contractor to climb out. As the contractor stepped on the first or second rung of the ladder, he received an electrical shock to his hand. The individual continued to ascend the ladder and was taken by coworkers to the local hospital where he was treated and released with no physical injuries. All work was stopped, the manhole was restricted for further entry, and the cause of the accident is under investigation.															
Similar OR Report Number:	1. TBD															
Facility Manager:	<table border="1"> <tr> <td>Name</td> <td colspan="3">WILLIAMS, CHERYLYNNE K</td> </tr> <tr> <td>Phone</td> <td colspan="3">(202) 586-1005</td> </tr> <tr> <td>Title</td> <td colspan="3">DIRECTOR, HQ SAFETY, HEALTH, AND SEC</td> </tr> </table>				Name	WILLIAMS, CHERYLYNNE K			Phone	(202) 586-1005			Title	DIRECTOR, HQ SAFETY, HEALTH, AND SEC		
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Originator:	<table border="1"> <tr> <td>Name</td> <td colspan="3">WILLIAMS, CHERYLYNNE K</td> </tr> <tr> <td>Phone</td> <td colspan="3">(202) 586-1005</td> </tr> <tr> <td>Title</td> <td colspan="3">DIRECTOR, HQ SAFETY, HEALTH, AND SEC</td> </tr> </table>				Name	WILLIAMS, CHERYLYNNE K			Phone	(202) 586-1005			Title	DIRECTOR, HQ SAFETY, HEALTH, AND SEC		
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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				
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NA	NA	NA	NA													
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Date	Time	Person Notified	Organization													
06/09/2009	14:00 (ETZ)	B.Costlow	MA													
Authorized Classifier(AC):																
6)Report Number:	NA--LASO-LANL-PHYSTECH-2009-0003 After 2003 Redesign															
Secretarial Office:	National Nuclear Security Administration															
Lab/Site/Org:	Los Alamos National Laboratory															
Facility Name:	Physical and Technical Supt.															
Subject/Title:	Management Concern: Tie Breaker Opened during Preventive Maintenance Resulting in an Unplanned Outage															
Date/Time Discovered:	06/15/2009 14:50 (MTZ)															
Date/Time Categorized:	06/15/2009 17:30 (MTZ)															
Report Type:	Notification/Final															
Report Dates:	<table border="1"> <tr> <td>Notification</td> <td>06/18/2009</td> <td>12:43 (ETZ)</td> </tr> </table>				Notification	06/18/2009	12:43 (ETZ)									
Notification	06/18/2009	12:43 (ETZ)														

	Latest Update	06/18/2009	12:43 (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:	A2B6C04 - Equipment/ material problem; Defective, Failed or Contaminated; End of life failure A4B5C04 - Management Problem; Change Management LTA; Risks / consequences associated with change not adequately reviewed / assessed		
ISM:	2) Analyze the Hazards		
Subcontractor Involved:	No		
Occurrence Description:	<p>MANAGEMENT SYNOPSIS: On June 15, 2009, at 1450, while tripping the main breaker on Switchgear 23 at Technical Area 5 during preventive maintenance (PM) activities, a tie breaker connected to the switchgear opened causing an unplanned power outage. The outage affected Technical Areas 18, 21, 33, 35, 46, 53, 54, and 63. After the Utilities and Infrastructure (U&I) linemen realized the tie breaker opened, they reset the tie and main breakers. Power was restored to the affected areas within two minutes. Subsequent review found a connection to a tie breaker through the protection relay which trips the breaker. This was not an issue during the last three year PM due to there being only one transformer in TA5-23 (TR 1); therefore, all loads were shifted off TR 1 to other circuits not impacted by the trip testing. A second transformer was added to the subject switchgear building in the past two and a half years. The U&I engineering personnel had not reviewed the equipment configuration change for operational and maintenance implications before the start of the current PM activity.</p> <p>BACKGROUND: According to U&I operations management, the breakers on the switchgear are maintained every three years, while the switchgear and all its components including the breakers are maintained every five years in accordance with the applicable National Fire Protection Association (NFPA) standards.</p> <p>As a result of the unplanned outage, the following events in some other technical areas occurred:</p> <p>Event 1</p>		

