ORPS Operating Experience Report

Production GUI - New ORPS

ORPS contains 56475 OR(s) with 59785 occurrences(s) as of 2/18/2014 6:43:26 AM
Query selected 6 OR(s) with 6 occurrences(s) as of 2/18/2014 6:44:13 AM

Download this report in Microsoft Word format.

1)Report Number: EM--PPPO-FBP-PORTSDD-2014-0009 **After 2003 Redesign**

Secretarial Office: Environmental Management

Lab/Site/Org: Portsmouth Gaseous Diffusion Plant

Facility Name: Portsmouth Decontamination and Decommissioning

Subject/Title: Employee Falls on Stairs Receiving Laceration to Leg

Date/Time Discovered: 02/11/2014 11:00 (ETZ)

Date/Time Categorized: 02/13/2014 14:30 (ETZ)

Report Type: Notification

Report Dates:

Notification	02/17/2014	15:04 (ETZ)
Initial Update		
Latest Update		
Final		

Significance Category: 2

Reporting Criteria: 2A(3) - Any single occurrence resulting in an occupational injury that requires in-patient hospitalization for 5 days or more, commencing within 7 days from the date the injury was received.
Note: This criterion is similar to one of the thresholds for initiating a Federal Accident Investigation Board. If such an investigation is begun, the event must be reported under Criterion 10(1), as well as under this criterion if the injury so warrants.

Cause Codes:

ISM: 6) N/A (Not applicable to ISM Core Functions as determined by management review.)

Subcontractor Involved: Yes
Fluor Government Group (FGG)

Occurrence Description: On February 11, 2014, at approximately 1100 hours an employee fell while descending the exterior steps on the west side of the X-152H Trailer. The trailer has 6 steps including a platform. The employee was on the 2nd step coming down from the platform and was holding the hand rail when the fall occurred. The fall was not due to adverse weather conditions (i.e., ice or snow) or lighting. The employee was assessed and treated for a laceration on his left leg by emergency medical personnel, then transported to an off-site medical facility for further evaluation. The employee was later admitted to the hospital.

Pre-existing non-occupational health conditions have impacted the duration of the employees hospital stay and the event became ORPS

	reportable at 1400 hours on February 13, 2014 per event criterion 2A(5)3; an initial prompt notification report was submitted. At 0914 hours on February 17, 2014, the Fluor-B&W Portsmouth LLC (FBP) Plant Shift Superintendent was notified that the employees hospital stay was ongoing and an updated prompt notification report was submitted under ORPS reporting criterion 2A(3)2.
Cause Description:	
Operating Conditions:	Normal Operations
Activity Category:	Normal Operations (other than Activities specifically listed in this Category)
Immediate Action(s):	--911 Emergency Medical Response initiated. --DOE, FBP Management, Occupational Safety & Health and subcontractor employee’s supervision all notified. --Employee assessed by FBP emergency medical personnel. --Employee transported to Adena Pike Hospital for further treatment, evaluation and admitted. --Area boundary established and area was cleaned of biohazards. --Problem Report was initiated. --Initiated the initial ORPS Prompt Notification Report per criterion 2A(5)3 on 2/13/2014 and upgraded the ORPS applicable reporting criterion to 2A(3)2 on 2/17/2014.
FM Evaluation:	
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is Required:	No
Division or Project:	Planning & Sitewide Integration
Plant Area:	G5
System/Building/Equipment:	X-152H Trailer
Facility Function:	Environmental Restoration Operations
Corrective Action:	
Lessons(s) Learned:	
HQ Keywords:	
HQ Summary:	
Similar OR Report Number:	

Facility Manager:

Name	Dennis Carr
Phone	(740) 897-3532
Title	Fluor-B&W/Portsmouth Site Project Director

Originator:

Name	BOOK, JACKIE
Phone	(740) 897-2569
Title	QUALITY PROGRAMS COORDINATOR

HQ OC Notification:

