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1)Report Number: EM--PPPO-BWCS-PORTDUCON-2013-0006 **After 2003 Redesign**
Secretarial Office: Environmental Management
Lab/Site/Org: Portsmouth Gaseous Diffusion Plant
Facility Name: Portsmouth Duf6 Conversion Plant
Subject/Title: A Potentially Inadequate Safety Analysis (PISA) has been identified for the Piketon Conversion Facility
Date/Time Discovered: 04/03/2013 16:00 (ETZ)
Date/Time Categorized: 04/03/2013 18:00 (ETZ)
Report Type: Notification
Report Dates:

Notification	04/05/2013	15:28 (ETZ)
Initial Update		
Latest Update		
Final		

Significance Category: 3
Reporting Criteria: 3B(2) - Declaration of a potential inadequacy of the documented safety analysis (a potential positive USQ), per 10 CFR Section 830.203(g). [Note: When a potential inadequacy of a documented safety analysis is found, it would be initially reported under Criterion 3B(2). If further analysis results in a positive USQ determination, then the occurrence report should be updated to recategorize it under Criterion 3B(1). If the analysis results in a negative USQ determination, the occurrence report should be updated to recategorize it under Criterion 3B(3).]

Cause Codes:
ISM:
Subcontractor Involved: No
Occurrence Description: On April 3, 2013, at the Piketon, OH Conversion Facility, four vendor supplied cylinders identified as new and empty were staged for cylinder modification (CMS). Due to the supplier identified status as new and empty, controls were not implemented for radiological and cylinder atmospheric concerns. After successfully processing one of the cylinders, work commenced on a second cylinder. At 16:00 EDT, after welding a collar on the cylinder, the work crew began to cut a hole in the second cylinder. When the 360 degree hole was nearly completed, a release of white smoke occurred indicating the presence of an undocumented amount of UF6. The area was immediately evacuated. Personnel in the immediate area were seen by an occupational medicine provider as a precautionary measure.

Wearing appropriate personnel protective equipment, entries were made into the area. Contamination was found near the location of the cut in the form of white powder and a PAC-III Hydrofluoric (HF) acid monitoring device also indicated levels of HF near where the cutting took place. Air sampling and radiological contamination swipes were taken and the team left the area. There was no indication of contamination outside of the CMS welding area. The area was posted in accordance with radiological control requirements, the scene was secured, and CMS activities were halted.

The contents of the cylinder are unknown at this time but thought to be UF6. The samples taken are being analyzed. The supplier was contacted and the history of the cylinder is being reviewed. The cylinder involved in the incident and the remaining cylinders from this supplier have been tagged as potentially deficient cylinders and remain on hold. There were no injuries as a result of this incident.

The event is under investigation. Given the unknown enrichment and mass of material contained in the cylinder, a potential inadequacy in the safety analysis for this circumstance has been identified. As a result of this incident, Cylinder modification activities have been halted at both the Piketon and Paducah Conversion facilities.

Cause Description:

Operating Conditions: Normal

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

Immediate Action(s): The samples taken are being processed for analysis. The vendor (Fluor-B&W Portsmouth,LLC [FBP]) was contacted and the history of the cylinder is being reviewed. The cylinder involved in the incident and the remaining FBP cylinders have been tagged as potentially deficient cylinders and remain on hold.

FM Evaluation: The event is under investigation and has revealed a potential inadequacy in the safety analysis for the Piketon Conversion Facility. As a result of this incident, cylinder modification activities have been halted at both the Piketon and Paducah Conversion facilities.

DOE Facility Representative Input:

DOE Program Manager Input:

Further Evaluation is Required: Yes.
Before Further Operation? Yes
By Whom: Plant Manager
By When: 04/12/2013

Division or Project: B&W Conversion Services

Plant Area: Grid Map Location F2

System/Building/Equipment: Cylinder Modification System

Facility Function: Uranium Conversion/Processing and Handling
Corrective Action:
Lessons(s) Learned:
HQ Keywords:
HQ Summary:
Similar OR Report Number: 1. EM--PPPO-BWCS-PORTDUCON-2013-0002

Facility Manager:

Name	Ken Collier
Phone	(740) 289-5441
Title	Plant Manager

Originator:

Name	BLACKMON, JOSIE Y
Phone	(740) 289-5439
Title	COMPLIANCE OFFICER

HQ OC Notification:

Date	Time	Person Notified	Organization
NA	NA	NA	NA

Other Notifications:

Date	Time	Person Notified	Organization
04/03/2013	19:05 (ETZ)	Kent Fortenberry	BWCS
04/03/2013	19:05 (ETZ)	Michelle Reichert	BWCS
04/03/2013	19:05 (ETZ)	Joe Roberts	BWCS
04/03/2013	19:05 (ETZ)	Ken Collier	BWCS
04/03/2013	19:26 (ETZ)	John Saluke	DOE PPPO
04/03/2013	19:29 (ETZ)	Jack Zimmerman	DOE PPPO