At approximately 1450, at TA53 outside of Building 6, in the north parking lot, a 6-inch water line from an 8-inch main to a fire hydrant failed when the diesel pump activated and increased pressure to 150 psi in the line. Water and debris (dirt, rocks, and asphalt chunks) were released into the air about 30 feet impacting ten private vehicles parked in the north parking lot. The vehicles sustained damages ranging from broken and/shattered windows to water damage inside the vehicles. The Laboratory's Legal Counsel Business Law Group is assessing the damages to the vehicles. Cost estimates for the vehicle damages are pending. The TA53 operations personnel barricaded the area pending mitigation of the situation. No personnel injuries resulted.

The U&I water crew was notified and responded to the scene. They isolated the water line at 1525. According to U&I engineering personnel, the 6-inch cast iron water line has been in service for over 30 years. Subsequent inspection of the water line found significant corrosion in the area of failure. The thickness of the remaining metal plus mortar lining was less than one-eighth inch at the edges of the break. The area of the corrosion hole was about 2.2 square inches. The booster pump which provided the water for the fire protection system operates 24 hours a day, 7 days a week. The primary electric fire pump will start when the booster pump fails and the distribution system pressure falls to the starting set point for the fire pumps. In this instance and because of the power outage, the electric pump did not start. Instead, the diesel pump, which is the secondary fire pump, started after a 30-second delay and ran for approximately 32 minutes. A Priority 1 work ticket was generated to repair the water line. At 2030, repairs to the line were completed and the fire protection system returned to service.

As a result of the drop in water pressure, several false fire alarms occurred in Buildings 1, 2, 3, and 365 and Sectors E and M, and the WNR Ice House. Fire watches were established in the affected areas until the fire protection system was restored.

The Laboratory's environmental personnel were also notified and responded to the scene. An estimated 24,000 gallons of potable water was released. Water flowed in the parking lot and discharged into a storm drain which flowed into Sandia Canyon. Visual inspection of a potential release site at the bottom of the Sandia Canyon found no impacts. Due to the amount of water released, the New Mexico Environmental Department (NMED) and the Environmental Protection Agency (EPA) were verbally notified of the release pursuant to 20.6.2.1203 of the New Mexico Activity Code of the New Mexico Water Quality Control Commission (NMWQCC) Regulations. The LANL environmental personnel will follow-up with the 7 and 10 day written reports.

	<p>Event 2</p> <p>At TA35, Building 124, prior to the outage, workers were carrying an electrical switch to a work bench. When the power was lost, the workers decided to lower the switch to the floor. One of the workers cut his right hand between the thumb and index finger on an adjacent piece of unistrut. He was taken to the LANL occupational medicine facility for evaluation and treatment. The worker's thumb injury required several stitches. After his evaluation and treatment, the worker was released back to work with no restrictions.</p> <p>Event 3</p> <p>Several other buildings within TA35 experienced power loss. After the power was restored, equipment in these buildings returned to service or was manually reset. At TA46, the facility equipment in the buildings affected by the power loss returned to service. At TAs 18 and 33, there was no identified failure of facility or programmatic equipment.</p>
<p>Cause Description:</p>	<p>According to U&I engineering personnel, the 6-inch cast iron water line has been in service for over 30 years. The diesel pump was designed to operate at high pressure in response to a catastrophic event. Subsequent inspection of the water line found significant corrosion in the area where the failure occurred. As a result of the increased pressure to the water line and primarily due to the significant corrosion, the water line failed releasing water to the environment. According to U&I operations management, the cast iron piping is evaluated and replaced as warranted when maintenance or failure occurs. They have determined it is not feasible to replace the cast iron piping due to the large volumes of piping installed throughout the Laboratory unless it is warranted. The causal factor which best describes this scenario is (A2B6C04) End of Life Failure. Corrective Action 1 addresses this causal factor.</p> <p>After the last three year PM was performed on the TA5-23 switchgear, Transformer 2 was added to the switchgear building. The U&I engineering personnel had not reviewed the equipment configuration change for potential implications to the operation and maintenance of the switchgear. As a result, the potential hazards associated with the equipment configuration change were not reviewed prior to the start of the current breaker maintenance on the switchgear. The causal factor which best describes this scenario is (A4B5C04) Risks/Consequences Associated with Change Not Adequately Reviewed/Assessed. Corrective Action 2 addresses this causal factor.</p>
<p>Operating Conditions:</p>	<p>Preventive Maintenance Activities</p>
<p>Activity Category:</p>	<p>Maintenance</p>

