HMNB CLYDE NUCLEAR SAFETY EVENT ASSESSMENT REPORT

Originators Ref No: ER 08/12	Event ID No: ID_54726
DTG & Location: EHJ 25/04/2012 07:35	
Lead Section / Department: Ships Staff	
Base Section(s) Involved:N/A	Vessel(s) Involved: [redacted]

Systems Affected		Failure Mode			
		Equipment Failure		Personnel Failure	
Electrical		Design		Incorrect Diagnosis	
Mechanical		Manufacture		Non-compliance	X
Civil Structure		Maloperation		Inappropriate Action	
Radiological	X	Stores		Performance	
Administrative	X	Installation		Spatial Error	
Berthing		Maintenance/Repair		Programme pressure	
Contractor		Incorrect Equipment		Other	
Maintenance		Worn Equipment		Documentation	
Weapons		Other (state)		Not available	
NAR				Inadequate	
Other (state)				Incorrect	
				Other (state)	

EVENT DESCRIPTION:

Failure of Ships Staff to issue dissymmetry to personnel as required by NOP 402B

Date Closed Out: 22NOV12

NUCLEAR SAFETY EVENT ASSESSMENT REPORT			
Category: D Date agreed by VSCM/WSA/NWSSSC: 07/05/2012			INES Level: Below Scale
Any further investigation Required: By:			
Investigation Findings / Recommendations / Corrective / Preventive Action(s):			

INVESTIGATION REPORT AND SUPPORTING DOCUMENTS:

See attached NRPA Event Report [redacted] 08/12

Name: MEO	Title: MEO	Tel No:	Date:

BY THE ASSURANCE DEPARTMENT:

ROOT CAUSES Failure to comply with a Nuclear Procedure.

HUMAN FACTORS

Poor Training- The Quarter Master failed to understand the requirement to issue accident dissymmetry to all non ships staff iaw NOP 402(B)

CORRECTIVE PREVENTIVE ACTIONS (CPAs)

See attached Event Report

RECOMMENDATIONS

See attached Event Report

LESSONS LEARNT

See attached Event Report

AD NSAO/OAG COMMENTS

This event has highlighted a failing with ships staff in regard to training their Quartermasters in the control of NOP 402(B). A full understanding and appreciation of this procedure is essential to controlling an effective exclusion zone.
It is to the credit of [redacted] self correcting culture that extra training has already been implemented. It is also noted that the PAG have further endeavored to enforce the issuing of dissymmetry by emboldening the specific statement that directs the issuing of both accident and occupational dissymmetry.

NSAM/OAM COMMENTS

The attached Event Report gives a detailed account of the circumstances that led to members of a FOST team entering the Exclusion Zone without being issued with Accident Dosimetry as required by NOP402(B). The report provides a frank and open account of the event, including prior training, identifies the root cause of the issue, provides evidence that lessons have been learnt and that actions have been taken to prevent a repeat occurrence.

The root cause of this event was the failing of the [redacted] to comply with NOP402(B): a procedure for which he had been given specific and directed training.

The actions taken by Ship's Staff are adequate and appropriate and are supported by the changes to the procedure being implemented by the PAG.

Assessing Officer: [redacted] RN (NSAM)

Actions Required	Target Date	Agreed By
1. Nil.		
2.		
3.		

Assessing Officer
Signed: _____ Title: _____ Date: _____

All recommendations/actions now completed.
Comments:

Signed: _____ Title: NSAO/OAG Date: _____

NSE closed-out: Review Required: Yes / No

Date sent to Life Time Records: _____

Signed: _____ Title: NSAO/OAG Date: _____

Review Required: Y / N	Review Date:	By Whom:

Comments:

Signed: _____ Title: NSAO/OAG Date: _____