

June 6, 2002

Mr. J. William Lessig
Plant Manager
Honeywell International, Inc.
P.O. Box 430
Metropolis, IL 62960-0430

SUBJECT: NRC INSPECTION REPORT 04003392/2002-003(DNMS)
AND NOTICE OF VIOLATION - HONEYWELL

Dear Mr. Lessig:

On May 10, 2002, the NRC completed 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. The NRC inspector discussed the findings with you and members of your staff at the conclusion of the inspection on May 10.

Areas examined during the routine inspection are identified in the enclosed 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 maintain the weight of product in the UF₆ vaporizer below the safe operating limit.

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, its enclosures, and your response to this letter 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/reading-rm/adams.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 acting for/

Patrick L. Hiland, Chief
Fuel Cycle Branch

Docket No. 04003392
License No. SUB-526

Enclosure: 1. Notice of Violation
2. Inspection Report 04003392/2002003(DNMS)

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

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NOTICE OF VIOLATION

Honeywell Specialty Chemicals
Metropolis, Illinois

Docket No. 04003392
License No. SUB-526

During an NRC inspection conducted May 6 through 10, 2002, a violation of NRC requirements was identified. In accordance with NUREG-1600, "General Statement of Policy and Procedure for NRC Enforcement Actions," the violation is listed below.

License Condition 10 of Source Materials License SUB-526, Amendment 14, authorizes, in part, the use of licensed materials in accordance with the statements, representations, and conditions in Chapter 1 through 7 of the license application.

Chapter 5, Section 5.4 of the license, "Chemical Safety Plan," 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 13.4.4.3 states, in part, "... each of the operating manuals (including the process containing HF, NH₃, UF₆, or LPG) address upper and lower operational limits for all pertinent process parameters, i.e. temperature, pressure, flow rates concentration, composition, etc." Page 44 of the Distillation Manual, dated April 11, 2002, stated that the safe operating limit for the UF₆ vaporizer weight was less than 12,000 pounds.

Contrary to the above on May 9, 2002, the inspector observed the UF₆ vaporizer weight indicate 12,000 pounds in violation of the Distillation Manual.

This is a Severity Level IV violation (Supplement VI).

Pursuant to the provisions of 10 CFR, Part 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 made 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), to the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be made available to the public without redaction. ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/reading-rm.html> (the Public Electronic Reading Room). 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 (e.g., 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 6th day of June 2002.

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket No. 04003392

License No. SUB-526

Report No. 04003392/2002-003 (DNMS)

Licensee: Honeywell International, Inc.

Facility: Metropolis Works

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

Dates: May 6 through 10, 2002

Inspector: Bruce L. Bartlett, Paducah Senior Resident Inspector

Approved by: Patrick L. Hiland, Chief
Fuel Cycle Branch
Division of Nuclear Materials Safety

EXECUTIVE SUMMARY

**Honeywell International, Inc.
Metropolis Works
NRC Inspection Report 04003392/2002-003(DNMS)**

This inspection included aspects of licensee operations, radiation protection, and emergency preparedness.

Operations

- During routine control room observations the inspector observed the weight of the UF₆ vaporizer exceed the Safe Operating Limit of less than 12,000 pounds. The inspector also observed control room operators, their supervisors, and the cognizant engineer display a casual attitude towards operating within established safe operating limits. The inspector identified one violation for exceeding the Safe Operating Limit weight of the distillation vaporizer. (Section O1.1)
- The inspector determined that the licensee's removal of control room instruments from service was in accordance with procedures. The inspector also determined that the licensee's procedure failed to address the removal of instruments from service when their associated equipment had been removed for maintenance or modification. (Section O1.2)

Plant Support

- The licensee effectively implemented the contamination survey and instrument calibration programs. Equipment was in good working order and within the required calibration frequency. Documentation was maintained supporting the calibration of the equipment. (Section R2.1)
- Employees and security personnel demonstrated adequate knowledge of contamination monitoring, of radiation detection equipment usage, and the appropriate procedure to follow in the event of either a personnel or vehicle contamination. All surveys observed by the inspector were performed in accordance with licensee requirements. (Section R4.1)
- The inspector verified that the licensee's emergency equipment and facilities specified in the emergency preparedness program were operable and properly maintained. All equipment examined was operable and maintained in good condition. (Section P2.1)
- The licensee's emergency preparedness training was consistent with the frequency and performance objectives outlined in the emergency plan. All fire pre-plans, training records, and procedures reviewed by the inspector were current and reflected appropriate special considerations. (Section P5.1)

I. Operations

O1.1 Failure to Comply with Safe Operating Limits

a. Inspection Scope (TI2600/003)

The inspector observed general operations in the Feed Materials Building (FMB) and other areas onsite to verify that the activities were performed safely and in accordance with applicable license conditions and regulatory requirements.

b. Observations and Findings

The inspector noted that the activities observed were generally conducted in accordance with applicable procedures and postings, and that operators used appropriate protective clothing and equipment. The FMB units (ore preparation, reduction, green salt, fluorination, and distillation) were all either in operation during the inspection or in startup following a planned maintenance outage. During control room observations on May 9, 2002, the inspector observed the uranium hexafluoride (UF_6) vaporizer weight exceed the safe operating limit. This occurred even though the inspector had held discussions with the licensee regarding operating close to the safe operating limit on the day before.