Immediate Action(s):	<p>1. The U&I water crew isolated the water line.</p> <p>2. The U&I operations personnel issued a Priority 1 work ticket to repair the water line. Repairs to the line were completed and the fire protection system returned to service at 2030 on June 15, 2009.</p> <p>3. The LANL environmental personnel verbally notified the NMED and the EPA of the water release. They will follow-up with the 7 and 10 day written reports.</p> <p>4. The Laboratory's Legal Counsel Business Law Group is assessing the damages to the vehicles. Cost estimates for the vehicle damages are pending.</p>			
FM Evaluation:				
DOE Facility Representative Input:				
DOE Program Manager Input:				
Further Evaluation is Required:	No			
Division or Project:	Utilities and Infrastructure Division			
Plant Area:	TA5-23			
System/Building/Equipment:	ETA Switchgear			
Facility Function:	Balance-of-Plant - Site/outside utilities			
Corrective Action 01:	<table border="1"> <tr> <td>Target Completion Date:06/15/2009</td> <td>Actual Completion Date:06/15/2009</td> </tr> </table>		Target Completion Date: 06/15/2009	Actual Completion Date: 06/15/2009
Target Completion Date: 06/15/2009	Actual Completion Date: 06/15/2009			
	<p>Title: Repaired Affected Water Line</p> <p>The Utilities and Infrastructure operations management issued a work ticket for the water crew to repair the affected water line at Technical Area 53. After the water line was repaired, fire protection personnel restored the fire protection system to service.</p> <p>Responsible Organization: UI-DO</p> <p>Deliverable: Documentation showing the affected water line was repaired and the fire protection system returned to service.</p>			
Corrective Action 02:	<table border="1"> <tr> <td>Target Completion Date:08/07/2009</td> <td>Actual Completion Date:</td> </tr> </table>		Target Completion Date: 08/07/2009	Actual Completion Date:
Target Completion Date: 08/07/2009	Actual Completion Date:			
	<p>Title: Review and Modify Switchgear Preventive Maintenance Documents</p> <p>The Utilities and Infrastructure operations management will have Utilities engineering personnel review the 18 month, 3 and 5 year breaker/switchgear preventive maintenance documents prior to</p>			

implementation. The review will ensure any equipment configuration changes have been identified and mitigated prior to the performance of the preventive maintenance. Existing procedures will be modified to reflect the engineering review and to include any changes or recommendations resulting from the review prior to executing the preventive maintenance.

Responsible Organization: UI-DO

Deliverable: Documentation showing the 18 month, 3 and 5 year breaker/switchgear preventive maintenance procedures have been modified to include an engineering review and the incorporation of results from the review prior to implementation.

Lessons(s) Learned:

HQ Keywords:

01B--Inadequate Conduct of Operations - Loss of Configuration Management/Control
01M--Inadequate Conduct of Operations - Inadequate Job Planning (Electrical)
01O--Inadequate Conduct of Operations - Inadequate Maintenance
02D--Environmental - Compliance Notification (from or to regulator without a violation)
02F--Environmental - Potable Water Release
03A--Fire Protection and Explosives Safety - Fire Protection Equip Degradation
05D--Mechanical/Structural - Mechanical Equipment Failure/Damage
05F--Mechanical/Structural - Corrosion/Material Degradation/EOL
07C--Electrical Systems - Power Outage
08D--OSHA Reportable/Industrial Hygiene - Injury
08K--OSHA Reportable/Industrial Hygiene - Near Miss (Other)
12B--EH Categories - Conduct of Operations
13A--Management Concerns - HQ Significant (High-lighted for Management attention)
14D--Quality Assurance - Documents and Records Deficiency
14E--Quality Assurance - Work Process Deficiency

HQ Summary:

