



Safety Performance for 2nd Quarter 2012

Strategic Safety Goals: Events DOE Strives to Avoid



	2007	2008	2009	2010	2011	2012 (Yr to Date)
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Fatalities

Total	2	4	1	3	1	1
(Vehicle)	1	3	1	0	0	1

Radiological exposures > 2 rem

Total	1	1	0	1	1*	0
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Radiological releases above regulatory limits

Total	1	0	0	0	0	0
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Chemical/hazardous material releases above regulatory limits

Total	2	3	2	0	2	0
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Infrastructure Losses > \$5 million

Total	0	0	0	0	1	0
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- In 2012, to date, there has been a single fatality involving a motor vehicle accident outside the boundary of the Waste Isolation Pilot Plant (WIPP) when a dump trailer and a General Services Administration (GSA) pickup driven by a WIPP employee collided.
- Two occurrences have been added to the 2011 calendar year total for chemical and hazardous material releases above regulatory limits. The first occurrence took place at the Idaho Cleanup Project when a sodium processing pipe burst releasing asbestos in quantities above the regulatory limits. The second occurrence took place at the Rocky Mountain Oilfield Testing Center (RMOTC) when a barrel containing copper sulfate was ruptured by a backhoe releasing the copper sulfate.
- One occurrence involving radiological exposures remains pending for 2011. If the radiological exposure is determined to be above 2 rem, the count of radiological exposures for 2011 will increase to two.



Reference Material





Strategic Safety Goals: Fatalities Backup Information



Fatalities

2007	ORPS Number	Report Title	EH Category	Discovery Date
NA	NA--SS-SNL-CASITE-2007-0002	Travel Fatality	12Q Vehicle Accident	03/27/2007
<p>On March 27, 2007, at approximately 0723, a vehicular fatality occurred involving a Sandia National Laboratory (SNL) employee operating a motorcycle and a semi-truck. There were no other injuries associated with the accident. California Highway Patrol "CHP" Hayward Personnel performed accident investigation.</p>				
EM	EM-SR-- WSIS-SECFOR-2007-0001	SRS Security Police Officer Fatality	12H Injuries Offsite Trtmnt	06/11/2007
<p>On June 11, 2011, while on duty, a Security Police Officer had just completed conducting a physical training session (running on the treadmill) when he collapsed and never regained consciousness. Two Security Police Officers in the same location immediately started conducting CPR while awaiting the arrival of the SRS ambulance. The individual was transported by ambulance to University Hospital in Augusta, Georgia.</p> <p>The Facility Manager concurs with the Improvement Opportunities identified in the WSI-SRS Special Investigation Report.</p>				



Strategic Safety Goals: Fatalities Backup Information



Fatalities (continued)

2008	ORPS Number	Report Title	EH Category	Discovery Date
SC	SC-ORO -- ORNL-X10BOPLANT-2008-0001	Employee Fatality in Single-Vehicle Accident	12Q Vehicle Accident	01/22/2008
<p>On January 22, 2008, a UT-Battelle employee left the ORNL site in his personal vehicle en route to Commerce Park, an office park in the nearby city of Oak Ridge. At approximately 7:05 AM, the employee's vehicle left the road, and the employee died in this accident. No other vehicles were involved. At the time of the accident, there were inclement weather conditions including icy roads.</p> <p>Oak Ridge Police Department is responsible for the investigation of the traffic accident.</p>				
NA	NA-SS-- SNL-NMFAC-2008-0017	Fatality as a Result of Complications Associated with Mesothelioma	12J OS/IH	09/18/2008
<p>On September 16, 2008, a millwright craftsperson died of complications associated with mesothelioma while being hospitalized for pneumonia. Sandia National Laboratories (SNL) Medical first became aware of the craftsperson's condition on September 9, 2008, when informed of a workers compensation claim. SNL Medical was informed that the sequence of events initiated with the craftsperson becoming sick in January 2008 and being diagnosed with pneumonia by their personal physician. In July 2008, the craftsperson was then diagnosed by their personal physician with mesothelioma.</p>				
BPA	Not Reported in ORPS	BPA employee driving a government vehicle suffered a fatal heart attack and collided head-on with a tanker truck		01/28/2008
<p>No accident investigation was conducted. A waiver was granted in February 2008.</p>				