Authorized Classifier(AC): Beth Keener Date: 04/05/2013

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2)Report Number: EM--PPPO-FBP-PORTSDD-2013-0012 **After 2003 Redesign**
Secretarial Office: Environmental Management
Lab/Site/Org: Portsmouth Gaseous Diffusion Plant
Facility Name: Portsmouth Decontamination and Decommissioning
Subject/Title: 480 VAC Electrical Junction Box Cover Removed Without Lockout/Tagout Protection
Date/Time Discovered: 04/05/2013 07:45 (ETZ)
Date/Time Categorized: 04/05/2013 10:55 (ETZ)
Report Type: Notification/Final
Report Dates:

Notification	04/05/2013	15:18 (ETZ)
Initial Update	04/05/2013	15:18 (ETZ)
Latest Update	04/05/2013	15:18 (ETZ)
Final	04/05/2013	15:18 (ETZ)

Significance Category: 4
Reporting Criteria: 2E(3) - Any failure to follow a prescribed hazardous energy control

process (e.g., lockout/tagout, hazardous energy control program).

Cause Codes:

ISM: 2) Analyze the Hazards
3) Develop and Implement Hazard Controls
4) Perform Work Within Controls

Subcontractor Involved: No

Occurrence Description: FBP Cut and Cap Shift Manager was informed of an alleged unsafe act performed by an employee, where the employee was said to have removed the cover from a 480 VAC electrical junction box without a Lockout/Tagout (LOTO) being issued for personnel protection. After an investigation into the allegation, and a review of the circumstances surrounding the alleged incident, affected management believes that the incident occurred, as described, without LOTO protection.

Cause Description:

Operating Conditions: Normal Operations

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

Immediate Action(s): - Operations secured the area for investigation
- X-326 Operations Manager had electrical supply secured and tagged out.
- Investigation initiated. Investigation to include personnel from Industrial Safety Group, Security Group, Industrial Relations Group, and Operations Management.

FM Evaluation: Investigation/Evaluation will be concluded by facility management.

DOE Facility Representative Input:

DOE Program Manager Input:

Further Evaluation is Required: No

Division or Project: Facility Stabilization and Deactivation

Plant Area: Grid Map: G-4

System/Building/Equipment: X-326, Cut & Cap Project

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	CRABTREE, RONALD P

Phone	(740) 897-3025
Title	PLANT SHIFT SUPERINTENDENT

HQ OC Notification:

Date	Time	Person Notified	Organization
NA	NA	NA	NA

Other Notifications:

Date	Time	Person Notified	Organization
04/05/2013	10:55 (ETZ)	Ken Whittle	PORTSFBP
04/05/2013	11:08 (ETZ)	Dennis Carr	PORTSFBP
04/05/2013	11:11 (ETZ)	Joel Bradburne	DOEPORTS

Authorized Classifier(AC): Teresa Mollette Date: 04/05/2013

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3)Report Number: EM-RP--WRPS-TANKFARM-2013-0005 **After 2003 Redesign**
Secretarial Office: Environmental Management
Lab/Site/Org: Hanford Site
Facility Name: Tank Farms
Subject/Title: Potentiometers Used for Thermocouple Temperature Readings not Calibrated per Quality Assurance Program Description
Date/Time Discovered: 04/04/2013 15:37 (PTZ)
Date/Time Categorized: 04/04/2013 15:37 (PTZ)
Report Type: Notification
Report Dates:

Notification	04/05/2013	14:17 (ETZ)
Initial Update		
Latest Update		
Final		

Significance Category: 3
Reporting Criteria: 3A(3) - Any violation or noncompliance of a credited hazard control specified in a Hazard Category 1, 2, or 3 nuclear facility's DOE approved Documented Safety Analysis [issued pursuant to 10 CFR Section 830.204, Documented Safety Analysis, and including Basis for Interim Operation (BIO), etc.], or DOE issued Safety Evaluation Report that are not addressed by Criteria 3A(1) and 3A(2).
Exceptions:
a) An event consisting solely of a violation of a safety management program (e.g., quality assurance, personnel training) cited in the Documented Safety Analysis.
b) An event consisting solely of a surveillance test (to include any periodic activity explicitly captured in the DSA that is used to ensure operability or viability of a structure, system, or component) performed after the prescribed surveillance period, and in which the structure, system, or component was found to be capable of performing its specified safety function. (See separate criterion for late surveillance tests below.)

