

Summary Report of Occurrences Reviewed *From March 31 – April 4, 2008*

Summary: 22 occurrences at 12 sites reviewed during this period.

Significant Occurrences 6)

Near Misses – 3 occurrences at 3 sites

- **EM – Oak Ridge National Laboratory (Significance Category 3).** On March 28, during demolition of a Waste Management temporary storage tent facility with a trackhoe equipped with a shear attachment, a piece of the tent structure (an aluminum beam) penetrated the door glass on the left side of the trackhoe cab and grazed the operator's leg. The incident scene was secured and the operator was transported to the East Tennessee Technology Park Health Services where he received first aid and was released.

- **NA – Y12 Nuclear Security Complex (Significance Category 3).** On March 27, after a steel 55-gallon waste drum in Building 9212 was found to be bulging, Operations personnel established administrative control around the drum and notified the shift manager. Industrial Safety and Fire Department personnel responded to the scene. Based on evaluation by Industrial Safety, written guidance was provided to allow safe movement of the drum to the hood to continue processing. The drum was moved without incident; however, when a worker removed the locking ring for the lid, pressure within the drum caused the lid to jump several feet into the air and hit the ceiling of the hood. No personnel were injured and no equipment was damaged. The reason for the pressurization has not been determined.

- **NA – Los Alamos National Laboratory (Significance Category 2).** On March 27, a bridge crane crew was unable to operate the Axis 1 Accelerator Hall Bridge Crane using a cordless controller. Crane electricians investigated the problem and discovered that the radio frequency for the hand-held controller they were using was assigned, and set, to operate the Axis 1 Power Supply Hall Bridge Crane. The investigation also found that the controller would, and did, operate the Power Supply Hall Bridge Crane from the Accelerator Hall through the thick concrete walls. Work using the four bridge cranes at the Dual Axis Radiographic Hydrodynamic Test (DARHT) facility was paused to assess the situation and properly label all cordless controllers. This event is significant because a crane in another location could potentially be commanded to move without anyone's knowledge.

Hazardous Energy Control – 1 occurrence at 1 site

- **EM – Idaho National Laboratory (Significance Category 3).** On March 28, a locking device failed to prevent rotation of a supply fan that was locked out for bearing repair at the FAST facility. A brief electrical power interruption at the Idaho Nuclear Technology & Engineering Center caused the shutdown of an operating supply fan while two exhaust fans continued to run, pulling air through the locked out supply fan. The air flow caused the fan blower to free-wheel/windmill. The stress from the turning blower exceeded the strength of the lockout device causing it to fail. The locking device is commercially available and is a plastic locking device and ¼-inch cable that functions similar to a zip tie or cable tie. A new lockout was installed using a heavier chain and shackle lock to secure the blower. The inlet damper was also secured shut.

Vehicle Accident – 1 occurrence at 1 site

- NA – Y12 Nuclear Security Complex (Significance Category 4). On March 31, a vehicle accident occurred in the north-side parking lot of Building 9219. A 33,000-pound diesel truck rolled into the front of a parked 45-passenger bus. There were no personnel in either vehicle. The truck was parked on a 2.2 degree slope. The truck driver had started the diesel engine to warm it up and left it unattended to go inside Building 9219. The driver did not verify that the parking air brake switch was in the on position but assumed the previous driver had set the air brake. The area of the accident was secured and a driver stand down was initiated.

Occupational Exposure – 1 occurrence at 1 site

- NA – Office of Secure Transportation (Significance Category 2). On April 2, three Federal Agents from Agent Operations Eastern Command were diagnosed and treated for scabies. On April 3, it was reported that an additional eight Federal Agents developed symptoms and have been treated for scabies. All equipment will be isolated for 80 hours minimum, and Agent Operations Eastern Command will be completely closed and unoccupied for 80 hours. Scabies is spread by direct contact with infected individuals and is caused by mites that burrow into the skin and deposit their eggs, which mature in 21 days. Scabies produces an itchy rash that is an allergic response to the mite.

Other Occurrences (16). 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	0	1	1	2	2
Near Miss	1	2	0	3	3
Authorization Basis	1	1	0	2	2
Radiological Concerns	2	0	0	2	2
Environmental	0	0	0	0	0
Fire Safety	1	0	0	1	1
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	3	2	0	5	3
Electrical Safety	0	1	0	1	1
Vehicle Accident	0	1	0	1	1
Equipment Failures	2	0	0	2	1
Safeguards and Security	0	0	0	0	0
Suspect & Counterfeit Parts	1	0	2	3	3
Other	0	0	0	0	0
Total	11	8	3	22	

Secretarial Office Summary

National Nuclear Security Administration	8 occurrences	(4 sites)
Office of Environmental Management	10 occurrences	(5 sites)
Office of Fossil Energy	1 occurrence	(1 site)
Office of Science	3 occurrences	(2 sites)