Summary Report of Occurrences Reviewed
From September 15 – 19, 2008

Summary: 34 occurrences at 19 sites reviewed during this period.

Significant Occurrences (8)

Near Miss – 4 occurrences at 2 sites

- ***EM – Hanford Site, Richland Operations Office (Significance Category 3).*** On September 10, the boom of an excavator snagged two sections of overhead communication line, which pulled down two utility poles and exposed underground electrical lines causing a circuit breaker to trip. A subcontractor heavy equipment operator was moving the excavator out of a construction zone at the Plutonium Finishing Plant and failed to lower the primary boom to the lowest position for transport. There was no spotter, as required. The nearest worker to any of the poles or communication lines was a security escort, who was more than 20 feet away. Work was immediately stopped and notifications were made.

- ***EM – Hanford Site, Richland Operations Office (Significance Category 3).*** On September 15, 2008, a teamster was preparing to load an empty ERDF container at the ERDF facility. As the teamster began to raise the truck loading rails while backing toward the container, he heard a loud noise. Upon investigation, the teamster and an eye witness discovered that the container tug cable had pulled against the truck D-ring hanger and the tension applied to the tug cable broke the weld of the hanger on which the D-ring was held. This caused the tug cable and D-ring to travel over the truck cab and the hanger into an adjacent area. There were no vehicles or workers nearby, and no injuries or significant damage beyond the failed hanger weld.

- ***EM – Hanford Site, Richland Operations Office (Significance Category 3).*** On September 15, a retrieved waste cask was being lifted by a crane in the 218-W-4C Low Level Burial Grounds when the slings used to rig the cask to the crane broke. The waste cask dropped approximately 4 inches and landed in an upright position. The cask was not damaged. Initial investigation found that the synthetic slings that had been selected were inappropriate for the rigging configuration and no softeners were used to cushion the slings against the sharp flange on the cask. Although no personnel were injured, Radiological Control Technicians conducted surveys and Operators cleared soil from the bottom of the cask while it was suspended before it was moved 30 feet and dropped when the rigging failed.

- ***SC – Pacific Northwest National Laboratory (Significance Category 3).*** On September 11, a subcontractor trackhoe tipped over on its side while in use at the Physical Sciences Facility construction site. The trackhoe operator apparently incorrectly positioned the bucket causing it to tip over onto its side. The trackhoe was equipped with rollover protection and the operator was wearing a seat belt. The operator received a minor cut to his hand from broken glass while exiting the cab and was treated at the onsite first aid station. There were no other injuries.

Injury – 2 occurrences at 2 sites

- ***EM – Idaho National Laboratory (Significance Category 4).*** On September 16, an employee suffered an injury to her right index finger while operating a paper cutter in the Willow Creek Building print shop. While clamping the paper for trimming, the employee's

finger was pinched by the clamp plate and a portion of the nail and skin was separated from the finger. The injured employee was transported to the Eastern Idaho Regional Medical Center along with portions of her finger and fingernail that were stuck to the paper being positioned for cutting. A hand specialist treated the injury and released the employee from the hospital.

- ***SC – Thomas Jefferson National Accelerator Site (Significance Category 3).*** On September 10, a crane operator and a rigger were assembling a shield wall near the Hall C beam dump. This wall was being constructed out of 2,300-pound steel shielding blocks, which were being lifted with a 4-ton boom crane. When a block that was placed on the wall at a height of about 3 feet began to shift, the crane operator instinctively reached to steady it with his left hand and caught his pinky finger between the moving block and another block. After removing his glove and examining his hand, he drove himself to an offsite emergency room. On September 12, the crane operator had surgery and a part of his pinky finger was amputated. Following the surgery, the employee reported the incident to his supervisor.

Industrial Hygiene Exposure – 2 occurrences at 2 sites

- ***SC – Sandia National Laboratories (Significance Category 2).*** On September 17, a Facilities Management and Operations Center millwright craftsperson, who worked at Sandia National Laboratories (SNL) since 1971, died of complications associated with mesothelioma while being hospitalized for pneumonia. SNL Medical first became aware of the craftsperson's condition on September 9, when the craftsperson filed a workers compensation claim. SNL Medical was informed that the sequence of events began when the craftsperson became sick in January 2008 and was diagnosed with pneumonia by their personal physician. In July 2008, the craftsperson was then diagnosed by their personal physician with mesothelioma.

- ***SC – Argonne National Laboratory (Significance Category 3).*** On September 12, a labeled class II laser used in a high resolution ruby fluorescence high pressure measurement system had its beam power level measured and it was found to be in the class IIIB power output range. The laser was supposed to have a nominal output no greater than 1 mW, but the measured output was 18 mW. The system was advertised as containing a class II laser and the received device was labeled as containing a class II laser. As such the device was installed and used in accordance with class II laser safety requirements. This is being reported so owners of these Optiprexx ruby fluorescence pressure measuring instruments are aware that the lasers in systems procured before 2007 may be at a higher class power level than advertised.

Other Occurrences (26). 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	4	6	6
Near Miss	3	0	1	4	2
Authorization Basis	1	1	0	2	2
Radiological Concerns	2	0	0	2	2
Environmental	1	0	1	2	2
Fire Safety	0	1	1	2	2
Shipping/Quality Assurance	2	0	0	2	2

Occurrence Category	Number of Occurrences				Number of Sites
	E&E	NNSA	SC	DOE Total	
Criticality Concerns	2	0	0	2	2
Industrial Operations	0	0	1	1	1
Conduct of Operations	2	0	0	2	1
Electrical Safety	0	1	2	3	3
Vehicle Accident	0	0	0	0	0
Equipment Failures	0	2	0	2	1
Safeguards and Security	0	0	0	0	0
Suspect & Counterfeit Parts	2	2	0	4	4
Other	0	0	0	0	0
Total	**16**	**8**	**10**	**34**	

Secretarial Office Summary

National Nuclear Security Administration	8 occurrences	(4 sites)
Office of Environmental Management	11 occurrences	(7 sites)
Office of Fossil Energy	1 occurrence	(1 site)
Office of Nuclear Energy	4 occurrences	(1 site)
Office of Science	10 occurrences	(6 sites)