

December 18, 2000

Mr. J. William Lessig
Plant Manager
Honeywell Specialty Chemicals
P.O. Box 430
Metropolis, IL 62690

SUBJECT: NRC INSPECTION REPORT 040-03392/2000-005(DNMS) (HONEYWELL)
AND NOTICE OF VIOLATION

Dear Mr. Lessig:

On November 28, 2000, the NRC concluded a routine inspection at your Metropolis, Illinois facility. The purpose of the inspection was to determine whether activities authorized by the license were conducted safely and in accordance with NRC requirements. At the conclusion of the inspection, the preliminary findings identified in the enclosed report were discussed with you and members of your staff.

Areas examined during the inspection are identified in the report. Within these areas, the inspection consisted of a selective examination of procedures and representative records, interviews with personnel, and observations of activities in progress. Based on the results of the inspection, the NRC has determined that a violation of NRC requirements occurred.

The violation is cited in the enclosed Notice of Violation (Notice) and the circumstances surrounding the violation are described in the enclosed report. The violation was cited for the failure to perform inspections within the required frequency for a critical piece of equipment identified for the safe operations of the processes. In addition, the inspector identified a lack of management control to remove equipment from service that has not been maintained in accordance with the license requirements.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. The NRC will use your response, in part, to determine whether further enforcement action is necessary to ensure compliance with regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available **electronically** for public inspection in the NRC Public Document Room **or** from the *Publicly Available Records (PARS) component of NRC's document system (ADAMS)*. ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/NRC/ADAMS/index.html> (the Public Electronic Reading Room).

J. Lessig

-2-

We will gladly discuss any questions you have concerning this inspection.

Sincerely,

/RA by M. Phillips for/

Patrick Hiland, Chief
Fuel Cycle Branch

Docket No. 040-03392
License No. SUB-526

- Enclosures:
1. Notice of Violation
 2. Inspection Report 040-03392/2000005(DNMS)

cc w/encl: T. Ortigier, Illinois Department of Nuclear Safety

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NOTICE OF VIOLATION

Honeywell Specialty Chemicals
Metropolis, Illinois

Docket No. 040-03392
License No. SUB-526

During an NRC inspection conducted November 16 through 21 and November 28, 2000, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," (Enforcement Policy) NUREG-1600, May 1, 2000, the violation is listed below:

License Condition 10, of Source Materials License SUB-526, Amendment 9, authorizes, in part, the use of licensed materials in accordance with the statements, representations, and conditions in Chapters 1 through 7 of the license application dated September 23, 1998, and supplement dated October 1, 1998.

Chapter 5, Section 5.4, "Chemical Safety Plan," of the enclosure dated October 1, 1998, requires, in part, that plant operations comply with the Chemical Safety Plan as described in Chapter 13.4 of the license application.

Chapter 13, Section 13.4.8, "Maintenance and Inspection Program," requires, in part, that inspections be performed within the frequencies established in the maintenance management system for equipment identified as critical to the safe operation of the processes.

Procedure No. 229, "Procedure for Identifying Critical Equipment," defines the equipment critical to safe operation of the processes and includes the Uranium Hexafluoride (UF₆) ME-12 Cylinder Hauler. The procedure also requires an annual grabber welds inspection and two-week mechanical inspections of the UF₆ ME-12 Cylinder Hauler.

Procedure No. MP-240, "MTW Equipment Inspection Frequency," allows a six-month grace period for one to four year inspection frequencies and a one week grace period for one to four week inspection frequencies.

Contrary to the above, the licensee failed to perform annual and 2 two-week inspections for the UF₆ ME-12 Cylinder Hauler, identified as a critical piece of equipment for the safe operation of the processes. Specifically, between December 8, 1998, and July 14, 2000, the licensee failed to perform the annual grabber welds inspection. Between May 19 and June 23, 2000, and between June 23 and July 28, 2000, the licensee failed to perform the two-week mechanical inspections of the UF₆ ME-12 Cylinder Hauler.