Strategic Safety Goals: Fatalities Backup Information



Fatalities (continued)

2008 cont.	ORPS Number	Report Title	EH Category	Discovery Date
WAPA	Not Reported in ORPS	Two government vehicles collided on a gravel service line road. One passenger killed		07/08/2008
<p>At approximately 1210 CDT, July 1, 2008, three Western employees were traveling south on North Dakota gravel road 59 th Avenue NE, in two Western/GSA vehicles. V2 was stopped at the stop sign at 59 th Avenue NE and paved ND Highway 17—8 miles west of Cando, Towner County, ND— waiting for a westbound semitractor trailer to clear the intersection when V1 ran into the left rear end of V2. V1 came to rest facing west just north of ND Highway 17 at the intersection and sustained total damage to the right front and side as well as induced damage to other areas of the vehicle. V2 came to rest in the northwest corner of the intersection facing northwest and sustained minimal damage to the left rear. Passenger in V1 sustained fatal injuries in the accident and was pronounced dead at Towner County Memorial Hospital. The other two Western employees felt they did not require medical treatment at the accident scene.</p> <p>CAUSES The direct cause of the accident was V1 ran into the left rear end of V2. The root cause of the accident was V1 driver did not maintain adequate visibility of objects in path of vehicle. The contributing causes of the accident were 1) V1 driver unfamiliar with area, road and route; 2) road type and weather conditions; 3) V1 driver not expecting stop sign before lunch at Leeds; and 4) after entering the dust cloud, V1's speed and following distance were not proper for the conditions.</p>				



Strategic Safety Goals: Fatalities Backup Information



Fatalities (continued)

2009	ORPS Number	Report Title	EH Category	Discovery Date
NA	NA -- LSO-LLNL-LLNL-2009-0028	On Site Vehicle Accident by Building 242 Results in Fatality	12Q Vehicle Accident	06/26/2009

On June 26, 2009, a lab worker was severely injured in a vehicular accident that resulted in his death on June 30, 2009. The one-vehicle accident occurred in the parking lot north of Building 242. Workers in the area heard loud engine (described as revving) and tire noises. There are no known witnesses to the event except for one worker who saw through his office window the truck moving at the same time, but could not see any individuals. When coworkers went to investigate the noise/movement, they observed that an LLNL pickup truck had impacted several other vehicles in the parking lot and discovered the injured worker. The worker was taken by ambulance to an on-site landing zone where it was met by a medical helicopter. The worker was transported to a local hospital for head trauma treatment. Notification of the worker's death was received on June 30, 2009.

CAUSES

- **The direct cause** of the accident was the ejection of the worker from V1.
- Further causes of the accident were 1) the vehicle safety features were not used and 2) unfamiliarity with operation of the vehicle.
- The **root cause** of the accident was that the vehicle safety features were not used.
- **The contributing cause** was unfamiliarity with the operation of the vehicle.
- The Board concluded that vehicle safety features were not used by LLNL employee.



Strategic Safety Goals: Fatalities Backup Information



Fatalities (continued)

2010	ORPS Number	Report Title	EH Category	Discovery Date
EM	EM-RL -- GORL-DDSC-2010-0002	A BPA worker was killed on DOE land while Loading a Bobcat on a trailer	12H Injuries Offsite Trtmnt	03/03/2010

On March 1, 2010, a Bonneville Power Administration (BPA) contractor was fatally injured while working at the BPA White Bluffs substation. The White Bluffs substation is located on Hanford land but is fully operated by BPA via permit from the DOE. Although this is not a DOE Hanford site event, it was reported to local stakeholders based upon the expected off-site media interest. The individual was loading a Bobcat with a backhoe attachment onto a transport trailer when he became trapped between the backhoe attachment and the Bobcat and was severely injured. The individual was transported by ambulance to the Kadlec Hospital, where he later died.

CAUSES

The direct cause of this accident was the worker activated the hydraulic controls while standing in the pinch point.