Date	Time	Person Notified	Organization
NA	NA	NA	NA

Other Notifications:

Date	Time	Person Notified	Organization
02/13/2014	15:56 (ETZ)	Dee Powell	DOEPORTS
02/13/2014	16:09 (ETZ)	Dennis Carr	PORTSFBP
02/13/2014	16:09 (ETZ)	Dennis Nixon	PORTSFBP
02/13/2014	16:14 (ETZ)	Bill Murphie	DOEPPPO

Authorized Classifier(AC): Barry Carlson Date: 02/17/2014

---

2)Report Number: NA--LASO-LANL-CMR-2014-0002 **After 2003 Redesign**

Secretarial Office: National Nuclear Security Administration

Lab/Site/Org: Los Alamos National Laboratory

Facility Name: Chemistry & Metallurgy Research

Subject/Title: Management Concern: Level 4 Criticality Infraction Leads to Work Control Concerns

Date/Time Discovered: 02/12/2014 16:03 (MTZ)

Date/Time Categorized: 02/12/2014 17:00 (MTZ)

Report Type: Notification

Report Dates:

Notification	02/14/2014	12:47 (ETZ)
Initial Update		
Latest Update		
Final		

Significance Category: 3

Reporting Criteria: 10(2) - An event, condition, or series of events that does not meet any of the other reporting criteria, but is determined by the Facility Manager or line management to be of safety significance or of concern for that facility or other facilities or activities in the DOE complex.
The significance category assigned to the management concern should be based on an evaluation of the potential risks and impact on safe operations. (1 of 4 criteria - This is a SC 3 occurrence)

Cause Codes:

ISM:

Subcontractor Involved: No

Occurrence Description: MANAGEMENT SYNOPSIS
On February 12, 2014, at 1603, at the Los Alamos National Laboratory (LANL) Chemistry and Metallurgy Research (CMR) facility, a Chemistry Division Inorganic, Isotope and Actinide Chemistry Group (C-IIAC) employee (E-1) identified a potential criticality safety issue in a radiological storage area located in a room in Wing 5. E-1 immediately notified the CMR Operations Center and Room A was posted as restricted access until the status of the radiological material

	stored in the room was verified. Additional notifications were made and a Criticality Safety Subject Matter Expert (CS-SME) arrived on site to evaluate the situation. Following discussion of the situation, the CS-SME determined there was no imminent hazard. Based on this information, the Radiological and Chemistry Operations (RCO) Facility Operations Director (FOD) initially categorized the event as sub-ORPS reportable. A critique was held on February 13, 2014, where additional information was discussed. The CS-SME determined the event resulted in a Criticality Safety Infraction Level 4 due to the room containing a radiological material storage configuration including both solids and solutions, when this was not authorized by the CMR Criticality Safety Limit Authorization (CSLA) document for that location. Additionally, there was discussion regarding the historical movement of the material within CMR and the controls to ensure compliant movement and storage. This resulted in the RCO FOD re-categorizing the event at 1145 to a Management Concern; 10(2c) significance category 3 due to work control concerns. There was no impact to the health and safety of personnel or the environment as a result of this event. BACKGROUND E-1 was evaluating potential storage locations for future receipt of radiological material into CMR when the non-compliance was discovered. E-1 identified that the room had one (1) Type-A container that had eight (8) small vials with material in a solution form (S-container). The other containers in the storage area contained material in solid form. The CSLA for the room stipulates that material stored in the room be in solid or solution form, but cannot be both. The non-compliant storage form led to the Criticality Safety Infraction Level 4, which is defined as “Partial loss of control of a single parameter with two or more parameters providing criticality safety margin.” The CS-SME and RCO FOD determined that the Level 4 Criticality Infraction was not a nuclear criticality safety control violation, nor was it a near miss to such a violation.
Cause Description:	
Operating Conditions:	Normal
Activity Category:	Normal Operations (other than Activities specifically listed in this Category)
Immediate Action(s):	1. Upon notification, the CMR Operations Center restricted access to the affected room in Wing 5. 2. Movement of radioactive material was paused until the extent of condition review is completed. 3. An extent of condition review was initiated. 4. The container with the liquid material will be moved to an approved location in Wing 5.
FM Evaluation:	

