Summary Report of Occurrences Reviewed
From February 4 – 8, 2008

Summary: 19 occurrences at 14 sites reviewed during this period.

Significant Occurrences (2)

Injuries – 1 occurrence at 1 site

- ***EM – East Tennessee Technology Park (Significance Category 3).*** On January 9, a maintenance mechanic received a puncture wound to the upper groin while performing routine maintenance on a 10-ton forklift. In an attempt to remove the drive axle from the forklift to access the brake shoes, the mechanic struck the drive lugs on the end of the axle with a steel sledge hammer per the instructions in the 24-year old service manual. A shard of metal broke loose from the drive lug and struck the mechanic just below his belt line, entering his body on his right side upper groin area. The mechanic was taken to on-site medical, assessed, and transported to Methodist Medical Center Emergency Room for observation. Surgery was performed later that evening to remove the metal shard. The mechanic continues to recuperate at home until the he can return to work the second week in February. Work on the forklift was temporarily suspended until completion of the incident investigation. Research has identified newer and safer tools and techniques to perform this maintenance task.

Conduct of Operations – 1 occurrence at 1 site

- ***NA – Los Alamos National Laboratory (Significance Category 4).*** On January 28, a machinist apprentice was struck on the left cheek by a round aluminum part that flew off a lathe in a fabrication shop. The machinist had just started the lathe and was preparing to make a face cut on the part. He attempted to hold the 7-inch diameter, 1-inch thick part with the 6-inch, three-jaw chuck of the Hardinge lathe; however, since the part was larger than the chuck, one of the jaws was not fully engaged in the scroll gear of the chuck. When he started the lathe, the aluminum part was thrown off. The machinist notified his supervisor and went to Occupational Medicine where the small cut was cleaned, and bandaged. The machinist was released for work with no restrictions. Machining operations in the shop were suspended. An installed, moveable protective shield was not in place during startup of the lathe because it restricts the machinist from aligning the cutting tool on the cutting surface. This practice is being reviewed.

Other Occurrences (17). See Table (Note: The Table includes the occurrences listed above).

Occurrence Category	Number of Occurrences				Number of Sites
	E&E	NNSA	SC	DOE Total	
Injury - Industrial Hygiene/Occupational Safety	1	1	0	2	2
Near Miss	0	1	0	1	1
Authorization Basis	1	0	1	2	2
Radiological Concerns	3	1	0	4	4
Environmental	0	0	0	0	0
Fire Safety	0	0	0	0	0
Shipping/Quality Assurance	0	1	0	1	1

Criticality Concerns	0	0	0	0	0
Industrial Operations	0	0	0	0	0
Conduct of Operations	2	1	0	3	3
Electrical Safety	0	1	0	1	1
Vehicle Accident	0	0	0	0	0
Equipment Failures	0	1	2	3	3
Safeguards and Security	0	0	0	0	0
Suspect & Counterfeit Parts	1	0	1	2	2
Other	0	0	0	0	0
Total	**8**	**7**	**4**	**19**	

Secretarial Office Summary

National Nuclear Security Administration	7 occurrences	(5 sites)
Office of Environmental Management	8 occurrences	(6 sites)
Office of Science	4 occurrences	(3 sites)