U.S. DEPARTMENT OF ENERGY

FOR IMMEDIATE RELEASE **August 4, 2009**

Media Contact:
Cameron Hardy, DOE-RL, 509-376-5365

DOE Completes Hanford Site Accident Investigation

A U.S. Department of Energy (DOE) probe into the July 1, 2009 accident that severely injured a Hanford contractor employee has found that the work being performed had not been fully analyzed for appropriate safety precautions, and that workers became distracted after the job scope informally changed.

The accident took place in a so-called "high bay" facility in Hanford's 300 Area. Hazardous material removal at the 65-foot-tall facility was completed in June, and the building is being prepared to be torn down. In preparation for demolition, crews were working to remove a large bridge crane stationed about 10 feet from the top of the facility, with three workers up on a catwalk. One descended through a hatch and, believing the group's assignment was finished, left the hatch open and expected his two co-workers to follow. Instead, the two remained to finish one more – unplanned – task, which involved repositioning the crane. As they walked toward opposite ends of the catwalk to push the crane, one worker fell through the open hatch and hit the midpoint guardrail before landing on the concrete floor, about 50 feet down. The worker suffered substantial leg and back injuries, but no internal or head injuries.

"We are fortunate beyond all measure that this accident did not result in a fatality," said DOE Richland Operations Office Manager Dave Brockman. "This is a company whose safety programs, record, and performance are very strong. But in that moment, a hole in those programs found us, and the consequences are life-changing for the individual involved."

The DOE accident investigation, which included more than 1,700 hours of interviews and reviews, analysis, and recommendation development, points to several causes, including 1) poor implementation of the contractor's work control process, which resulted in the hazards of the job and proper controls not being sufficiently identified; 2) inadequate supervisory and safety oversight methods and resources to support the job; and 3) a fall protection procedure and implementation that did not comply with applicable Occupational Safety and Health Administration standards and did not provide adequate protection to workers.

DOE is mandating a number of improvements, including substantive changes to fall protection and work control processes. Among the report's recommendations are that the contractor should 1) instill a workforce culture in which employees understand and take appropriate action when the work being performed begins to extend beyond the planned and analyzed work scope; 2) balance its work schedule commensurate with its trained and qualified work supervisors; and 3) re-evaluate the fall protection program in its entirety and retrain workers.

The DOE Richland Operations Office has also launched a review of federal actions and oversight of the contractor's safety programs to determine why the deficiencies weren't identified earlier. "We are all responsible for making sure something like this doesn't ever happen again," said Brockman. "If there are actions the federal staff should have taken along the way, we're going to identify them and take action."

Brockman noted that the company had been passionate in its response to the event, and has already taken a number of actions, including halting all elevated work and reevaluating protective measures; conducting an immediate corporate-led investigation of the event to proactively look for needed improvements; reviewing all active work packages and Job Hazard Analyses (JHA) with employee work teams; and holding breakout sessions with employees to discuss safety and employee concerns.

"Our confidence in WCH's ability to work safely has not changed," said Brockman. "l know the company will learn from this accident, and share improvements with other contractors at Hanford and in the DOE complex. Ultimately, the lesson here is that a single weakness in a great program can cost you tremendously."

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