DOE Facility Representative Input:

DOE Program Manager Input:

Further Evaluation is Required: Yes.
Before Further Operation? No
By Whom: QPA-PA & CMR Ops
By When: 03/28/2014

Division or Project: RCO Facility Operations

Plant Area: TA3-29 Wing 5

System/Building/Equipment: Radiological Storage in Wing 5

Facility Function: Laboratory - Research & Development

Corrective Action:

Lessons(s) Learned:

HQ Keywords:

HQ Summary:

Similar OR Report Number:

Facility Manager:

Name	Clifford W. Kirkland
Phone	(505) 606-0576
Title	RCO Facility Operations Director

Originator:

Name	TANNER, KIMBERLI K
Phone	(505) 665-8197
Title	OCCURRENCE INVESTIGATOR

HQ OC Notification:

Date	Time	Person Notified	Organization
NA	NA	NA	NA

Other Notifications:

Date	Time	Person Notified	Organization
02/12/2014	17:24 (MTZ)	Randi Allen	NNSA

Authorized Classifier(AC): Kimberli Tanner Date: 02/14/2014

---

3)Report Number: NA--LSO-LLNL-LLNL-2014-0005 **After 2003 Redesign**

Secretarial Office: National Nuclear Security Administration

Lab/Site/Org: Lawrence Livermore National Lab.

Facility Name: Lawrence Livermore Nat. Lab. (BOP)

Subject/Title: Near Miss - Exposure to laser at JASPER

Date/Time Discovered: 02/12/2014 16:30 (PTZ)

Date/Time Categorized: 02/13/2014 10:00 (PTZ)

Report Type: Notification

Report Dates:

Notification	02/14/2014	20:07 (ETZ)
Initial Update		

Latest Update		
Final		

Significance Category: 3

Reporting Criteria: 10(3) - A near miss to an otherwise ORPS reportable event, where something physically happened that was unexpected or unintended, or where no or only one barrier prevented an event from having a reportable consequence.
The significance category assigned to the near miss must be based on an evaluation of the potential risks and extent of personnel exposure to the hazard. (1 of 3 criteria - This is a SC 3 occurrence)

Cause Codes:

ISM:

Subcontractor Involved: No

Occurrence Description: On February 12, 2014, at approximately 1630, during safing and reentry processes following an experiment ("shot"), three workers entered the JASPER secondary confinement chamber, while Class 3b laser light from the Optical Beam Break (OBB) system was on, contrary to the JASPER Laser Safety Operating Procedure/Work Control. None of the workers were exposed to the laser, and no symptoms of laser eye exposure were experienced. The workers were performing a visual assessment and did not introduce any tools that could create a reflected beam. The laser shielding, orientation, and aperture size reduced the risk of exposure. The work was being executed under an LLNL Secondary REOP.

This occurrence report is being tracked in LLNL's Issues Tracking System, reference Assessment No. 37558.

Cause Description:

Operating Conditions: Normal Operations

Activity Category: Normal Operations (other than Activities specifically listed in this Category)

Immediate Action(s): The work supervisor immediately invoked a work pause, personnel exited the secondary confinement chamber, and the laser was turned off. The JASPER facility manager was briefed and placed a "stop work" on all laser operations at the facility until further notice, and an initial fact gathering meeting was conducted. The employees were directed to medical services for precautionary evaluation. A critique was scheduled.

FM Evaluation: Submit the final occurrence report to the ORO by 03/26/2014. Enter the final occurrence report into ORPS by 03/31/2014.