This is a Severity Level IV violation (Supplement VI). (VIO 040-03392/2000005-01)

Pursuant to the provisions of 10 CFR 2.201, Honeywell Specialty Chemicals, is hereby required to submit a written statement or explanation to the U. S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555, with a copy to the Regional Administrator, Region III, 801 Warrenville Road, Lisle, Illinois 60532-4351, within 30 days of the date of the letter transmitting this Notice of Violation (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for the violation: (1) the reason for the violation, or, if contested, the basis for disputing the violation; (2) the corrective steps that have been taken and the results achieved; (3) the corrective steps that will be taken to avoid further violations; and (4) the date when full compliance will be achieved. Your Notice

of Violation response may reference or include previously docketed correspondence, if the correspondence adequately addresses the required response. If an adequate reply is not received within the time specified in this Notice, an Order or Demand for Information may be issued as to why the license should not be modified, suspended, or revoked, or why such other action as may be proper should not be taken. Where good cause is shown, consideration will be given to extending the response time.

If you contest this enforcement action, you should also provide a copy of your response to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555-0001.

Because your response will be placed in the NRC Public Document Room (PDR), to the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction. If personal privacy or proprietary information is necessary to provide an acceptable response, then please provide a bracketed copy of your response that identifies the information that should be protected and a redacted copy of your response that deletes such information. If you request withholding of such material, you must specifically identify the portions of your response that you seek to have withheld and provide in detail the bases for your claim of withholding (for example, explain why the disclosure of information will create an unwarranted invasion of personal privacy or provide the information required by 10 CFR 2.790(b) to support a request for withholding confidential commercial or financial information). If safeguards information is necessary to provide an acceptable response, please provide the level of protection described in 10 CFR 73.21.

In accordance with 10 CFR 19.11, you may be required to post this Notice within two working days.

Dated this 18th day of December 2000.

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket No: 040-03392
License No: SUB-526

Report No: 040-03392/2000-005(DNMS)

Licensee: Honeywell Specialty Chemicals

Facility: Metropolis Works

Location: P. O. Box 430
Metropolis, IL 62960

Dates: November 16 through 21 and November 28, 2000

Inspector: C. A. Blanchard, Paducah Senior Resident

Approved By: Patrick Hiland, Chief
Fuel Cycle Branch
Division of Nuclear Materials Safety

EXECUTIVE SUMMARY
Honeywell Specialty Chemicals
NRC Inspection Report 040-03392/2000-005(DNMS)

Operations

- Operations were conducted in accordance with the applicable procedures for the specific tasks being performed. Operators were knowledgeable of safe operating parameters, surveillance requirements, and safety interlocks for cognizant equipment. The inspector concluded that the Feed Materials Building operators' command and control promoted the safe operation of cognizant equipment. (Section O1.1)

Maintenance

- The licensee failed to adequately implement required inspections for the uranium hexafluoride ME-12 cylinder hauler. In addition, the inspector identified a weakness in the control of equipment with an expired inspection. (Section M1.1)
- The licensee adequately implemented a surveillance program for the safety-related weight scale systems for the cold traps and product cylinder fill positions. However, a surveillance enhancement was noted. (Section M1.2)

Engineering

- The management of change program, referred to as PT-101, was currently being implemented with several recent self-initiated enhancements. (Section E1.1)

Plant Support

- The inspector identified a weakness with the licensee's adherence to a self-imposed action plan to address the breaching of natural uranium ore from deteriorated 55-gallon drums. The inspector concluded that the As-Low-As-Reasonably-Achievable and "B" council meetings were functional. (Section R1.1)

Report Details

I. Operations

01.1 Conduct of Operations

a. Inspection Scope (88020)

The inspector observed general operations in the Feed Materials Building (FMB), ore sampling facility, and other areas onsite. In particular, the inspector observed the following activities:

- cylinder disconnect, weighing, and storage;
- FMB and control room operations; and
- routine rounds of the FMB.

b. Observations and Findings

The inspector noted that these activities were conducted in accordance with applicable procedures and postings, and that operators used appropriate protective clothing and equipment. The FMB units (ore preparation, hydrofluorination, fluorination, and distillation) operated without any abnormal conditions during the inspection. Control room operations were conducted with attention focused on equipment important to safety. Operation log books were current and conclusive for activities conducted during the shift.

On November 17, the inspector observed cylinder filling operations in the FMB and the change-out of product cylinders. The cylinder was placed in the fill position that has two independent load cells during the product filling process. The inspector noted that the load cell weights were continuously monitored and recorded by the distillation operators in the FMB. In addition, the distillation operators manually calculated the cylinder fill times and monitored the product flow totalizer to ensure that a product cylinder was not overfilled. The inspector noted that the distillation operators stopped filling Cylinder UR 545 at the precalculated time and that the weights displayed by the load cells and flow totalizer were within the allowable deviation tolerances. Cylinder UR 545 official weight was 26,374 pounds which was less than the administrative cylinder weight limit of 26,500 pounds for 48Y cylinders. The greatest deviation in final fill weights between the two independent load cells and weight displayed by the totalizer was less than 0.4 percent. The inspector observed that the operators who disconnected Cylinder UR 545 and hooked up the pigtail for Cylinder UR 473 donned the proper personal protective equipment and safely transferred the filled Cylinder UR 545 to the cylinder cooling pad. The inspector noted that cylinder filling operations were conducted in accordance with governing procedures.

