LLE INSTRUCTION 6950E

SUBJECT: INCIDENTAL REVIEW AND REPORTING

ENCLOSURE: (1) Incident Report Format

1. **Purpose:** To formalize procedures for reporting, investigating, and documenting incidents and taking corrective actions to prevent their recurrence. This instruction applies to the Omega Facility and all other laboratories within LLE.

2. **Definition:** An incident is defined as any event that causes or could have caused personnel injury resulting in hospital emergency room treatment or lost time, significant equipment damage, exceeding environmental release limits for hazardous or radioactive material, or a significant loss of Omega system effectiveness or availability.

3. **Discussion:** Prevention of incidents is of paramount importance in laboratory operations. Implicit in this objective is to learn from incidents when they occur and implement actions to prevent their recurrence. This requires that incidents be promptly and thoroughly investigated to determine what happened and what caused it to happen. Causes can be classified as Personnel, Procedure, Equipment, and/or Material. The root cause of most incidents is often due to human error. For example, if a piece of equipment fails due to improper operation, maintenance, or assembly, the cause of an incident is Personnel or Procedure and not Equipment or Material. The investigation of an incident must be thorough enough to get past “first impressions” and determine root causes. The purpose of an investigation is not to assign blame or to determine punitive action. Rather, it is to seek the truth so that the reason for an incident is clearly understood and so that proper and sufficient corrective actions can be implemented.

   In some instances, the potential follow-on consequences of an incident may be severe enough that operations must be curtailed pending investigation, review, and corrective action. For example, if an incident causes a serious injury or extensive equipment damage or the potential for significant subsequent damage exists, operations should be curtailed in the affected area until the incident investigation and review are completed and necessary corrective actions are implemented to prevent recurrence.

4. **Procedures:** All events that have the potential of being incidents within the context of this instruction shall be immediately reported to the cognizant Area Supervisor, Group Leader, Division Director, and the Associate Director for Operations; and for Omega Operations events, to the Shot Director, Associate Laser Facility Manager, Laser Facility Manager, and Operations Manager after a safe situation has been established. Any incident that affects or could have affected personnel safety should also be reported to the Laboratory Safety Officer.
Operations will be temporally halted until the cognizant Division Director has made a determination as to whether the event is an incident or not.

a. **Non Incident**—If the event is determined not to be an incident by the cognizant Division Director, as applicable, operations may be resumed.

b. **Incident**—If the event is classified as an incident by the cognizant Division Director, the Division Director, Laser Facility Manager (for operations events), and Laboratory Safety Officer (for safety related incidents) determine the necessary actions to be completed in advance of the resumption of operations. Thereafter an individual will be appointed by the cognizant Division Director to conduct the review/investigation and to prepare a draft Incident Report.

c. **Incident Investigation**—The individual assigned will conduct a thorough investigation within a reasonable time, usually one day. More time may be required depending on the seriousness and extent of the incident to access damage, obtain analysis results, or interview personnel who are not immediately available. The investigation may take the form of holding a joint review meeting with all involved personnel followed by individual interviews with personnel involved, obtaining written statements, review of applicable logs and records, inspection, analysis, etc. If the investigation does not lead to closure in a reasonable time, the investigator should seek the advice of the applicable Division Director or Laboratory Safety Officer (for safety-related incidents) and proceed accordingly.

d. **Incident Report**—Once the investigation is completed, a draft Incident Report will be prepared by the individual assigned to investigate the incident using the format of Enclosure (1). The report shall be submitted to the reviewers for comment as designated in Enclosure (1). The recipients will submit comments to the applicable Division Director who will prepare the Incident Report. Incident reports will be approved by all reviewers before distribution. If all corrective actions cannot be completed in a timely manner, a Preliminary Incident Report will be issued first, and a Final report will be issued when all corrective actions have been completed. Preliminary and Final Incident Reports will be distributed to the Laboratory Director, Associate Director for Operations, Division Directors, Laboratory Safety Officers, and Group Leaders. Group Leaders will be responsible for reviewing relevant incidents with their Group.

e. **Corrective Actions**—The completion of corrective actions will be administered by the Omega Facility Director. Personnel assigned in the Preliminary Incident Report to implement corrective actions will take the requisite actions and report in writing to the Omega Facility Director when such actions are completed. If circumstances prevent the completion of corrective actions by the time specified, personnel assigned responsibility shall inform the Omega Facility Director prior to the due date of the reason for the delay. After all corrective actions are completed, a Final Incident Report will be written by the Omega Facility Director, and distributed.