DOE Facility Representative Input:

DOE Program Manager Input:

Further Evaluation is Required: Yes.
Before Further Operation? No

By Whom: James Sloan
By When:

Division or Project: WCI
Plant Area: Nevada Test Site
System/Building/Equipment: JASPER facility at NNSS otical beam break system
Facility Function: Laboratory - Research & Development
Corrective Action:
Lessons(s) Learned:
HQ Keywords:
HQ Summary:
Similar OR Report Number: 1. None

Facility Manager:

Name	Mark Martinez
Phone	(925) 423-7572
Title	WCI Deputy Principal Associate Director for Operat

Originator:

Name	LUDWIG, MARK E.
Phone	(925) 422-6964
Title	OCCURRENCE REPORTING OFFICER

HQ OC Notification:

Date	Time	Person Notified	Organization
NA	NA	NA	NA

Other Notifications:

Date	Time	Person Notified	Organization
02/13/2014	11:24 (PTZ)	Dave Weirup	LEDO
02/13/2014	11:28 (PTZ)	Jim Mecozzi	ES&H TL
02/13/2014	11:31 (PTZ)	Lois Marik	NNSA LFO

Authorized Classifier(AC): James Sloan Date: 02/14/2014

---

4)Report Number: NA--PS-BWP-PANTEX-2014-0009 **After 2003 Redesign**
Secretarial Office: National Nuclear Security Administration
Lab/Site/Org: Pantex Plant
Facility Name: Pantex Plant
Subject/Title: H-Gear Configuration Issue
Date/Time Discovered: 02/11/2014 12:30 (CTZ)
Date/Time Categorized: 02/11/2014 13:00 (CTZ)
Report Type: Notification

Report Dates:

Notification	02/14/2014	15:08 (ETZ)
Initial Update		
Latest Update		
Final		

Significance Category: 2

Reporting Criteria:	10(2) - An event, condition, or series of events that does not meet any of the other reporting criteria, but is determined by the Facility Manager or line management to be of safety significance or of concern for that facility or other facilities or activities in the DOE complex. The significance category assigned to the management concern should be based on an evaluation of the potential risks and impact on safe operations. (1 of 4 criteria - This is a SC 2 occurrence)
Cause Codes:	
ISM:	
Subcontractor Involved:	No
Occurrence Description:	On 2/10/2014 at 0900 hours a Supply Chain Division manager was notified that two improperly configured items were received in a production facility. At 1245 hours it was determined that the event should be reported. At 1300 hours the Pantex Operations Center was notified and a preliminary categorization of 10.2.SC3 was assigned. After a critique on 2/11/2014 it was determined that the categorization should be changed to 10.2.SC2. The Pantex Operations Center was notified at 1100 hours.
Cause Description:	
Operating Conditions:	Facility was operational
Activity Category:	Normal Operations (other than Activities specifically listed in this Category)
Immediate Action(s):	Checked that other itams of the same type available for issue in inventory are correctly configured.
FM Evaluation:	
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is Required:	No
Division or Project:	Supply Chain Management Division
Plant Area:	Zone 12 South MAA
System/Building/Equipment:	Zone 12 South MAA
Facility Function:	Balance of Plant - Infrastructure (Other Functions not specifically listed in this Category)
Corrective Action:	
Lessons(s) Learned:	
HQ Keywords:	
HQ Summary:	
Similar OR Report Number:	
Facility Manager:	

Name	Darlene Saldivar
Phone	(806) 477-4587

Title	Department Manager II

Originator:

Name	OTTO, THOMAS L
Phone	(806) 477-4298
Title	PROJECT SCIENTIST

HQ OC Notification:

Date	Time	Person Notified	Organization
NA	NA	NA	NA

Other Notifications:

Date	Time	Person Notified	Organization
02/11/2014	12:45 (CTZ)	Michael Tryon	B&W Pan.
02/11/2014	13:00 (CTZ)	R. Casteneda-Hernandez	NPO
02/12/2014	11:20 (CTZ)	R. Casteneda-Hernandez	NPO
02/12/2014	11:20 (CTZ)	Bobby Russell	B&W Pan.