On June 15, 2009, a tie breaker connected to electrical switchgear opened causing an unplanned power outage at eight other LANL Technical Areas. After the utilities personnel realized the tie breaker opened, they reset the tie and main breakers. Power was restored to the affected areas within two minutes. Subsequent review found a connection to a tie breaker through the protection relay which trips the breaker. As a result of the unplanned outage, the following two events occurred in other LANL technical areas. The first event involved activation of a diesel fire pump that overpressurized and ruptured a 6-inch main to a hydrant, releasing water and debris into the air about 30 feet impacting ten private vehicles parked in the north parking lot. An estimated 24,000 gallons of potable water was released and reported to the New Mexico Environmental Department and the Environmental Protection Agency. The second event occurred when

TA35 workers were carrying an electrical switch to a work bench and decided to lower it to the floor when the power was lost. One of the workers cut his right hand between the thumb and index finger on a piece of unistrut. The worker's thumb injury required several sutures. The worker was released back to work with no restrictions. Appropriate utility system investigation and external environmental regulatory agency follow-up activities are underway.

Similar OR Report Number:

Facility Manager:	Name	Andrew Erickson
	Phone	(505) 667-4222
	Title	U&I Facility Operations Director

Originator:	Name	YAZZIE, ALVA M
	Phone	(505) 664-0666
	Title	OCCURRENCE INVESTIGATOR

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

Other Notifications:	Date	Time	Person Notified	Organization
	06/15/2009	17:40 (MTZ)	Notification Line	NNSA
	06/16/2009	14:00 (MTZ)	Isaac Valdez	NNSA

Authorized Classifier(AC): Antonia Tallarico Date: 06/18/2009

7)Report Number: [NA--LSO-LLNL-LLNL-2009-0027](#) 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: Non-Energized Electrical Cable Cut Without Proper Energy Isolation

Date/Time Discovered: 06/22/2009 17:15 (PTZ)

Date/Time Categorized: 06/23/2009 16:50 (PTZ)

Report Type: Update

Report Dates:	Notification	06/25/2009	16:59 (ETZ)
	Initial Update	06/29/2009	12:22 (ETZ)
	Latest Update	06/29/2009	12:22 (ETZ)
	Final		

Significance Category: 3

Reporting Criteria: 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:	Yes Contra Costa Electric
Occurrence Description:	<p>On Monday, June 22, 2009, at 1715, it was discovered that a non-energized 220-Volt electrical cable had been cut in Building 581. Proper Lockout/Tagout (LOTO) processes to ensure de-energization were not implemented.</p> <p>It was unclear at initial discovery whether proper LOTO processes had been used, and further inquiries were needed to determine categorization. An investigation has been initiated.</p> <p>An LLNL Electrical Safety Subject Matter Expert (SME) utilized the DOE Electrical Severity Measurement Tool to determine a ranking score for this event. The result was a score of "zero," due to the non-energized state of the cable.</p> <p>Update 6/29/2009: Reporting Criteria 2C(2) was removed from this report. No hazardous energy was present in the cable.</p>
Cause Description:	
Operating Conditions:	Does not apply
Activity Category:	Normal Operations (other than Activities specifically listed in this Category)
Immediate Action(s):	The electrical circuit was locked and tagged out.
FM Evaluation:	<p>The Final Report is due to the ORO by 8/4/2009.</p> <p>The Final Report is due for entry into ORPS by 8/7/2009.</p>
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is Required:	<p>Yes. Before Further Operation? No By Whom: Valerie Roberts By When: 08/07/2009</p>
Division or Project:	NIF
Plant Area:	Site 200
System/Building/Equipment:	Building 581

Facility Function:	Laboratory - Research & Development															
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) 07D--Electrical Systems - Electrical Wiring 08H--OSHA Reportable/Industrial Hygiene - Safety Noncompliance 08J--OSHA Reportable/Industrial Hygiene - Near Miss (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 June 22, 2009, it was discovered that a non-energized 220-Volt electrical cable had been cut in Building 581. The proper Lockout/Tagout (LOTO) processes to ensure it had been de-energized were not implemented. The electrical circuit was then locked and tagged out and an investigation was initiated.															
Similar OR Report Number:	1. NA--LSO-LLNL-LLNL-2009-0019 2. NA--LSO-LLNL-LLNL-2009-0013 3. NA--LSO-LLNL-LLNL-2009-0006 4. NA--LSO-LLNL-LLNL-2008-0032 5. NA--LSO-LLNL-LLNL-2008-0017 6. NA--LSO-LLNL-LLNL-2008-0012 7. NA--LSO-LLNL-LLNL-2008-0011 8. NA--LSO-LLNL-LLNL-2008-0010															
Facility Manager:	<table border="1"> <tr> <td>Name</td> <td colspan="3">Valerie Roberts</td> </tr> <tr> <td>Phone</td> <td colspan="3">(925) 424-3662</td> </tr> <tr> <td>Title</td> <td colspan="3">Acting Dep. Principal Associate Director for Ops</td> </tr> </table>				Name	Valerie Roberts			Phone	(925) 424-3662			Title	Acting Dep. Principal Associate Director for Ops		
Name	Valerie Roberts															
Phone	(925) 424-3662															
Title	Acting Dep. Principal Associate Director for Ops															
Originator:	<table border="1"> <tr> <td>Name</td> <td colspan="3">FREEMAN, JEFFREY W</td> </tr> <tr> <td>Phone</td> <td colspan="3">(925) 424-6787</td> </tr> <tr> <td>Title</td> <td colspan="3">OCCURRENCE REPORTING</td> </tr> </table>				Name	FREEMAN, JEFFREY W			Phone	(925) 424-6787			Title	OCCURRENCE REPORTING		
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Phone	(925) 424-6787															
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NA	NA	NA	NA													
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Date	Time	Person Notified	Organization													
06/23/2009	17:07 (PTZ)	Tracey Simpson	ESH TL													
06/23/2009	17:10 (PTZ)	David Corporandy	NNSA/LSO													

	06/23/2009	17:15 (PTZ)	Glenn Fox	LEDO
Authorized Classifier(AC):				

8)Report Number:	SC--BHSO-BNL-BNL-2009-0014 After 2003 Redesign		
Secretarial Office:	Science		
Lab/Site/Org:	Brookhaven National Laboratory		
Facility Name:	Brookhaven National Laboratory (BOP)		
Subject/Title:	Waste Water Pump Failure		
Date/Time Discovered:	06/23/2009 14:45 (ETZ)		
Date/Time Categorized:	06/25/2009 09:10 (ETZ)		
Report Type:	Notification		
Report Dates:	Notification	06/26/2009	16:36 (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:	<p>At approximately 1445 hrs on 6/23/09 an Experimenter working in lab 1-100 felt a slight tingle when turning off the faucet after washing hands in the sink. The User notified the lab steward of the condition. The lab steward then contacted Control Room staff, which summoned the Electricians, Electrical Engineer, and Safety Officer to investigate. The only electrical device in the immediate area was a wastewater pump, attached to the sink waste line via PVC piping. After discussing the situation with the supervising Electrical Engineer, Electricians attempted to obtain a voltage measurement between the sink and faucet, but were unable to get a reading. A portable Ground Fault Circuit Interrupter was then installed between the electrical outlet and the supply line to the pump. This device tripped immediately when plugged in. The wastewater pump plugs were removed from the line cords, and the unit was red tagged out of service. There were no injuries due to this event.</p>		