The inspector discussed with approximately fifty percent of the FMB operators, ongoing operation activities, the risk associated with cognizant operations, and status of equipment. The inspector observed that operational alarms were promptly addressed and only a few standing alarms existed which were generally fixed by the end of the shift. In each case where a standing alarm was noted, the operators initiated appropriate compensatory actions to address safe operations. The inspector observed that fluorination operators were cognizant of critical operating parameters of the

freezer/sublimers (F/S). Specifically, the fluorination operators explained clearly the cold trap's current special nuclear material (SNM) fill status, the maximum SNM fill limit, and the calibration frequency of load cells and instrumentation.

The inspector discussed conduct of operations with the hydrofluorination, fluorination, and distillation operators. In discussions with the inspector, each operator stated they were responsible for the safe operation of their respective equipment and at no time would they start another functional areas equipment. The operators explained that at times there were minor routine equipment adjustments performed by the cognizant operator, and that these adjustments could require the isolation of local energy sources which, if inadvertently reactivated, may injure an operator. Operators stated that they were comfortable performing these activities because only they were allowed to operate their respective equipment. The inspector noted that 29CFR 1910.147, "The Control of Hazardous Energy (lockout/tagout)," allowed minor tool changes and adjustments, and other minor servicing activities, which take place during normal production operations to be performed using alternative control measures other than equipment lockout/tagout. The inspector observed that all equipment and system manipulations required for maintenance were controlled by the cognizant operation manager and operator. In discussions with the inspector, operators were knowledgeable of current maintenance activities being performed, who was working on the equipment, the status of the maintenance activity, and what hazardous systems were isolated to perform the activity.

During facility tours, the inspector observed housekeeping practices. The inspector noted that attention to housekeeping in the FMB and other facilities had improved. The floors of the FMB were clear of obstructions and appeared generally clean. The inspector brought to the Health Physics (HP) Manager's attention a small (approximately 2 inches in diameter) spill of what appeared to be uranium oxide adjacent to the conversion plant during one tour. The inspector observed that the spill was addressed within 30 minutes after being identified.

c. Conclusion

Operations were conducted in accordance with the applicable procedures for the specific tasks being performed. Operators were knowledgeable of safe operating parameters, surveillance requirements, and safety interlocks for cognizant equipment. The inspector concluded that the FMB operators' command and control promoted the safe operation of cognizant equipment.

II. Maintenance and Surveillance

M1.0 Conduct of Maintenance

M1.1 Critical Equipment Inspection Activity Review

a. Inspection Scope (88025)

The inspector reviewed required inspection records for the uranium hexafluoride (UF₆) Cylinder Scale, UF₆ handling crane, UF₆ ME-12 Cylinder Hauler, and equipment included on the licensee's critical equipment list as described in Procedure No. 229, "Procedure for Identifying Critical Equipment." In addition, the inspector discussed with

select maintenance staff what compensatory actions were imposed when required inspections were not conducted within required frequencies.

b. Observations and Findings

On November 28, the inspector reviewed quarterly and annual inspection records for the UF₆ cylinder scale. The inspectors reviewed the 1999 and 2000 quarterly inspections for the UF₆ cylinder scale and determined that the scale met all of the as found tolerances. Specifically, the scale was tested with certified weights in thousand pound increments to 32,000 pounds. The inspector noted that the scale was accurate within the required 2 pounds tolerance for quarterly inspections. The annual UF₆ cylinder scale required maintenance to completely disassemble the scale and clean each component. However, a note in the file stated to by-pass the annual inspection because the quarterly inspections ensured the scales accuracy. In a follow-up discussion with the inspector, a reliability engineer explained the annual disassembly resulted in premature wear to the scale and was not recommended by the scale's manufacturer. However, the reliability engineer was not aware of any technical documented justification for postponing the annual inspection.