Authorized Classifier(AC): Stanley Stambaugh Date: 02/14/2014

---

5)Report Number: NA--YSO-BWXT-Y12NUCLEAR-2014-0002 **After 2003 Redesign**

Secretarial Office: National Nuclear Security Administration

Lab/Site/Org: Y12 National Security Complex

Facility Name: Y12 Nuclear Operations

Subject/Title: Suspect Counterfeit (S/CI) Bolts Discovered on Heat Exchanger

Date/Time Discovered: 02/12/2014 11:45 (ETZ)

Date/Time Categorized: 02/12/2014 12:33 (ETZ)

Report Type: Notification/Final

Report Dates:

Notification	02/17/2014	13:09 (ETZ)
Initial Update	02/17/2014	13:09 (ETZ)
Latest Update	02/17/2014	13:09 (ETZ)
Final	02/17/2014	13:09 (ETZ)

Significance Category: 4

Reporting Criteria: 4C(2) - Discovery of any other suspect or counterfeit item or material (i.e., not found in a Safety Class or Safety Significant Structure, System, or Component) that is found in any application whose failure could result in a loss of safety function, or present a hazard to public or worker health and safety.

Cause Codes:

ISM: 5) Provide Feedback and Continuous Improvement

Subcontractor Involved: No

Occurrence Description: Suspect bolts were identified during Equipment Testing and Inspection (ET&I) certification of equipment in Building 9998. The suspect bolts were on a bracket and do not affect safety of the equipment.
These bolts were used by the equipment manufacturer to mount the two oil/water heat exchangers to the frame of the equipment. Four bolts are

	used to mount each heat exchanger. The age of the bolts is unknown but is estimated to be over 15 years. The equipment was in the final stages of assembly at the manufacturer's facility in late 1999.
Cause Description:	
Operating Conditions:	Normal Operations
Activity Category:	Inspection/Monitoring
Immediate Action(s):	The system was tagged out of service. The Engineering Subject Matter Expert inspected similar equipment in the area. No additional S/CI bolts were discovered.
FM Evaluation:	
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is Required:	No
Division or Project:	Production
Plant Area:	Protected
System/Building/Equipment:	9998
Facility Function:	Uranium Conversion/Processing and Handling
Corrective Action:	
Lessons(s) Learned:	
HQ Keywords:	
HQ Summary:	
Similar OR Report Number:	1. NA--YSO-BWXT-Y12NUCLEAR-2012-0024 2. NA--YSO-BWXT-Y12SITE-2012-0052 3. NA--YSO-BWXT-Y12SITE-2013-0012 4. NA--YSO-BWXT-Y12SITE-2013-0019

Facility Manager:

Name	S. R. Baker
Phone	(865) 574-2476
Title	Manager, Depleted Uranium Production

Originator:

Name	BRYNESTAD, ASTRID
Phone	(865) 574-1566
Title	OCCURRENCE REPORTING ADMINISTRATOR

HQ OC Notification:

Date	Time	Person Notified	Organization
NA	NA	NA	NA

Other Notifications:

Date	Time	Person Notified	Organization
02/12/2014	12:33 (ETZ)	W.C. Tindal	Product.
02/12/2014	12:45 (ETZ)	S.A. Watkins	NPO
02/12/2014	12:50 (ETZ)	G.A. Smith	Engr.