The root cause of this accident was that the worker bypassed the Bobcat safety features.

Contributing causes of this accident were 1) the worker did not receive a sufficient J-1 (pre-job briefing that included work planning, job hazards analysis, and controls); and 2) the J-1 briefing for the entire crew was insufficient on the day of the accident.



Strategic Safety Goals: Fatalities Backup Information



Fatalities (continued)

2010	ORPS Number	Report Title	EH Category	Discovery Date
FE	FE -- SPRO-SPR-BM-2010-0001	Crude Oil Storage Tank Cleaning Project Fatality	12H Injuries Off Site Trtmnt	07/08/2010
<p>On July 8, 2010, a worker collapsed during Crude Oil Storage Tank #2 cleaning at the Bryan Mound Site. Following CPR administration, the worker was transported by ambulance to a local hospital and was pronounced dead by emergency room doctors. It was noted that air quality readings have been within safe parameters for approximately a week, oxygen levels were normal with slight Benzene levels being recorded. New Orleans DOE personnel coordinated with DOE HQ safety personnel to determine what type of accident investigation was appropriate. The Texas Medical Examiner determined that this fatality was the result of asphyxiation. An independent review was performed in place of a formal investigation.</p>				
NA	NA -- YSO-BWXT-Y12SITE-2010-0036	Employee Suffered Fatal Heart Attack on Site	12H Injuries Off Site Trtmnt	09/28/2010
<p>On September 23, 2010, an employee suffered a heart attack when he was waiting to perform a weld inspection. Nearby coworkers began CPR and dialed 911. Emergency response personnel arrived and continued CPR. Several attempts were made with no success to resuscitate the individual using a defibrillator. The employee was transported directly to the Methodist Medical Center hospital where attempts were unsuccessful to resuscitate the employee.</p>				



Strategic Safety Goals: Fatalities Backup Information



Fatalities (continued)

2011	ORPS Number	Report Title	EH Category	Discovery Date
FE	FE -- SPRO-SPR-BM-2011-0001	Grass Cutting Fatality at SPR Storage Site	12H Injuries Off Site Trtmnt	09/13/2011

On September 13, 2011, the control room at the Bryan Mound Strategic Petroleum Reserve site was notified that an Ashton contract employee had been injured on a riding lawn tractor. An ambulance was requested at Cavern 005. The site Emergency Response Team responded and began performing CPR. The injured employee was transported to Brazosport Memorial Hospital. Accident scene was taped off and an investigation was performed.

CAUSES

- The **direct cause** of this accident was an untrained subcontractor employee struck three large elevated pipes with significant force while operating a front deck mower.
- The **two root causes** of this accident were that the worker failed to follow the supervisor's direction to stay off Mower 1, and that the SPR-BM site Stop Work policy and its implementation did not address less than imminent danger situations.
- **The contributing causes** were 1) Less than Adequate Work Control Process (JHA, SWP, pre-job briefing, work assignments); 2) worker's lack of competency in operating Mower 1; 3) worker was a new employee with previous experience at the SPR-BM site; 4) Unavailability of the supervisor due to other duties; and 5) worker was left alone with Mower 1 when other workers left the worksite.



Strategic Safety Goals: Fatalities Backup Information



Fatalities (continued)

2012	ORPS Number	Report Title	EH Category	Discovery Date
EM	EM-CBFO -- WTS-WIPP-2012-0007	Accident Involving Government Vehicle Results in Fatality	12Q Vehicle Accident	06/25/2012

On June 25, 2012, a highway accident involving two vehicles on fire was reported to the Waste Isolation Pilot Plant (WIPP) Facility Shift Manager (FSM). The two vehicles consisted of a large tractor/belly dump trailer and a pickup truck. WIPP Emergency Response personnel were dispatched to assist as part of a Memorandum of Understanding (MOU) with local organizations. When the fire was extinguished, it was determined that the driver of the tractor/trailer was uninjured but the driver of the pickup truck was deceased. Due to the effects of the fire, the driver of the pickup and the owner of the pickup could not be identified at that time. WIPP management investigated to see if the pickup truck driver was a WIPP employee and if the truck was a General Services Administration (GSA) vehicle. The model of the pickup truck appeared to be the same as the GSA vehicle that was unaccounted for late in the workday and normally driven by a WIPP employee who was also unaccounted for at that time. At approximately 2100 hours, the New Mexico State Police, in charge of the accident investigation, notified WIPP management that the pickup truck matched the GSA vehicle information and information found at the scene matched that of a WIPP employee.



