

## Summary Report of Occurrences Reviewed From June 15 – 19, 2009

**Summary:** 31 occurrences at 17 sites reviewed during this period.

### Significant Occurrences (2)

#### **Conduct of Operations – 2 occurrences at 1 site**

- **NA – Los Alamos National Laboratory (Significance Category 4).** On June 8, two smoke detection fire alarms actuated at Technical Area 53, Building 3, when loose connections caused two cables from a power supply to overheat, melting insulation and fusing wires. Firefighters from the Los Alamos Fire Department immediately responded, but found the TA-53 gate closed because it was after normal business hours. Attempts to enter the facility using the badge reader failed and the override key for the badge reader could not be found. After approximately 10 minutes, firefighters gained access to TA-53 and did not find any evidence of smoke or fire. This event involves several issues including emergency responder access, communication between several LANL functions, and equipment control/management. It was learned that emergency personnel were not added to the authorized users' list for the badge readers after the method of access was changed a month earlier. In addition, miscommunication resulted in the firefighters initially responding to Section F rather than Section S. These issues are being responded to by LANL management.
  
- **NA – Los Alamos National Laboratory (Significance Category 4).** On June 15, during preventive maintenance on electrical switchgear, a tie breaker opened, causing an unplanned power outage at eight LANL Technical Areas. Utilities personnel reset the tie and main breakers, restoring power within two minutes. Subsequent review found a protection relay connection to the tie breaker that tripped the breaker. Investigators also learned that a second transformer had been added to the switchgear a few years ago, which had not been included in any operational or maintenance review. This unknown switchgear configuration resulted in the loss of electrical loads from the second transformer when the tie breaker tripped. The unplanned outage also caused a diesel fire pump to start, which ruptured a corroded 6-inch main to a hydrant, releasing water and debris 30 feet into the air impacting ten private vehicles in a parking lot. An estimated 24,000 gallons of potable water was released. In addition, a TA35 worker cut his right hand between the thumb and index finger on a piece of Unistrut® while lowering an electrical switch to the floor. The injured worker and another worker were carrying the switch to a workbench but decided to set it down because of the power loss. The wound required several sutures. The worker was released back to work with no restrictions. A utility system investigation is underway.

**Other Occurrences (29).** 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	0	3	4	3
Near Miss	2	0	0	2	2
Authorization Basis	2	1	1	4	4
Radiological Concerns	1	1	0	2	2
Environmental	1	0	0	1	1
Fire Safety	0	2	0	2	2
Shipping/Quality Assurance	0	0	0	0	0
Criticality Concerns	0	0	0	0	0

Occurrence Category	Number of Occurrences				Number of Sites
	E&E	NNSA	SC	DOE Total	
Industrial Operations	0	0	0	0	0
Conduct of Operations	3	4	1	8	6
Electrical Safety	2	0	0	2	2
Vehicle Accident	1	0	0	1	1
Equipment Failures	2	1	0	3	3
Safeguards and Security	0	0	0	0	0
Suspect & Counterfeit Parts	1	0	1	2	2
Other	0	0	0	0	0
<b>Total</b>	<b>16</b>	<b>9</b>	<b>6</b>	<b>31</b>	

### Secretarial Office Summary

National Nuclear Security Administration	9 occurrences	(7 sites)
Office of Environmental Management	12 occurrences	(5 sites)
Office of Legacy Management	1 occurrence	(1 site)
Office of Nuclear Energy	3 occurrences	(1 site)
Office of Science	6 occurrences	(3 sites)