October 26, 2006

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-II-06-004

This preliminary notification constitutes EARLY notice of events of possible safety or public interest significance. The information is as initially received without verification or evaluation, and is basically all that is known by Region II staff (Atlanta, Georgia) on this date.

Facility	**Licensee Emergency Classification**
AREVA NP, Inc.	Notification of Unusual Event
AREVA -Richland	Alert
Richland, WA	Site Area Emergency
Dockets/License: 70-1257/SNM-1227	General Emergency
	X Not Applicable

Subject: Workers Exposed To Hydrogen Fluoride (HF) Release

Region II on-site inspectors were provided initial information from the licensee (ANP-Richland) on October 24, 2006, of a worker being exposed to a release of HF vapor. At around noon (PDT) on October 23, 2006, two workers entered a process area inside the dry conversion building. Workers noted an unusual odor and immediately evacuated the process area. Workers obtained respiratory protection equipment and returned to the location to collect air samples to determine the source of the leak. It was determined that the HF was leaking from a deteriorated weld on a plug in the reactor off-gas system for chemical conversion process line 3. Air sample results for chemical and radioactive gases indicated that HF levels in the vicinity of conversion line 3 were elevated. Workers reported to the site first-aid station for evaluation. One of the two workers later that evening reported to the hospital for further evaluation and was subsequently hospitalized for exposure to HF vapor. There was no indication of elevated levels of airborne radioactivity, and no indication of the release spreading beyond the immediate process area or to the environment. No other workers were exposed.

The licensee shut down line 3 conversion operations and inspected other line 3 process equipment to verify that no other breach of containment or significant physical damage existed with line 3 equipment. On October 26, evidence of a second crack was found in the weld near the original crack in the line 3 equipment. Inspection of the remaining conversion lines is planned this weekend to verify the integrity of equipment. The licensee has established a root cause team to further investigate the release, and determine the causes and the appropriate actions to prevent recurrence.

Region II received initial notification of this occurrence by telephone from licensee contact. This information presented herein has been discussed with the licensee and is current as of 4:00 p.m., October 26, 2006. The State of Washington has been notified.

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