Strategic Safety Goals: Radiological Exposures Backup Information



Radiological exposures > 2 rem

Year	ORPS Number	Report Title	EH Category	Discovery Date
2007	NA -- LASOLANL-CMR-2007-0002	Injury Sustained during Glovebox Work	12N Rad Skin Cont/ Upt/Overexp	01/09/2007
<p>The individual received a CEDE of 7.530 rem from a plutonium intake at LANL.</p> <p>In January 2007, a metallographic glovebox worker sustained an injury to the left index finger due to a screwdriver puncture while working at a glovebox at the Chemical & Metallurgy Research (CMR) facility. The wound count was positive for radiological contamination, the isotope being plutonium 239 (Pu-239).</p>				
2008	NA -- LASO-LANL-TA55-2008-0019	Skin Contamination Detected after Glovebox Work	12N Rad Skin Cont/ Upt/Overexp	05/27/2008
<p>There were no individuals who exceeded 5 rem (50 mSv) TEDE from 2004 to 2006, but one individual received a TEDE in excess of 5 rems (50 mSv) in 2007.</p> <p>In 2008, no individual received a TEDE in excess of 5 rem (50 mSv). However, there was one individual who received an organ dose in excess of the 50 rem (500 mSv) DOE annual organ dose limit.</p>				



Strategic Safety Goals: Radiological Exposures Backup Information



Radiological exposures > 2 rem (continued)

2010	ORPS Number	Report Title	EH Category	Discovery Date
EM	EM-SR--SRNS-CPWM-2010-0008	Contaminated Puncture Wound During TRU Drum Remediation (ARRA)	12N Rad Skin Cont/ Upt/Overexp	06/04/2010

An event occurred in June 2010 at SRS that led to an exposure in excess of DOE annual limits when one individual received a TED in excess of 5 rem (50 mSv).

A technician received a puncture wound while performing remediation work in a glovebox. The technician was placing a flag indicator in a waste can and accidentally punctured his protective gloves with the sharp end, resulting in an internal contamination of Pu-238 and Am-241.



Strategic Safety Goals: Radiological Exposures Backup Information



Radiological exposures > 2 rem (continued)

Year	ORPS Number	Report Title	EH Category	Discovery Date
2011	NE-ID--BEA-ZPPR-2011-0001	ZPPR Workroom Pu Contamination Event in MFC-775	12N Rad Skin Cont/ Upt/Overexp	11/08/2011
<p>On November 8, 2011, workers at the Idaho National Laboratory (INL) Materials and Fuels Complex (MFC) Zero Power Physics Reactor (ZPPR) Facility were packaging plutonium (Pu) reactor fuel plates.</p> <p>Upon opening one of the storage containers, the workers discovered a Pu fuel plate wrapped in plastic and tape. When the workers attempted to remove the wrapping material, an uncontrolled release of radioactive contaminants occurred, resulting in the contamination of 16 workers and the facility.</p> <p>The radiological dose assessment will take several months to complete because many bioassay samples will be needed over time to assess the retention of the radioactive material in the body.</p> <p>(CAUSES continue on next page)</p>				



Strategic Safety Goals: Radiological Exposures Backup Information



Radiological exposures > 2 rem (continued)

Year	ORPS Number	Report Title	EH Category	Discovery Date
2011 (cont.)	NE-ID--BEA-ZPPR-2011-0001	ZPPR Workroom Pu Contamination Event in MFC-775	12N Rad Skin Cont/ Upt/Overexp	11/08/2011

CAUSES

The **direct cause** was the cutting and handling of the plastic wrapping around the Pu fuel plate, which released the Pu contaminants.