Cause Codes:	
ISM:	4) Perform Work Within Controls
Subcontractor Involved:	No
Occurrence Description:	During a routine engineering process review, it was discovered that thermocouple temperature readings associated with liquid waste transfer activities that took place on November 13, 2012, may have been taken with calibrated instrumentation not meeting the requirements of the "Control of Measuring and Testing Equipment" section of the Quality Assurance Program Description (TFC-PLN-02, Section 2.12). Technical inquisitiveness of the engineer further identified that potentiometers used to take thermocouple readings on these systems were in fact not calibrated in accordance with TFC-PLN-02. The Justification for Continued Operation (JCO) required that the waste transfer be performed using measuring and testing equipment (M&TE) calibrated temperature measurement instrumentation. This issue, which was identified in Problem Evaluation Request WRPS-PER-2013-0532, is the failure to meet the compensatory measure requirement of the JCO safety basis, which is equivalent to the Tank Farms Documented Safety Analysis. The observation identified that there was no failure to comply with a Specific Administrative Control (SAC) requirement. Additionally, because M&TE is not designated safety significant, there was no failure to have verified the important attributes of a Design Feature when the Design Feature is first required to be applicable, and no failure to perform a Design Feature in-service inspection or test within the required time limit established by the SAC. Evaluations have indicated that at no time were waste transfer system temperatures outside of the safe operating envelope.
Cause Description:	
Operating Conditions:	Does not apply.
Activity Category:	Inspection/Monitoring
Immediate Action(s):	Transfers between April 1 and September 30, 2012, did not require temperature monitoring where these potentiometers may be used; therefore, no immediate actions required. Transfer between October 1, 2012, and March 31, 2013, will require the use of measuring and testing equipment (M&TE) calibrated potentiometer and Safety Significant thermocouple to perform transfer.
FM Evaluation:	
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is Required:	Yes. Before Further Operation? No By Whom: Ringo, Steven D By When:
Division or Project:	Washington River Protection Solutions LLC (WRPS)
Plant Area:	200 East

System/Building/Equipment: Waste/Waste Transfer Piping/Thermocouple
Facility Function: Nuclear Waste Operations/Disposal
Corrective Action:
Lessons(s) Learned:
HQ Keywords:
HQ Summary:
Similar OR Report Number:
Facility Manager:

Name	Ringo, Steven D
Phone	(509) 373-2212
Title	Manager, Waste Transfer

Originator:

Name	WATERS, SHAUN F
Phone	(509) 373-3457
Title	OPERATIONS SPECIALIST

HQ OC Notification:

Date	Time	Person Notified	Organization
NA	NA	NA	NA

Other Notifications:

Date	Time	Person Notified	Organization
04/04/2013	15:37 (PTZ)	Ringo, S. D.	WRPS
04/04/2013	15:48 (PTZ)	Stickney, B. J.	DOE-ORP
04/04/2013	15:55 (PTZ)	Boyce, M. L.	MSA-EOC

Authorized Classifier(AC):

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4)Report Number: SC--BHSO-BNL-AGS-2013-0001 **After 2003 Redesign**
Secretarial Office: Science
Lab/Site/Org: Brookhaven National Laboratory
Facility Name: Alternating Gradient Synchrotron
Subject/Title: Failure to Follow a Prescribed Hazardous Electrical Energy Control Process
Date/Time Discovered: 04/03/2013 11:15 (ETZ)
Date/Time Categorized: 04/03/2013 13:55 (ETZ)
Report Type: Notification
Report Dates:

Notification	04/05/2013	09:37 (ETZ)
Initial Update		
Latest Update		
Final		

Significance Category: 3
Reporting Criteria: 2E(3) - Any failure to follow a prescribed hazardous energy control process (e.g., lockout/tagout, hazardous energy control program).

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:	On April, 3, 2013, at Brookhaven National Laboratory (BNL) a worker was assigned the job of replacing a feedback transformer in an RF power amplifier located within the Alternating Gradient Synchrotron (AGS) ring. At about 11:15 AM, after replacement of the transformer had commenced, the worker's supervisor discovered that the correct breakers had been opened in Building 929 to de-energize the RF power amplifier and do the work, but the opened breakers were not locked out and tagged out as required by procedure. There was no injury and no contact with any hazardous energy.
Cause Description:	
Operating Conditions:	Normal Shutdown Condition
Activity Category:	Maintenance
Immediate Action(s):	To ensure safety, the supervisor immediately opened and locked out an upstream breaker in Building 929, and then went to the AGS Ring. Work to replace the transformer was halted by the supervisor. The Collider Accelerator Department (C-AD) management initiated an investigation.
FM Evaluation:	This condition was initially declared a Significance Category 4 occurrence. At 1430, after further consideration, C-AD management elected to raise the categorization of this condition to a SC-3 Management Concern.
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is Required:	Yes. Before Further Operation? No By Whom: By When:
Division or Project:	Collider Accelerator Department
Plant Area:	AGS Ring
System/Building/Equipment:	Building 929
Facility Function:	Accelerators
Corrective Action:	
Lessons(s) Learned:	
HQ Keywords:	