The inspector reviewed the annual UF₆ handling crane inspection. The inspection was thorough and checked all aspects of the crane's mechanical and electrical functions. The inspection was conducted in accordance with an authorized work order and associated checklists. The inspector noted the annual UF₆ handling crane inspection had been performed by a certified crane inspection company and within the grace period for yearly inspections as allowed in Procedure MP0240, "MTW Equipment Inspection Frequency."

The inspector reviewed the annual and bi-weekly inspection for the UF₆ ME-12 cylinder hauler. The inspector noted that the UF₆ ME-12 cylinder hauler was included in the licensee's critical equipment list. The critical equipment list included equipment that if failed had the potential to produce a chemical accident with radiological implications. The annual inspection included a detailed nondestructive evaluation of the UF₆ ME-12 cylinder hauler's welds. Specifically, the paint was removed from the UF₆ ME-12 cylinder hauler's weld joints on the cylinder grabber and a nondestructive dye penetration weld check was performed by a reliability engineer. In review of the annual inspection records, the inspector identified that the last annual dye inspection was performed on July 14, 2000. The annual inspection prior to the July 14, 2000 inspection was completed on December 18, 1998. The inspector noted that the 19 months between the two inspections was beyond the 12 month inspection requirement plus the allowed 6 month grace period for inspection frequencies of 1-4 years as specified in Procedure MP-20.

The inspector proceeded to review the bi-weekly mechanical UF₆ ME-12 cylinder hauler inspection records from January through September 2000. The inspector identified two inspection periods which exceeded the two week inspection period plus the one week grace period allowed in Procedure MP-20. Specifically, the two exceeded frequencies occurred between May 19, and June 23, 2000 and between June 23, and July 28, 2000.

The inspector reviewed the process to control required maintenance inspection activities for safety equipment addressed on the licensee's critical equipment inspection list and maintenance management system (MMS). The inspector noted that reliability

engineering issued a monthly report to maintenance and operations which identified the required inspections for the following 60 days. The report was generated from the licensee computerized MMS database. In discussions with the inspector, maintenance personnel explained they were not aware of a formal process to remove equipment from service that was beyond the required inspection frequency. However, plant management explained that they believed the UF₆ ME-12 cylinder hauler's missed inspections were unique, but that an investigation would be performed and corrective actions taken.

License Condition 10, of Source Materials License SUB-526, Amendment 9, authorizes, in part, the use of licensed materials in accordance with the statements, representations, and conditions in Chapters 1 through 7 of the license application dated September 23, 1998, and supplement dated October 1, 1998. Chapter 5, Section 5.4, "Chemical Safety Plan," of the supplement dated October 1, 1998, requires, in part, that plant operations comply with the Chemical Safety Plan as described in Chapter 13.4 of the license application. Chapter 13, Section 13.4.8, "Maintenance and Inspection Program," requires, in part, that inspections be performed within the frequencies established in the maintenance management system for equipment identified as critical to the safe operation of the processes.

Procedure No. 229, "Procedure for Identifying Critical Equipment," defined the equipment critical to safe operation of the processes and included the UF₆ ME-12 Cylinder Hauler. In addition, the procedure required annual grabber weld and two-week mechanical inspections of the UF₆ ME-12 Cylinder Hauler. Procedure No. MP-240, "MTW Equipment Inspection Frequency," allowed a six-month grace period for one to four year inspection frequencies and a one week grace period for one to four week inspection frequencies. However, the inspector identified that cylinder grabber and mechanical inspections were not being performed within the required frequencies. Specifically, between December 8, 1998, and July 14, 2000, the licensee failed to perform the annual grabber weld inspection. Between May 19 and June 23, 2000, and between June 23 and July 28, 2000, the licensee failed to perform the two-week mechanical inspections of the UF₆ ME-12 Cylinder Hauler. The failure to perform these required inspections is a violation **(VIO 040-03392/2000005-01)**.

c. Conclusion

The licensee failed to adequately implement required inspections for the UF₆ ME-12 cylinder hauler. In addition, the inspector identified a weakness in the control of equipment with an expired inspection.