f. **Completed Incident Reports**—Hard copies of signed incident reports will be filed by the OMEGA Facility Director Administrative Assistant. Additionally, the incident reports will be filed electronically in a searchable webpage.
5. Responsibilities

a. Individual
   (1) Any individual who believes that an event may be an incident within the context of this instruction shall immediately report the event to his supervisor as appropriate (i.e., Shot Director, Area Supervisor, Group Leader, or Division Director).

b. Group Leader or Shot Director
   (1) Report an event to cognizant Division Director, Laser Facility Manager (for operations incidents), and the Laboratory Safety Officer (for personnel safety-related incidents).
   (2) Support the incident investigation as appropriate and as requested by the person assigned responsibility for the incident investigation.
   (3) Review the draft Incident Report and give comments to the applicable Division Director within one working day.

c. Incident Investigator
   (1) Conduct a timely and thorough investigation to determine what happened, the extent of damage or injury, and the causes of the incident.
   (2) Recommend temporary and long-term permanent corrective action to prevent recurrence of the incident.
   (3) Prepare a draft Incident Report using the format of Enclosure (1).

d. Group Leader, Laser Facility Manager (for operations incidents), and Laboratory Safety Officer (for safety related incidents)
   (1) Recommend whether or not an accident or event should be classified as an incident within the context of this instruction.
   (2) Determine temporary actions necessary to resume operations (if any). Actions may include investigation, procedure changes, equipment modifications, and training.
   (3) Review the draft Incident Report and give comments to the applicable Division Director within one working day.

e. Division Director
   (1) Make a determination as to whether or not an event should be classified as an incident within the context of this instruction.
   (2) Appoint an individual to conduct the investigation and write the preliminary incident report.
   (3) Authorize the resumption of operations.
   (4) Report the incident to the Associate Director of Operations.
(5) Prepare Preliminary and Final Incident Reports based on investigations and preliminary reports and comments received. Approve preliminary and final incident reports.

(6) Ensure that specified corrective actions are taken by the time indicated in the final incident report.

f. OMEGA Facility Director

(1) Direct the overall laboratory incident program.

(2) Maintain a file of Incident Reports and follow up to ensure corrective actions identified in Preliminary Incident Reports are completed by the date indicated in the Preliminary Incident Report.

(3) Administer periodic refresher training for each operational group for relevant incidents.

g. Associate Director for Operations

(1) Review and approve all incident reports.

Robert L. McCrory
(Preliminary/ Final) LLE Incident Report

Area: (OMEGA, OMEGA EP, C&TF, Student Lab, LLE general)

Key Words:

Category: (Safety or Operational)

Injury: (yes, no)

Date of Incident:

1. **DESCRIPTION of INCIDENT**: (describe what happened including indications)

2. **IDENTIFICATION OF APPARENT CAUSE**: (describe cause and events leading up to the incident)

   ______Personnel ______Procedure ______Equipment ______Material

3. **CORRECTIVE ACTIONS**
   
   a. **IMMEDIATE ACTIONS** (actions taken at the time of the incident to establish stable conditions)
   
   b. **TEMPORARY CORRECTIVE ACTIONS** (actions taken to resume normal operations in advance of completion of permanent actions, identify specific actions, persons responsible, and completion due date)
   
   c. **PERMANENT CORRECTIVE ACTIONS** (permanent corrective actions to prevent recurrence, identify specific actions, person responsible, and completion due date)
4. SUBMITTED BY ___________________________ Date ___________
   Person Investigating the Incident

5. REVIEWED BY a. ___________________________ Date ___________
   Applicable Group Leader

   b. ___________________________ Date ___________
   OMEGA Laser Facility Manager
   (for OMEGA incidents)

   c. ___________________________ Date ___________
   OMEGA EP Laser Facility Manager
   (for OMEGA EP incidents)

   d. ___________________________ Date ___________
   OMEGA Operations Manager
   (for OMEGA incidents)

6. APPROVED BY a. ___________________________ Date ___________
   Applicable Division Director

   b. ___________________________ Date ___________
   Laboratory Safety Officer
   (for safety-related incidents)

   c. ___________________________ Date ___________
   Associate Director for Operations

Distribution: