

Notable Event Report

Title of Event			
Event Title:	Employee Injures Left Shoulder While Descending a Ladder		
Date and Time of Occurrence:	01/04/2016 Approximately 8:00 pm	Notable Event Number:	ENG-16-0104
Event Location:	Hall D Refrigerator Building	Date Notable Event Report is Due*:	02/04/2016

*The Notable Event Report is due to the ESH&Q Reporting Officer with 30 days of the Initial Fact Finding Meeting unless an extension is requested.

Summary of Event and / or Injuries, including Initial Fact Finding Meeting information: determine the chain of events and timeline. Use attachment as necessary.

On January 4, 2016 around 8:00 pm, an employee was using a step ladder to access a valve located on the top of cold box to start the cool down process. The valve need to be turned one half of a turn to do so. The employee visually inspected the step ladder and did not identify any hazards.

The employee ascended the step ladder and turned the valve without incident. Upon descent of the step ladder, the employee misjudged the distance to the ground and began to fall. His body's natural reaction of tensing up occurred and while his left hand maintained his grip on the handle of the cold box, his left shoulder absorbed the employee's full body weight.

The Employee heard a pop. He went home and immediately called his supervisor. He reported to Occupational Medicine the following morning where he was referred off-site for evaluation. The employee was later diagnosed with a torn rotator cuff. The employee returned to work with no use of left arm until cleared by a physician.

Notes;

- The task was well thought out and the employee inspected the ladder prior to its use.
- The employee used the step ladder instead of standing on his toes to access the valve. The valve is just above an average man's reach (Approximately 5 foot 10 inches). The employee could have reached the valve while standing on his tip toes and reaching up.
- There were no hazards identified in that area on the evening or the following morning.
- This activity is only performed on an average of 2 times a year.
- No time restraints were identified for this task.

Causal Analysis: (Use attachment as necessary)

Root Cause:	Mental lapse while descending the ladder. It appears that the employee was not fully invested in the task of descending the ladder and therefore misjudged his footing.
Contributing Causes: (List as many as apply.)	N/A

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Extent of Condition Check	<u>JLab CATS Number</u>	Target Date	Action Owner
N/A- There are no similar set-ups here at the lab that require this type of access.			

Corrective Action(s)	<u>JLab CATS Number</u>	Target Date	Action Owner
All- Staff email to the Lab reminding them that maintaining situation awareness while completing a task is vital to their mission.		02/29/2016	Mary Logue
Evidence of Completion: All Staff email			

Lessons Learned (Confer with Lessons Learned Coordinator) (Use attachment as necessary)	<u>Lessons Learned Number</u>
Even when a task seems simple, maintain your situational awareness until that task is completed.	931

Witness Accounts: (Use attachments as necessary. Box will expand as necessary)
N/A



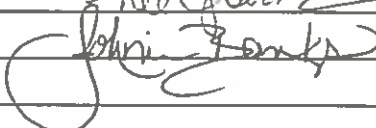
Records, Documents, Pictures, and Other References: (Copy and paste, use attachments or document links as necessary)

Emergency Notifications Made (Subsequent to the Event):	Date	Time
Fire, Rescue & Emergency Medical: (9-911)		
Guard Post: x5822; 269-5822		
Occupational Medicine 269-7539		
ESH&Q Reporting Officer: 876-1750	01/05/2016	~ 08:10 am
Crew Chief 630-7050		
Industrial Hygiene: 269-7863:		
Other:		


<p>Confirmation Review Distribution: Investigation Team Members Affected Division Managers ESH&Q Reporting Officer</p>	<p>It is asked that you review and provide comments to this document to the Lead Investigator (denoted on Page 1) within 30 days. Your comments will be reviewed and incorporated as appropriate. Thank you for your consideration in this matter.</p>
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Investigation Team Confirmation:

The below signees, confirm to the best of their knowledge, that the information presented in this document is accurate and complete.

Role	Print	Signature	Date
Lead Investigator	Paul Collins, DSO, SME		02/11/16
ESH&Q	Tina Johnson		02/11/16
Occ Medicine	Johnie Banks		02/11/16

Acceptance/Acknowledgement of Facts

	Print	Signature	Date:
Associate Director/ Department Manger	Will Oren		2/11/16

Upon confirmation submit document to the ES&H Reporting Officer for completion and distribution.

Documentation of Findings: (To be Completed by ESH&Q Reporting Officer)	
Notable Event Number:	ENG-16-0104
CATS Number:	NE-2016
Lessons Learned Number:	931
ORPS Number:	SC--TJSO-JSA-TJNAF-2016-0002

<u>NTS Number:</u>	N/A
<u>CAIRS Entry:</u>	16-0104 (GIC # 134578)
<u>DOE Cause Code:</u>	A3 Human Performance LTA, B1 Skills Based Error, C03 Metal Lapse.
<u>ISM Code:</u>	N/A

Unless otherwise specified the following is to be completed by the Lead Investigator.