Cause Description:							
Operating Conditions:	Normal						
Activity Category:	Research						
Immediate Action(s):	The wastewater pump plugs were removed from the line cords, and the unit was red tagged out of service.						
FM Evaluation:							
DOE Facility Representative Input:							
DOE Program Manager Input:							
Further Evaluation is Required:	Yes. Before Further Operation? No By Whom: R. Chmiel, NSLS By When:						
Division or Project:	NSLS						
Plant Area:	725 NSLS						
System/Building/Equipment:	Lab 1-100 Waste Water Pump						
Facility Function:	Accelerators						
Corrective Action:							
Lessons(s) Learned:							
HQ Keywords:	07D--Electrical Systems - Electrical Wiring 08A--OSHA Reportable/Industrial Hygiene - Electrical Shock 08H--OSHA Reportable/Industrial Hygiene - Safety Noncompliance 12C--EH Categories - Electrical Safety 14E--Quality Assurance - Work Process Deficiency						
HQ Summary:	On June 23, 2009, an experimenter working in a lab felt a slight tingle while turning off the sink faucet after washing hands. The experimenter notified facility staff of the condition. An immediate investigation noted that the only electrical device in the immediate area was a wastewater pump that was attached to the sink waste line by PVC piping. Electricians attempted to obtain a voltage measurement between the sink and faucet, but were unable to get a reading. A portable Ground Fault Circuit Interrupter was then installed between the electrical outlet and the supply line to the pump. This device tripped immediately when plugged in. The wastewater pump plugs were removed from the line cords, and the unit was red tagged out of service. There were no injuries due to this event. Further investigation is underway.						
Similar OR Report Number:							
Facility Manager:	<table border="1"> <tr> <td>Name</td> <td>BUCKLEY, MICHAEL F</td> </tr> <tr> <td>Phone</td> <td>(631) 344-8097</td> </tr> <tr> <td>Title</td> <td>QUALITY REPRESENTATIVE</td> </tr> </table>	Name	BUCKLEY, MICHAEL F	Phone	(631) 344-8097	Title	QUALITY REPRESENTATIVE
Name	BUCKLEY, MICHAEL F						
Phone	(631) 344-8097						
Title	QUALITY REPRESENTATIVE						

Originator:	Name	BENDER, PATRICIA A		
	Phone	(631) 344-3145		
	Title	ES&H COORDINATOR		
HQ OC Notification:	Date	Time	Person Notified	Organization
	NA	NA	NA	NA
Other Notifications:	Date	Time	Person Notified	Organization
	06/23/2009	17:00 (ETZ)	C. C. Kao	BNL
	06/25/2009	09:25 (ETZ)	P. Kelley	BHSO
Authorized Classifier(AC):				

9)Report Number:	SC--PNSO-PNNL-PNNLBOPER-2009-0013 After 2003 Redesign		
Secretarial Office:	Science		
Lab/Site/Org:	Pacific Northwest National Laboratory		
Facility Name:	Energy Research Programs (PNNL)		
Subject/Title:	Electrical Conduit Damage by Subcontractor during Excavation		
Date/Time Discovered:	06/29/2009 10:30 (PTZ)		
Date/Time Categorized:	06/29/2009 12:44 (PTZ)		
Report Type:	Notification		
Report Dates:	Notification	07/01/2009	11:30 (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:	Yes Burner Construction		
Occurrence Description:	On Monday, June 29, 2009, a PNNL subcontractor preparing for a Radiological Portal Monitor (RPM) installation in Eastport, Maine,		

	damaged an electrical conduit while excavating with a backhoe. The conduit contained two conductors (that were on a timer and not energized during the day). There was no personnel injury or equipment damage.		
Cause Description:			
Operating Conditions:	Temp 55 F; dew point 54; humidity 86%; wind speed 5 mph (ESE); precip 0"		
Activity Category:	Research		
Immediate Action(s):	The facility owner was contacted and the affected circuit was locked and tagged out. All excavation activities at the (3) RPM Ferry Crossing sites in Maine have been suspended pending further evaluation. A critique was held June 30, 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:	National Security Directorate		
Plant Area:	Offsite		
System/Building/Equipment:	RPM Site, Eastport, ME		
Facility Function:	Balance of Plant - Infrastructure (Other Functions not specifically listed in this Category)		
Corrective Action:			
Lessons(s) Learned:			
HQ Keywords:	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 14G--Quality Assurance - Procurement Deficiency		
HQ Summary:	On June 29, 2009, a PNNL subcontractor, preparing for a Radiological Portal Monitor installation in Eastport, Maine, damaged an electrical conduit while excavating with a backhoe. The conduit contained two conductors, which were on a timer and not energized during the day. There was no personnel injury or equipment damage. A critique was conducted.		
Similar OR Report Number:	1. SC--PNSO-PNNL-PNNLBOPER-2009-0010		
Facility Manager:	<table border="1"> <tr> <td>Name</td> <td>Hevland, M. E.</td> </tr> </table>	Name	Hevland, M. E.
Name	Hevland, M. E.		