02/12/2014	13:03 (ETZ)	Duty Fac Rep	NPO

Authorized Classifier(AC): M.D. Trundle Date: 02/17/2014

---

6)Report Number: SC--BSO-LBL-OPERATIONS-2014-0003 **After 2003 Redesign**
Secretarial Office: Science
Lab/Site/Org: Lawrence Berkeley National Laboratory
Facility Name: Operations Division
Subject/Title: Sanitary Sewerage Overflow Entered Storm drain
Date/Time Discovered: 02/12/2014 09:45 (PTZ)
Date/Time Categorized: 02/12/2014 12:45 (PTZ)
Report Type: Notification/Final
Report Dates:

Notification	02/14/2014	12:06 (ETZ)
Initial Update	02/14/2014	12:06 (ETZ)
Latest Update	02/14/2014	12:06 (ETZ)
Final	02/14/2014	12:06 (ETZ)

Significance Category: 4
Reporting Criteria: 5A(2) - Any release (onsite or offsite) of a pollutant from a DOE facility that is above levels or limits specified by outside agencies in a permit, license, or equivalent authorization, when reporting is required in a format other than routine periodic reports.
[Note: See Group 1, Criterion 1, for situations under which releases of pollutants into the environment exceeding permit limits would be reported under “Operational Emergencies.”]

Cause Codes:
ISM: 5) Provide Feedback and Continuous Improvement
Subcontractor Involved: No
Occurrence Description: On 02/12/2014 at around 0945 hours, Facilities' Work Request Center received notification of sewer back up and spill from a sanitary sewer manhole(SSMH) south of Building 61. Approximately 50 gallons of untreated sewage overflowed onto Lawrence Road and about 30 gallons of which entered a storm drain. This amount was estimated by examination of the wet surface area on the street. Upon being informed of the overflow, the LBNL Environmental Services Group (ESG) leader immediately made the required report to the California Office of Emergency Services (OES).

Cause Description:
Operating Conditions: Outdoors, foggy, dry, daytime
Activity Category: Normal Operations (other than Activities specifically listed in this Category)
Immediate Action(s): - Dechlorination tablets were placed in the path of the discharge and dechlorinated potable water was used to wash and clean the affected area.

	- LBNL Environmental Services Group (ESG) leader immediately reported the incident to the California Office of Emergency Services and notified University of California, Berkeley.
FM Evaluation:	- The line was hydro cleaned and video inspected in 2012. - The line was cleared and regained its normal flow by 1015 hours on 2/12/2014. No sewage was recovered from the storm drain. - City of Berkeley was notified of the sewage overflow by the California OES. - The overflow was caused by paper towels and candy bar wrappers that clogged the sewer. - In the afternoon of 2/12, LBNL ESG staff performed a visual inspection of the Chicken Creek located below the Lab site and saw no impact from the overflow. The Creek flows into the South Fork of Strawberry Creek located on UC Berkeley campus. - ESG staff collected samples from the Chicken Creek and the South Fork of Strawberry to further access impacts; City of Berkeley also suggested sampling.
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is Required:	No
Division or Project:	Facilities Division
Plant Area:	Lawrence Road
System/Building/Equipment:	Lawrence Road Sanitary Sewer Manhole
Facility Function:	Balance of Plant - Infrastructure (Other Functions not specifically listed in this Category)
Corrective Action:	
Lessons(s) Learned:	
HQ Keywords:	
HQ Summary:	
Similar OR Report Number:	

Facility Manager:

Name	David A. Leary
Phone	(510) 486-6339
Title	Acting Division Director

Originator:

Name	MOU, FLORENCE P.
Phone	(510) 486-7872
Title	SENIOR ADMINISTRATOR

HQ OC Notification:

Date	Time	Person Notified	Organization
NA	NA	NA	NA

Other Notifications:

Date	Time	Person Notified	Organization
02/12/2014	14:34 (PTZ)	Mary Gross	BSO

02/12/2014	14:34 (PTZ)	Kevin Hartnett	BSO

Authorized Classifier(AC):

| ORPS HOME | Data Entry | FM Functions | Search & Reports | Authorities | Help | Security/Privacy Notice |

Please send comments or questions to orpssupport@hq.doe.gov or call the Helpline at (800) 473-4375. Hours: 7:30 a.m. - 5:00 p.m., Mon - Fri (ETZ). Please include detailed information when reporting problems.