The **local root causes** were 1) BEA did not accurately analyze the Pu hazard in the safety basis and establish commensurate controls; and 2) the management system lacked requirements intended to influence the decision making of the manager and shift supervisor, resulting in a single-point decision to cut the wrapping

The **systemic root causes** were 1) DOE-ID accepted the risk of known safety basis deficiencies and allowed continued operation of the ZPPR Facility within the framework of a multi-year safety basis upgrade plan without putting effective interim controls in place; and 2) BEA continued operation of the ZPPR Facility with known safety basis deficiencies and without adequately analyzing the hazard to the workers or establishing effective work control processes.

The three **contributing causes** to this accident were 1) the organizational transition resulted in a loss of knowledge and past practices and records that indicated the conditions associated with the fuel plates; 2) senior MFC management did not recognize the significance of information provided by the history of Pu fuel plate failures and by the MFC ISRC Chairman's white paper; and 3) the process worksheet used to conduct the work did not contain directions governed by any of the referenced operating instructions, leading to the creation of work steps without an appropriate hazard analysis or accompanying means of mitigation.



Strategic Safety Goals: Radiological Releases Backup Information



Radiological releases above regulatory limits

2007	ORPS Number	Report Title	EH Category	Discovery Date
EM	EM-RP--CHG-TANKFARM-2007-0009	Tank 241-S-102 Waste Spill	12M Rad Control	07/27/2007

While performing a tank to tank waste transfer shutdown radiological survey, a Health Physics Technician identified unexpected radiation levels near the S-102 transfer pump. Radiation levels were 100 to 200 mR/hr 8 to 12 feet from the S-102 transfer pump. The area was evacuated and S Complex placed on restricted access pending an investigative survey. An entry team found a dark stain with some standing liquid approximately 8 feet in diameter around the S-102 pump pit. Initial radiation readings reported were 25 R/hr (beta window open) and 1 R/hr (beta window closed) 1 foot from the liquid. The on-duty shift manager dialed 911 initiating protective actions for the 200 West Area and activated the Incident Command Post in the 200 East Area. Perimeter surveys and air sampling were completed with no contamination detected at the facility boundary. The spill area was stabilized with two coats of fixative and a high radiation area boundary was established around the spill location. A Type A Accident Investigation was performed.

CAUSES

The **direct cause** was leakage of high level waste from the retrieval pump system in S-102, due to the failure of a utility hose in the dilution line as a result of overpressure.

The **root cause** was the failure to implement the Documented Safety Analysis (DSA) requirement to provide isolation (e.g., backflow prevention) of this hose from the waste transfer route, as prescribed in the technical safety requirements (TSRs).



Strategic Safety Goals: Chemical/Hazardous Material Releases Backup Information



Chemical/hazardous material releases above regulatory limits

2007	ORPS Number	Report Title	EH Category	Discovery Date
EM	EM--NVSO-NST-NTS-2007-0004	Receipt of leaking waste package	12D Environ Release/Comp	02/09/2007
<p>During a radiological clearance survey of a flatbed truck used to ship a Sea Land container from Sequoyah in Oklahoma to the Nevada Test Site, a radiological control technician noticed a yellow liquid substance on the bed of the truck. A direct frisk indicated a total contamination of 5k dpm alpha and 700k dpm beta. Removable contamination levels were determined to be at the 10 CFR 835 Appendix D values for uranium. The truck and container were segregated and secured. Notifications were made to the shipper and the DOT National Response Center. The shipper's remaining shipments were suspended.</p> <p>The delay in reporting was due to National Security Technologies (NSTec) not being the shipper of record for this occurrence. Since it was determined by NSTec Transportation that the National Response Center should be notified, it was decided by the NSTec Environmental Management Director to report this event under the environmental criteria for reports to outside agencies.</p>				
EM	EM-ID--CWI-BIC-2007-0005	Elemental Mercury Spill During D&D Activities	12D Environ Release/Comp	11/08/2007
<p>During removal of waste water piping from the TAN Hot Shop, a 20-foot section of piping was being lifted onto an established containment area when elemental mercury began leaking from a pipe stub. The pipe stub had been wrapped in an absorbent pad, double-bagged and reinforced with canvas prior to moving the pipe. Work was suspended on the piping removal, with the exception of spill cleanup activities. The amount of mercury spilled was approximately 1/2 cup (3 pounds), which exceeds the Reportable Quantity for mercury (1 pound). Event notifications were made and spill cleanup was completed. No personnel were injured or exposed to a hazardous material.</p>				