	Title	Deputy Manager, Radiation Portal Monitor Project		
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
	06/29/2009	12:52 (PTZ)	Davies, T. H.	PNSO
Authorized Classifier(AC):	Pollari, R. A. Date: 07/01/2009			

10)Report Number:	SC--SSO-SU-SLAC-2009-0014 After 2003 Redesign		
Secretarial Office:	Science		
Lab/Site/Org:	Stanford Linear Accelerator Center		
Facility Name:	Stanford Linear Accelerator Center		
Subject/Title:	Mild Shock Experienced While a Holding Crane Pendant and Simultaneously Touching Another Object		
Date/Time Discovered:	06/30/2009 13:05 (PTZ)		
Date/Time Categorized:	07/01/2009 13:30 (PTZ)		
Report Type:	Notification		
Report Dates:	Notification	07/01/2009	18:57 (ETZ)
	Initial Update		
	Latest Update		
	Final		
Significance Category:	3		
Reporting Criteria:	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:	An employee was shocked while working in B044 Room 128 (Klystron Test Lab) bake area. He was holding on to the crane control pendant at the same time that he was touching a bake vacuum bake station. When he activated the pendant control he felt the shock in both hands.		

	Employee has been checked and cleared by the Medical Department. He has returned to work.						
Cause Description:							
Operating Conditions:	Does not apply						
Activity Category:	Normal Operations (other than Activities specifically listed in this Category)						
Immediate Action(s):	Area secured, employee taken to Medical Dept. Crane and vacuum bake station were taken out of service.						
FM Evaluation:							
DOE Facility Representative Input:							
DOE Program Manager Input:							
Further Evaluation is Required:	Yes. Before Further Operation? No By Whom: SLAC Accident Committee By When:						
Division or Project:	Engineering and Technical Support (ETS)						
Plant Area:	Bldg. 44 Room 128						
System/Building/Equipment:	Bldg. 44 (Klystron Test Lab)						
Facility Function:	Accelerators						
Corrective Action:							
Lessons(s) Learned:							
HQ Keywords:	08A--OSHA Reportable/Industrial Hygiene - Electrical Shock 12C--EH Categories - Electrical Safety 14L--Quality Assurance - No QA Deficiency						
HQ Summary:	On June 30, 2009, a lab worker received an electrical shock while working in the Klystron Test Lab area. He was holding on to a crane control pendant at the same time that he was touching a bake vacuum bake station. When he activated the pendant control, he felt the electrical shock in both hands. The worker was cleared by the Medical Department and returned to work. The crane and the bake station have been taken out of service.						
Similar OR Report Number:							
Facility Manager:	<table border="1"> <tr> <td>Name</td> <td>LOUGEE, LAWRENCE</td> </tr> <tr> <td>Phone</td> <td>(650) 926-2997</td> </tr> <tr> <td>Title</td> <td>FACILITY MANAGER DESIGNEE</td> </tr> </table>	Name	LOUGEE, LAWRENCE	Phone	(650) 926-2997	Title	FACILITY MANAGER DESIGNEE
Name	LOUGEE, LAWRENCE						
Phone	(650) 926-2997						
Title	FACILITY MANAGER DESIGNEE						
Originator:	<table border="1"> <tr> <td>Name</td> <td>JOHNSON, HOPE E</td> </tr> <tr> <td>Phone</td> <td>(650) 926-4322</td> </tr> <tr> <td>Title</td> <td>FACILITY MANAGER ADMIN.</td> </tr> </table>	Name	JOHNSON, HOPE E	Phone	(650) 926-4322	Title	FACILITY MANAGER ADMIN.
Name	JOHNSON, HOPE E						
Phone	(650) 926-4322						
Title	FACILITY MANAGER ADMIN.						

HQ OC Notification:	Date	Time	Person Notified	Organization
	NA	NA	NA	NA
Other Notifications:	Date	Time	Person Notified	Organization
	06/30/2009	14:00 (PTZ)	Lance Lougee	SLAC
	06/30/2009	14:30 (PTZ)	Paul Golan	SSO DOE
Authorized Classifier(AC):				

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