Step 1 Initial Fact-Finding Meeting (To be held as soon as reasonably possible following event (within 24 hours))			
Date:	01/07/2015	Time:	11:00 am
Location:	MCC Conference Room		
Required Attendees: (Print Name)		Optional Attendees: (Print Name) Present	
Lead Investigator:	Paul Collins/SME/DSO	Associate Director:	Will Oren Notified
ESH&Q Representative:	Tina Johnson	TJSO Observer:	Steve Neilson Invited
Supervisor of involved persons(s):		Subject Matter Expert(s), Facility/Equipment Owner as applicable:	
Involved or impacted person(s):	Jonathan Creel	Johnie Banks	
Witness(es):			

Agenda (Ensure the pace of the meeting allows time for accurate note taking.)	√ if Complete
1. Introduction – Provide Event Title, Date and Time of Occurrence, and Location:	√
2. Attendance - Are Required Attendees present.	√
3. Purpose of Initial Fact-Finding meeting.	√
4. Event Reconstruction – Use information to complete Section 3. <u>Summary of Event and/or Injuries</u> below.	√
a. Personnel and organizations involved in the event.	√
b. Conditions and actions preceding the event.	√
c. Chronology (timeline) of the event; and	√
d. Immediate actions taken in response to the event.	√
5. Clarify information – <u>Subject-Matter Expert</u> (SME) confirms work conditions.	√
6. <u>Stop Work</u> or the <u>Tag Out</u> Required? If “Yes” – establish the restart criteria and inform the affected Management chain.	N/A
7. Compensatory Actions Required? If “Yes” determine responsibility and include confirmation documentation.	N/A
8. Records or documentation required to confirm, clarify, or complete information (i.e., work plans, work control documents, photos, etc).	√
9. Other Questions or Concerns: Ask attendees if there are any other questions, concerns, or information that they wish to provide.	√
10. Obtain TJSO Observer feedback on conduct of fact finding meeting and potential improvements.	-

Notable Event Worksheet

Step 2 Investigation Team:		Date Convened:	01/07/2016 Followed Fact Finding	
		(Within 24 hours of Fact Finding Meeting.)		
Role	Name	Department/Group	Phone	
Lead Investigator	Paul Collins	12GeV, ENG. DSO, SME	5981	
Reporting Officer	Tina Johnson	ESH&Q	7611	
Occ Med	Johnie Banks	ESH&Q	7539	
TJSO Observer				
	Steve Neilson	TJSO	Invited	

Environmental Aspects			
Type of Material Released:		Quantity:	
Source:		Time Flow was Halted or Controlled:	
For Investigation Team (✓ All That Apply):			
<input type="checkbox"/> Reportable Quantity	<input type="checkbox"/> Impact Ground/Soil	<input type="checkbox"/> Storm Water Channel/Drain	<input type="checkbox"/> Sanitary Sewer

Categorization and Reporting			
(To be completed by ESH&Q Reporting Officer within two hours – unless essential information is still pending)			
ORPS Determination:	Date:	01/06/2016	Time: 4:32 pm

Categorization and Reporting

(To be completed by ESH&Q Reporting Officer within two hours – unless essential information is still pending)

ORPS Determination: **Date:** 01/06/2016 **Time:** 4:32 pm

CAIRS/ORPS/NTS Determination: Follow-up re: Engineering Jan 06

Incident Notification

From: Tina Johnson
To: Johnie Banks
Cc: Will Oren Mary Logue Bob May Harry Fanning Chandler Bert Manzlak
 Bill Rainey Dick Owen econley Jennifer Williams Show more...

All:

OSHA Recordkeeping Evaluation: Based on the information below, this case is recordable (DART).

Which work-related injuries and illnesses should you record?

Record those work-related injuries and illnesses that result in:

- ▼ death,
- ▼ loss of consciousness,
- ▼ days away from work,
- ▼ restricted work activity or job transfer, or
- ▼ medical treatment beyond first aid.

Based on information obtained so far, we do not believe the event meets ORPS reportable criteria.

We will follow the Notable Event Process and we will complete the CAIRS entry within the 7 day time limit. Please call me with any questions or concerns.

Thank you,
 Tina

10 CFR 851 Screen: **Date:** 01/06/2016 **Time:** ~4:32 pm

Negative: This event does not meet the voluntary criteria as a discreet or as a programmatic weakness.

Final Distribution:

- [ES&H Reporting Officer](#) (Original)
 Associate Director/Department Manager
- [Division Safety Officer](#)
- Investigation Team Members
- [ESH&Q Liaisons](#)

Form Revision Summary

- Revision 1.5 – 10/04/13** – Changed COE to Lessons Learned; updated links.
- Revision 1.4 – 09/06/12** – Qualifying Periodic Review. Clarification of content only.
- Revision 1.3 – 01/31/12** – Updated ESH&Q Reporting Officer assignment from S.Smith to C.Johnson per M.Logue
 Edited to clarify process steps.
- Revision 1.2 – 10/20/11** – Updated ESH&Q Reporting Officer assignment from J.Kelly to S.Smith per M.Logue.
- Revision 1.1 – 05/24/11** – Edited to clarify process steps.
- Revision 1.0 – 11/23/10** – Updated to reflect current laboratory operations.

ISSUING AUTHORITY	FORM TECHNICAL POINT-OF-CONTACT	APPROVAL DATE	REVIEW DATE	REV.
ESH&Q Division	Tina Johnson	10/04/13	10/04/16	1.5

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