M1.2 Cold Trap and Product Fill Station Surveillance Review

a. Inspection Scope (88025)

The inspector reviewed the surveillance activities performed to ensure that the weight measuring systems and alarms for the cold trap and product cylinder fill positions function as designed.

b. Observations and Findings

The inspector noted the safety significance of over filling cold traps and product cylinders with UF₆. Liquid UF₆ specific weight was approximately 30 percent less than solid UF₆, which equated to a volumetric increase of approximately 30 percent during the phase change from a solid to a liquid. The inspector noted that the volumetric increase from a solid to a liquid had the potential to cause a hydraulic rupture of the cold trap or cylinder during heating. The licensee had installed several measuring systems on the cylinder product fill positions to ensure that a cylinder was not over filled as discussed in Section O1.1 of this report. To preclude cold trap over filling, safety controls included administrative fill limits that were established below and at approximately 60 percent of the cold traps' design limits. The fill limit at approximately 60 percent of the cold traps' design limit was the limit described in the license and if exceeded would require notification to the NRC. The inspector noted that two control room annunciators would sound to warn operators if a cold trap exceeded a fill limit.

The inspector reviewed the surveillance activity for the cold traps and product cylinder fill positions. The surveillance included a comprehensive yearly evaluation of each circuit to ensure that the weight monitoring systems performed as designed. In discussion with the inspector, an instrument mechanic explained that by checking and adjusting individual circuits to predetermined acceptable set-points and tolerances, the licensee could ascertain the weight systems function ability and accuracy, but clarified that the audible and visual control room annunciators were confirmed during this yearly surveillance. The inspector noted that Surveillance J01841, "E-408 Cold Trap Electrical Loop Check," did not clearly articulate the conformation of the audible or visual alarm during the yearly surveillance. The inspector confirmed through record review that weight measuring system surveillances for the cold traps and product fill positions were current and acceptable.

c. Conclusion

The licensee adequately implemented a surveillance program for the safety-related weight scale systems for the cold traps and product cylinder fill positions. However, a surveillance enhancement was noted.

III. Engineering

E1 Conduct of Engineering

E1.1 Management of Change

a. Inspection Scope (88005)

The inspector reviewed the sufficiency of the management of change program, referred to as PT-101 in the license.

b. Observations and Findings

The licensee uses a management of change process referred to as PT-101 in the license. The inspector reviewed the process to confirm that once a change has been identified, a formal process was in place to approve, review, authorize, implement,

verify, and document this change. In May of 2000, the PT-101 process was implemented on a computer database. The PT-101 program was managed through the use of a password-protected, limited access computer database. Prior to implementing the computer database several internal audits were performed which required changes to enhance the program's effectiveness and internal tracking rigor.

c. Conclusions

The management of change program, referred to as PT-101, was currently being implemented with several recent self-initiated enhancements.

IV. Plant Support

R1 Radiation Protection Controls

R1.1 Safety Committee Review

a. Inspection Scope (88010 and 88045)

The inspector reviewed the As-Low-As-Reasonably-Achievable (ALARA) committee meeting agenda, frequency, and attendees for compliance with the requirements established in Chapter 2.3 of the license. In addition, the inspector attended the November "B" Council Committee meeting.

b. Observations and Findings

Chapter 2.3 of the license application requires, in part, that an ALARA committee shall be utilized by management to ensure that exposures and effluent releases are effectively controlled. The inspector reviewed meeting minutes for 1999 and through the 3rd quarter of 2000 and noted the following:

- Attendees included the Plant Manager, HP Manager and Supervisor, the Vice-President and President of the local union, and a majority of the Department Managers;
- Meetings were conducted quarterly;
- Meeting minutes attested that the committee reviewed the radiological safety program performance for the previous quarter and formulated and completed actions for reducing employee or environmental radiation exposure; and
- Graphs were used to illustrate radiation exposures to workers and the closest resident and uranium losses to the environment.

The inspector noted that the licensee was complying with the requirements specified in Chapter 2.3 of the license.

The inspector reviewed the following corrective actions for the select ALARA projects:

- The licensee identified that the coke boxes, used to remove uranium by-product particulate from the process, were a significant source of uranium airborne contamination. Several corrective actions were completed by the licensee to address this problem and were clearly articulated in the meeting minutes. The licensee used graphs to illustrate the plant's and major contributors' total uranium release to the atmosphere. The inspector noted that when the licensee completed the corrective actions the uranium loss to the atmosphere decreased by approximately a factor of three.
- The inspector reviewed ALARA Sub-Team's corrective actions to address deteriorated 55-gallon drums of hard uranium ore concentrate received from a uranium conversion plant. In discussions with the inspector, the HP Manager explained that the plant had reduced the quantity of drums with hard uranium ore concentrate to approximately 12,000 drums in April 1999 from over 25,000. Of these 12,000 drums remaining, the HP Manager explained that approximately 600 of the drums were suspected of leaking uranium concentrate. As corrective action, the licensee assigned six employees to transfer the hard uranium concentrate from the worst deteriorated drums to new 55-gallon drums during the April 23 through May 6, 2000 plant closure. This effort resulted in repackaging over 100 leaking drums and moving approximately 2,000 drums into a covered building. In addition, a process manager explained that since April 2000 approximately 1,000 drums of hard uranium concentrate had been processed through wet recovery.