HQ Summary:

Similar OR Report Number:

Facility Manager:

Name	LESSARD, EDWARD T
Phone	(631) 344-4250
Title	C-AD ASSOCIATE CHAIR FOR ESSH&Q

Originator:

Name	SIERRA, EDWARD A
Phone	(631) 344-4080
Title	ORPS COORDINATOR

HQ OC Notification:

Date	Time	Person Notified	Organization
NA	NA	NA	NA

Other Notifications:

Date	Time	Person Notified	Organization
04/03/2013	11:50 (ETZ)	R. Karol	BNL
04/03/2013	13:45 (ETZ)	L. Stiegler	BNL
04/03/2013	14:45 (ETZ)	A. Janczewski	BHSO/DOE

Authorized Classifier(AC):

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5)Report Number: SC--FSO-FNAL-FERMILAB-2013-0002 **After 2003 Redesign**

Secretarial Office: Science

Lab/Site/Org: FERMI National Accelerator Laboratory

Facility Name: FERMI National Accelerator Lab.(BOP)

Subject/Title: Helium over pressurization causes bursting of plastic bladder inside gas storage trailer

Date/Time Discovered: 04/03/2013 15:30 (CTZ)

Date/Time Categorized: 04/04/2013 14:23 (CTZ)

Report Type: Notification

Report Dates:

Notification	04/05/2013	15:30 (ETZ)
Initial Update		
Latest Update		
Final		

Significance Category: 3

Reporting Criteria: 2F(2) - Any unexpected discovery of an uncontrolled hazardous energy source (e.g., powered mechanical hazards, steam, pressurized gas). This criterion does not include discoveries made by zero-energy checks and other precautionary investigations made before work is authorized to begin.

Cause Codes:

ISM:

Subcontractor Involved: No

Occurrence Description:	On Wednesday April 3, 2013, a temporary helium recovery unit stationed outside Building IB3A was subjected to an over-pressurization condition that resulted in its failure and associated damage to an enclosed rented trailer. The trailer is lined with foam panels for insulation and mechanical protection and contains a large bag (i.e., a bladder) that collects the helium gas vented from the cryostats inside the IB3A building. The gas is then compressed and pumped into a gas storage trailer for later purification and reuse. As is typical of a commercial trailer, access is by a double door at the back. In order to maintain the integrity of the rented trailer, a framed wall with appropriate penetrations was constructed that filled the aperture of one of the doors (which was held folded back around the side of the trailer). Due to an operational anomaly on the afternoon of April 3, 2013, the two sides of the trailer were bulged out several inches, as was the roof, due to the over-pressurization. The back wall was moved out of position, though still attached to the trailer. Some foam panels from inside the trailer were driven outside to the ground. The bag (bladder) was empty, upon discovery, and later found to have been split open at the end nearest the back of the trailer. No personnel were injured as a result of this incident.
Cause Description:	
Operating Conditions:	Normal
Activity Category:	Normal Operations (other than Activities specifically listed in this Category)
Immediate Action(s):	The Deputy Division Head and Division Senior Safety Officer arrived at the scene immediately after being notified by the Test Cryostat Operator. The area was secured and the Technical Division began an investigation into the event.
FM Evaluation:	The COO issued a shutdown directive for the IB3A Helium Recovery Unit which required the incident scene to be secured and the control of the scene given to the ESH&Q Section. Furthermore, the COO requested a three stage approach emphasizing incident data collection, thorough investigation and line management review and response.
DOE Facility Representative Input:	
DOE Program Manager Input:	
Further Evaluation is Required:	Yes. Before Further Operation? Yes By Whom: Investigation Committee By When: 04/30/2013
Division or Project:	Technical Division/IB3A Temp. Helium Recovery Unit
Plant Area:	IB3A
System/Building/Equipment:	Helium Recovery Unit/IB3A/Gas Storage Trailer
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	Jack Anderson
Phone	(630) 840-3930
Title	Chief Operating Officer

Originator:

Name	BAIRD, DAVID I.
Phone	(630) 840-3945
Title	ESH SPECIALIST

HQ OC Notification:

Date	Time	Person Notified	Organization
04/04/2013	11:15 (CTZ)	John Scott	DOE-FSO

Other Notifications:

Date	Time	Person Notified	Organization
04/04/2013	11:15 (CTZ)	Nancy Grossman	FNAL ESH
04/04/2013	11:15 (CTZ)	Martha Michels	FNAL ESH
04/04/2013	11:30 (CTZ)	Jack Anderson	FNAL COO

Authorized Classifier(AC):

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