Strategic Safety Goals: Chemical/Hazardous Material Releases Backup Information



Chemical/hazardous material releases above regulatory limits (continued)

2008	ORPS Number	Report Title	EH Category	Discovery Date
EM	EM-ID--BBWI-AMWTF-2008-0004	Drum Filters Found Outside Permitted Storage Areas	12D Environ Release/Comp	04/09/2008
<p>On April 9, 2008, several waste drums stored in a permitted RCRA waste storage building at the Advanced Mixed Waste Treatment Project were found with the bung-style filters missing. These drums contain mixed hazardous transuranic waste. A search was initiated, and the filters were found on the ground outside the building. None of the filters was contaminated, and there was no spread of contamination. However, the filters are considered to be mixed hazardous waste, and their presence outside the permitted storage area was considered a release, which prompted a non-routine report to the State of Idaho Department of Environmental Quality.</p>				
EM	EM-OH-MCP-ARC-MOU1-2008-0001	PRS-7 West Sanitary Line	12M Rad Control	04/10/2008
<p>During the start of excavation activities of the PRS 7 Sanitary Line at an offsite location near MH-314, a piece of clay pipe (approximately 2 feet below grade) was unearthed during the excavation. The interior surface of the clay pipe was smeared to determine radiological content. The removable contamination was 137 dpm/100cm² and the total contamination was 3,000 dpm/100cm². The exterior was uncontaminated. Analysis identified contaminants as americium-241, plutonium-238, radium-226, thorium-232, uranium-238, and lead-210. Further excavation was halted.</p>				
NA	NA--SS-SNL-2000-2008-0007	Release of Tritium From Building 870	12M Rad Control	07/28/2008
<p>While preparing a 50 mL sample bottle of tritium in a fume hood for mass spectrometry, a worker removed the wrong cover allowing tritium to be released into the fume hood. The worker immediately realized the error, shut the sash to the fume hood and checked the room tritium monitor. The tritium monitor was not alarming. The worker made notifications and secured the bottle. A critique was held.</p>				



Strategic Safety Goals:

Chemical/Hazardous Material Releases Backup Information



Chemical/hazardous material releases above regulatory limits (continued)

2009	ORPS Number	Report Title	EH Category	Discovery Date
NA	NA -- LASO-LANL-FIRNGHELAB-2009-0008	Oil Spilled Potentially Containing PCB at the County Transfer Station	12D Environ Release/Comp	05/09/2009
<p>On May 19, 2009, an oil filled capacitor that had been transported to the Los Alamos County Landfill leaked oil containing Polychlorinated Biphenyls (PCBs). Less than 5 gallons of oil leaked, but more than one pound of PCBs is estimated to have been released onto a concrete floor. Access to the spill area was restricted. The capacitors, which had been removed from transformers, may have posed a shock hazard and these capacitors have been rendered safe. The spilled PCB oil is being cleaned up and samples are being analyzed for PCB content. The capacitors came from an electrical upgrade project being conducted at TA-09-21. The electrical upgrade project work approval was rescinded and a non-routine report was sent to the State of New Mexico.</p>				
NA	NA--LASO-LANL-FIRNGHELAB-2009-0011	Unearthed Capacitor Leaked Oil in a MDA	12D Environ Release/Comp	06/29/2009
<p>On June 29, 2009, lab management was notified that a punctured capacitor had leaked Polychlorinated Biphenyls (PCBs) containing oil in excess of the permitted levels in a Material Disposal Area. On June 23, 2009, environmental staff sampled the oil from the first capacitor and took swipes from a second capacitor's samples. Results indicated that the first capacitor was 100% PCBs and the second capacitor swipe level was 370,000 ppm. On June 25, 2009, environmental staff visually located spots in the excavation pit area that were presumed to be from the capacitors and sampled them. Of the 13 spots sampled, 11 contained measurable amounts of PCBs ranging from 0.16 ppm to 660,000ppm. The capacitors had been excavated in a May 2009 project.</p>				



