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Energy Department Investigation Finds INEEL Fatal Accident Was Avoidable

The Department of Energy (DOE) today announced the findings of its investigation into a tragic accident in Idaho in July, which caused one death and several life-threatening injuries. The investigation determined that numerous deficiencies in areas such as safety requirements, system design, emergency preparedness and management systems contributed to the accident. The incident involved the accidental release of carbon dioxide, a toxic and potentially lethal fire retardant, during maintenance operations at the Experimental Test Reactor Building, a non-defense facility, at the department's Idaho National Engineering and Environmental Laboratory.

"Our hearts go out to the family and friends of Kerry Austin," said Secretary of Energy Bill Richardson. "I admire the heroic efforts of the workers who rescued their colleagues from a very dangerous situation - a situation that never should have happened. This report underscores how important it is to make safety an integral part of how we do our jobs. The safety of our workers must be of utmost importance. I am very disappointed that the system to ensure their safety failed. I have directed the manager of the department's Idaho Operations Office to report within 30 days on the corrective actions that have and will be taken to respond to this investigation's findings."

Peter N. Brush, DOE's Acting Assistant Secretary for Environment, Safety and Health, appointed a group of DOE experts, called an Accident Investigation Board, to examine the causes and possible management failures leading to the death of Austin, injuries to several workers and carbon dioxide exposure to 15 workers. The investigation, a "Type A," is the most comprehensive conducted by the department. In addition to its findings on the causes of the July 28 accident, the board also made numerous recommendations for corrective actions.

"The department's policies and operations clearly necessitate that no hazardous work within DOE be treated as routine," said Brush. "Management must be committed to a work environment that is supported by well-established safety procedures and that allows free and open expression of safety concerns that lead to action."

The board found many serious deficiencies that contributed to the accident in the following five areas, including:

1. Inadequate work planning and control - There were failures to analyze, communicate and appropriately control the hazard. Procedures that would have prevented inadvertent operation of the carbon dioxide system were not followed.

2. System design was deficient and not in accordance with code - A monitoring circuit that would ensure a pre-discharge alarm and a shutoff valve for the carbon dioxide system were not installed.
3. Inadequate worker safety controls and emergency preparedness for accidental carbon dioxide discharge - There was a failure to ensure that the carbon dioxide system was shutdown. Clear exit pathways, breathing apparatus, training and oxygen supplies were not provided to ensure safe escape or immediate rescue in the event of an emergency.
4. Failure to institutionalize safety requirements - Applicable industry safety requirements were not implemented or institutionalized through safety policies, procedures or training.
5. Inadequate management systems - Corrective actions to previous accidents and investigations were inadequate. Safety infrastructure was reduced in an effort to save money and there was a failure to ensure an integrated, disciplined and consistent approach to the control of work and hazards.

Since the accident, the department's Idaho Operations Office and the laboratory's contractor, Lockheed Martin Idaho Technologies Co., have imposed a stop work order on all maintenance activities until they determine that potential hazards and adequate work controls have been identified for each job. Both Idaho Operations Office and contractor senior management have become more directly involved in reviewing and approving work control plans. The Idaho Operations Office has established a standing team to conduct real-time review of work control in the field.

These and other actions will remain in place until the Department's policy on integrated safety management is fully implemented. In addition, the Idaho Operations Office and the contractor will make greater use of technical assistance from throughout the department, and they have requested a site-wide assessment of INEEL's safety program by the department's Office of Environment, Safety and Health. All DOE sites are conducting a review of fire suppression systems and additional safety precautions are being implemented.

The board's report can be found on the Internet at http://tis.eh.doe.gov/oversight/acc_inv/ineelai.pdf or hard copies can be requested from the Office of Environment, Safety and Health's Information Center at 301/903-8358.

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