Jefferson Lab
Thomas Jefferson National Accelerator Facility

Notable Event Worksheet

(See ES&H Manual Chapter 5200 Appendix T1 Event Investigation and Causal Analysis for Instructions)

Click For Word Doc

Title of Event			
Event Title:	Inadvertent Airbag Deployment Resulting in an Injury		
Date and Time of Occurrence:	04/17/2012 ~ 8:30 am	**Notable Event Number:**	TEDF-12-0417
Event Location:	TED Bldg and Test Lab Addition Courtyard	**Date Notable Event Report is Due*:**	05/27/2012

*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.

Categorization and Reporting ***Response was delayed pending the review of the facts surrounding this event***
(To be completed by ESH&Q Reporting Officer within two hours – unless essential information is still pending)

ORPS Determination:	Date:	04/27/2012	Time:	3:30 pm

From Tina Johnson ☆ Reply Reply All Forward Archive Junk Dele

Subject **CAIRS Determination: TEDF-12-0417 Inadvertent Airbag Deployment Resulting in an Injury** 4/27/2012 3:30 F

To Steve Neilson ☆

Cc Mary Logue ☆, Keith Royston ☆, Rusty Sprouse ☆, Richard Jacobsen ☆, Tina Johnson ☆ Other Actions

Steve,

Good Afternoon! As a follow-up to Mary's phone call (04/20/2012) in reference to the accidental airbag deployment and injury of the subcontractor (event occurred on 04/17/2012), we are officially informing you tha this event is CAIRS recordable: Medical treatment beyond a first aide was given to one of the subcontractors

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.

We will enter this case into the CAIRS database within the 7 day time limit, however, due to the unique nature of this event, we will not follow the "formal" notable event process, per Mont and Mike's email approval. I will complete the Notable Event worksheet and post as soon as possible.

If you have any questions or concerns, feel free to contact me.

Thank you in advance,

Tina

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Notable Event & Lessons Learned Worksheet

Categorization and Reporting ***Response was delayed pending the review of the facts surrounding this event***
(To be completed by ESH&Q Reporting Officer within two hours – unless essential information is still pending)

ORPS Determination:	**Date:**	04/27/2012	**Time:**	3:30 pm
10 CFR 851 Screen:	**Date:**	**04/27/2012**	**Time:**	**3:30 pm**

This event does not meet the voluntary reporting criteria either as a discreet event or as a programmatic weakness.

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

Step 1 Initial Fact-Finding Meeting (unofficial)

Date:	04/19/2012	**Time:**	10:30	**Location:**	Mortenson Trailer

Required Attendees:	**Optional Attendees:**	**√ if Present**
Lead Investigator:	**Associate Director:**	
(Print Name):	(Print Name):	
ESH&Q Representative:	**TJSO Observer:**	x
(Print Name):	(Print Name): Rick Korynta	
Supervisor of involved persons(s):	**Subject Matter Expert(s), Facility/Equipment Owner** as applicable:	
(Print Name): Ken Mitchell	(Print Name): Jeff Woeste, Mortenson	x
Involved or impacted person(s):	(Print Name): Chris Johnson, Mortenson	x
(Print Name): Contractor 1	(Print Name):	
(Print Name): Contractor 2	(Print Name):	
Witness(es):	(Print Name):	
(Print Name):	(Print Name):	

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. Summary of Event and/or Injuries 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 – Subject-Matter Expert (SME) confirms work conditions.	
6. Stop Work or the Tag Out Required? If "Yes" – establish the restart criteria and inform the affected Management chain.	

7.	Compensatory Actions Required? If "Yes" determine responsibility and include confirmation documentation.	
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.	

Step 2 Investigation Team: **Date Convened:** (Within 24 hours of Fact Finding Meeting.)

Role	Name	Department/Group	Phone
Lead Investigator	Tina Johnson	Reporting Officer	7611
TJSO Observer		TJSO	

Step 3 Summary of Event and / or Injuries, including Initial Fact Finding Meeting information: determine the chain of events and timeline. Use attachment as necessary.