The inspector observed several drums significantly breaching uranium ore during a routine tour of the drum pad, and noted several ALARA action items not completed to address the deteriorated drums. Specifically, the inspector noted that the ALARA committee meeting minutes for the 1st Quarter of 2000 scheduled the completion of uranium concentrate repackaging from leaking drums to new drums by September 1, 2000. In addition, the inspector learned that the March 20, 2000 ALARA sub-team minutes documented that they discussed several different options to address deteriorated drums and made a decision to request the following:

- repackage deteriorated drums, and
- hire two employees for approximately 45 days to clean up the drum spills, repackage deteriorated drums, and sort through remaining drums.

The ALARA sub-team identified that completion of the above items in a short time frame would prevent, or reduce, the possibility of exposure to the public, as well as reduce the possibility of employee exposure. In addition, the inspector noted that natural uranium breaching from deteriorated drums challenged the licensee's effluent outfall processing. However, the inspector did not identify any adverse trends in effluent releases. Effluent releases were within regulatory limits. The licensee's plan to address the breaching natural uranium ore from 55-gallon drums will be tracked as an **Inspection Followup Item (IFI 040-03392/2000-005-02)**.

The inspector noted that the licensee conducted the "B" council meeting monthly, developed an agenda for each meeting, and ensured that all employees attended a meeting. The inspector attended the November "B" safety council meeting. The inspector observed that an electrical foreman presented a new site policy for the replacement fuse box fuses. The foreman explained that the current policy allowed operators to replace some fuse box fuses which could still be energized after the disconnect was opened because of equipment interlocks. The new policy required an electrician to replace fuses that were not on a simple circuit. To implement this policy, electricians were labeling boxes throughout the plant to clarify if the fuse box disconnect was a simple circuit type. A demonstrative fuse box with an interlock circuit was used to visually illustrate the safety significance of an electrified interlock circuit. The instructor opened the main fuse box disconnect but showed that electrical power remained due to the interlock circuit by tossing a small piece of steel wool in the fuse box. The steel wool flashed abruptly after making contact with the electrified interlock circuit. In addition, the instructor used additional fuse boxes to display other safety issues associated with fuse replacement.

c. Conclusions

The inspector identified a weakness with the licensee's adherence to a self-imposed action plan to address the breaching of natural uranium ore from deteriorated 55-gallon drums. The inspector concluded that the ALARA and "B" safety council meetings were functional.

V. Management Meeting

X. Exit Meeting Summary

The inspector presented the inspection results to members of the plant staff and management at the conclusion of the inspection on November 28, 2000. The plant staff acknowledged the findings presented. The inspector asked the plant staff whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

PARTIAL LIST OF PERSONS CONTACTED

Honeywell Specialty Chemicals

- M. Davis, Health Physics Supervisor
- W. Lessig, Plant Manager
- * H. Roberts, Health Physics Manager
- * M. Shepherd, Manager, Environmental and Regulatory Affairs

Other members of the licensees' staff were also contacted during the inspection.

INSPECTION PROCEDURES USED

- IP 88005: Management Organization and Controls
- IP 88020: Operations Review
- IP 88025: Maintenance and Surveillance
- IP 83045: Environmental Protection

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened:

040-03392/2000005-01	NOV	Failure to perform required routine inspections for the Uranium Hexafluoride ME-12 Cylinder Hauler.
040-03392/2000005-02	IFI	Address breaching natural uranium ore from 55-gallon drums.

Closed:

None

Discussed:

None

LIST OF ACRONYMS USED

ALARA	As-Low-As-Reasonably-Achievable
CFR	Code of Federal Regulations
DNMS	Division of Nuclear Material Safety
FMB	Feed Materials Building
F/S	Freezer/Sublimator
HP	Health Physics
IP	Inspection Procedure
MMS	Maintenance Management System
NRC	Nuclear Regulatory Commission
PDR	Public Document Room
SNM	Special Nuclear Material
UF ₆	Uranium Hexafluoride