Strategic Safety Goals: Chemical/Hazardous Material Releases Backup Information



Chemical/hazardous material releases above regulatory limits (continued)

2011	ORPS Number	Report Title	EH Category	Discovery Date
EM	EM-ID--CWI-BIC-2011-0009	Facility is Evacuated After Sodium Excursion Caused Fracture of Secondary Piping and Release of Asbestos (ARRA)	12J OS/IH	05/09/2009
<p>On November 11, 2011, while Idaho Cleanup Project D&D personnel were treating passivated sodium in sodium boiler building Materials and Fuels Complex-766, a pressure excursion in the piping occurred. The excursion separated a piece of 12-inch pipe that was a dead leg in the system and ejected treatment solution from the piping. Personnel located near MFC-766 left the area upon hearing several loud noises and called the fire department. The Idaho National Laboratory (INL) Emergency Operations Center (EOC) was activated and initiated a Take Cover for all personnel located within the MFC. D&D personnel continued to monitor treatment system variables using remote cameras and the system remained stable. On-Scene Command personnel surveyed the areas outside MFC-766 and saw no signs that a fire had occurred. After establishing an exclusion zone around MFC-766, the INL EOC released the Take Cover and deactivated the emergency response command. D&D project personnel made a fact gathering entry into the exclusion zone around the building. A release of asbestos had occurred during the excursion that exceeded reportable quantities, but everything else appeared stable.</p>				
FE	FE---GONP-RMOTC-2011-0007	Copper Sulfate Release at Well Site 25-SX-14	12D Environ Release/Comp	12/13/2011
<p>On December 13, 2011, during clean-up activities, a small cardboard barrel of copper sulfate, a toxic pesticide, was crushed, causing it to release its contents onto the ground. The release was reported to the Technical Assurance Department and preliminary notifications were made. After calculating the densities of the soil and the chemical, it was determined that the amount of chemical spilled was 11 pounds, and the reportable quantity for copper sulfate is 10 pounds. The cardboard barrel of copper sulfate was mistakenly placed in the 'trash' pile by third-party contractors, and Rocky Mountain Oilfield Testing Center (RMOTC) personnel commenced to pick it up with a backhoe, not knowing that it contained a hazardous material, and ruptured the barrel. The solid chemical was completely contained in the soil that it fell upon, and the chemical-contaminated soil was completely cleaned up and placed in a waste container. The spill was cleaned up per the Material Safety Data Sheet directions and is now stored in the RMOTC Hazardous Waste Storage Yard for proper disposal through an Environmental Protection Agency-approved disposal company.</p>				



Strategic Safety Goals: Infrastructure Losses > \$5 million Backup Information



Infrastructure Losses > \$5 million

2011	ORPS Number	Report Title	EH Category	Discovery Date
NA	NA-- LASO-LANL-LANL-2011-0002	Operational Emergency: Las Conchas Wildland Fire Threatens LANL Property & Facilities	12F Fire Protection	6/27/2011

On June 27, 2011, the Los Alamos National Laboratory (LANL) declared an Operational Emergency, Health and Safety Event when the Las Conchas wild land fire crossed over into Laboratory property in Technical Area 49 (TA-49). The fire crossed over into an area that had been previously mitigated for fire protection purposes, which helped to keep the fire low to the ground and aid fire fighters in containing the fire. At the time of the declaration, all radioactive and hazardous materials were appropriately accounted for and protected. Laboratory staff coordinated the onsite response and supported the county and federal fire response. Laboratory operations were suspended until the conditions of the emergency were mitigated. All appropriate Department of Energy (DOE), National Nuclear Security Administration (NNSA), New Mexico Federal Congressional Delegation, and NM State Government authorities were notified and were actively engaged in the event response. On August 1, 2011, the Las Conchas wild land fire was 100% contained and had burned over 156,593 acres. With the exception of the one-acre spot fire in TA-49, no additional fire activity occurred and no structures or facilities were damaged on DOE/LANL property due to the Las Conchas fire.