This event is unique and is being handled as a life event. There was an unofficial fact-finding meeting held however, there was no investigation team meeting held.

On 04/17/2012 at approximately 8:50 a.m. in the courtyard between the TED building the TLA, two Bay Electric employees got into their pickup to go to another location on-site. Within a few seconds of starting the vehicle and putting it in gear, the driver side and passenger side air bags deployed (the front air bags did not deploy). On the passenger side an additional air bag from the side of the seat deployed.

Their immediate response was to check each other for injuries and inspect the exterior of the vehicle. They then called the Bay Electric Shop Manager, Supervisor, and Project Manager. They also called Rick Dahlberg (Mortenson). Rick escorted them to JLab Medical and after being examined they were referred for follow-up examination. The Contractors went to Patient First. Contractor #2 was released with no prescriptions or restrictions, and Contractor #1 received 3 prescriptions.

When they returned to the vehicle they cut the air bags free and drove the truck back to their shop to get another truck. The truck was taken to a body shop to be evaluated and it was determined that there was a faulty sensor in the 2010 GMC truck which caused the inadvertent deployment of the airbags.

** The Notable Event process was delayed pending the review of the facts surrounding this event.

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Notable Event & Lessons Learned Worksheet

Notable Event Report

Emergency Notifications Made (Subsequent to the Event):	Date	Time
Fire, Rescue & Emergency Medical: (9-911)		
Guard Post: x4444; 269-5822		
Occupational Medicine 269-7539	04/17/2011	9:30 am
ESH&Q Reporting Officer: 876-1750	04/17/2011	9:30 am
Crew Chief 630-7050		
Industrial Hygiene: 269-7863:		
Other:		

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

None

Environmental Aspects

Type of Material Released:	Quantity:
N/A	
Source:	**Time Flow was Halted or Controlled:**

For Investigation Team (√ All That Apply):

☐ Reportable Quantity ☐ Impact Ground/Soil ☐ Storm Water Channel/Drain ☐ Sanitary Sewer

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

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Notable Event & Lessons Learned Worksheet

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

Causal Analysis: (Use attachment as necessary)	
Root Cause:	Equipment failure
Contributing Causes: (List as many as apply.)	None were determined

Extent of Condition Check	Responsible Person(s)	JLab CATS Number	Target Date
N/A	N/A	N/A	N/A

Corrective Action(s)	JLab CATS Number	Target Date
The truck was immediately removed from the site and taken to the body shop for repair	N/A	N/A

Lessons Learned (Confer with Division/Department Lessons-Learned Coordinator) (Use attachment as necessary)	JLab COE Number
Life events are unexpected and can occur at work or home.	N/A

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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	Tina Johnson	Tina Johnson	5/30/12

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:	TEDF-12-0417
CATS Number:	N/A
JLab COE Number:	N/A
ORPS Number:	N/A
NTS Number:	N/A
CAIRS Entry:	12-0417
DOE Cause Code:	A2 Equipment/Material Problem, B6 Defective, Failed, or Contaminated, C01 Defective or failed part.
ISM Code:	N/A

Acceptance/Acknowledgement of Facts

	Print	Signature	Date:
Associate Director/ Department Manger	John R Sprouse	John R Sprouse	30 May 12

Distribution:
ES&H Reporting Officer (Original)
Associate Director/Department Manager
Division Safety Officer
Investigation Team Members

Form Revision Summary

Revision 1.3 – 01/31/12 – Updated ESH&Q Reporting Officer assignment from SSmith to CJohnson per MLogue Edited to clarify process steps.
Revision 1.2 – 10/20/11 – Updated ESH&Q Reporting Officer assignment from JKelly to SSmith per MLogue.
Revision 1.1 – 05/24/11 - Edited to clarify process steps.
Revision 1 – 11/23/10 – Updated to reflect current laboratory operations.

ISSUING AUTHORITY	FORM TECHNICAL POINT-OF-CONTACT	APPROVAL DATE	EXPIRATION DATE	REV.
ESH&Q Division	Tina Johnson	10/19/09	10/09/12	1.3

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