Summary Report of Occurrences Reviewed
From February 15 – 19, 2010

Summary: 26 occurrences at 13 sites reviewed during this period.

Occurrences of Significant Interest (2)

Near Miss – 1 occurrence at 1 site

- ***EM – Idaho Cleanup Project (Significance Category 3).*** On February 16, during construction of Retrieval Enclosure 5 at the Accelerated Retrieval Project, ironworkers were preparing to rig and lift Bay 14 truss subassembly into place, when they heard a pop and the truss slowly collapsed on its side to the south. The truss subassembly, which is approximately 20-feet wide, 150-feet long and weighs 35,000 pounds, was completed earlier in the day and was staged to be hoisted onto its final assembly location. A Manitowoc 4100 crane had swung rigging over the truss as four riggers were waiting in two man lifts on the north side of the truss to attach the rigging when the truss collapsed towards the Manitowoc crane and adjacent Grove 65-ton mobile cranes. The arch truss came to rest on the front of the unoccupied Grove crane. Sixteen workers were in the area but they were generally at or beyond the fall radius of the truss. There were no injuries and property damage was limited to a total loss of the Bay 14 truss subassembly and minor non-structural damage to the Grove crane. The immediate area was secured and the damaged crane was tagged out of service.

Industrial Hygiene Exposure – 1 occurrence at 1 site

- ***NA – Lawrence Livermore National Laboratory (Significance Category 3).*** On February 11, management learned that a journeyman machinist may have machined a legacy beryllium part on a lathe in Building 321A, a non-beryllium work area. While working the part, which was identified as non-hazardous, the machinist noticed a change in its behavior. The machinist mentioned the anomalous behavior to a senior machinist who immediately recognized the behavior as a characteristic of machining beryllium. As a precaution, the areas around the machines used to work the part (a metal saw, a lathe and a granite bench) were isolated and management notifications were started. The ES&H Team Industrial Hygienist expanded the boundaries around the affected areas and performed surface samples, which were positive for beryllium. Nasal swabs were taken from the affected machinist and three others who had been in close proximity when the part was machined. On February 12, results from the nasal swabs for one machinist were positive for beryllium. Results of the swabs for the other three machinists were "non-detect" for beryllium. A fact-finding critique was held.

Other Occurrences (24). See Table (Note: The Table includes the occurrence listed above).

Occurrence Category	Number of Occurrences				Number of Sites
	E&E	NNSA	SC	DOE Total	
Injury - Industrial Hygiene/Occupational Safety	1	3	1	5	4
Near Miss	3	1	0	4	3
Authorization Basis	3	0	1	4	4
Radiological Concerns	1	1	0	2	2
Environmental	0	1	0	1	1
Fire Safety	2	1	1	4	4

Occurrence Category	Number of Occurrences				Number of Sites
	E&E	NNSA	SC	DOE Total	
Shipping/Quality Assurance	0	0	0	0	0
Criticality Concerns	0	0	0	0	0
Industrial Operations	0	0	0	0	0
Conduct of Operations	1	1	0	2	2
Electrical Safety	1	0	0	1	1
Vehicle Accident	0	0	0	0	0
Equipment Failures	2	0	0	2	1
Safeguards and Security	1	0	0	1	1
Suspect & Counterfeit Parts	0	0	0	0	0
Other	0	0	0	0	0
Total	**15**	**8**	**3**	**26**	

ORPS Significance Categories	OE	SC1	SC2	SC3	SC4	R
Totals for the Week:	0	0	0	19	7	0

Secretarial Office Summary

National Nuclear Security Administration	8 occurrences	(4 sites)
Office of Environmental Management	15 occurrences	(6 sites)
Office of Science	3 occurrences	(3 sites)