During the time the inspector was on site the licensee was in the process of restarting that portion of their operation which removed impurities from the UF_6 . The UF_6 flowed into a vaporizer, then into the low boiler re-boiler and then to the high boiler re-boiler. The licensee was experiencing problems controlling the process steam to these components. The problems resulted in UF_6 flowing alternately from the re-boiler into its associated distillation vessel and then back to the re-boiler. During normal operations the distillation process flowed smoothly between the re-boiler and the distillation vessel with minimal oscillation.

The re-boiler had been placed on load cells but the distillation vessels did not have load cells. As the product would surge between the re-boiler and its associated distillation vessel, the indicated weight of the low boiler re-boiler and high boiler re-boiler slowly oscillated. The oscillation would be as much as 6,000 pounds over a one-hour timeframe. In addition, the weight/pressure changes in the low boiler re-boiler affected the amount of material flowing from the vaporizer such that the vaporizer's weight was also oscillating.

The indicator for the weights of the vaporizer, low boiler re-boiler, and high boiler re-boiler read out in tens of pounds. For example, if the weight of one of the vessels was 11,950 pounds the instrument would indicate 1195. However, this had the effect of causing the reading to also indicate 1195 if the true weight was 11,959 pounds. Thus if the instrument indicated 1195 then weight could be as low as 11,950 pounds and as high as 11,959 pounds.

During routine control room observations on Wednesday, May 8, 2002, the inspector first observed the weight oscillations. At that time the inspector noted that the high boiler re-boiler weight was greater than the procedural limit of 10,500 pounds and had peaked at about 11,960 pounds. During the time the weight of the high boiler re-boiler

oscillated to 11,960 pounds, the operators' primary focus was on control of the steam heating to the vessel. Vaporization Manual, step 3.5.11 stated, in part:

"When 8,000 to 10,000 pounds have been added to the Low [sic] boiler re-boiler, set WIC-432 in automatic to control at 10,000 pounds. Do not exceed 10,500 pounds in the high boiler re-boiler." *Original emphasis maintained.*

Based on discussions with the operator, his supervisor, and the cognizant engineer, the inspector concluded that a limit meant for steady state conditions had been inadvertently placed in the startup section of the Vaporization Manual. The licensee stated that they would revise the Vaporization Manual to change the error regarding the low boiler re-boiler comment in the high boiler re-boiler section and revise the 10,500 pound limit upwards to the less than 12,000 pound safe operating limit.

The inspector questioned the operator and his supervisor as to why they had allowed the high boiler re-boiler to oscillate to within 0.3 percent (40 pounds or less) of the safe operating limit. Licensee personnel stated that they felt it was acceptable to exceed the safe operating limit as long as the ultimate limit was not exceeded. Licensee personnel performed an unreviewed informal calculation that indicated the ultimate limit was about 14,000 pounds.

The inspector determined, through conversations with various members of the licensee's staff up to and including the acting Operations Manager, that the licensee did not view the safe operating limit as a do not exceed limit. The inspector also determined that the less than 12,000 pound safe operating limit applied to all three vessels (vaporizer, low boiler re-boiler, and high boiler re-boiler).

The following day, Thursday May 9, 2002, the inspector performed another control room observation. Problems with the steam heating coils continued, and the operators, their supervisors, and the cognizant engineer were spending a significant amount of their time attempting to get the steam heating system to operate properly. The inspector observed the operators concentrate on controlling steam flow to the re-boiler steam heating coils while only occasionally glancing at the indications from the load cells. The high boiler re-boiler was more stable than the day before, but it was still oscillating. The inspector observed that the vaporizer weight was oscillating more than the previous day and was increasing about 10 pounds every 45 to 60 seconds. At approximately 2:45 p.m. a shift change was begun and at 3:00 p.m. the shift change was completed. The inspector did not observe any special attention being given to the vaporizer weight during the turnover even though it was approximately 11,850 pounds and increasing.

At approximately 3:15 p.m. the weight was approximately 11,970 pounds and continuing to increase; however, the operators were still maintaining their primary focus on frequent adjustments to the steam heating coils. The inspector interrupted the conversation of the lead engineer and asked if the vaporizer weight would be allowed to exceed the less than 12,000 pound safe operating limit. The lead engineer glanced at the load cell indication and requested the operator to "Do anything you have to, to keep the weight below 12,000 pounds" and then returned his focus to the steam heating coils.

The control room operator isolated the inlet valve to the vaporizer which appeared to slow the weight increase. The control room operator also sent another operator to locally isolate the vaporizer. The weight peaked at 11,980 pounds then oscillated

between 11,980 and 11,960 pounds. Several seconds later the indicated weight increased from 11,960 pounds to 12,000 pounds and an annunciator set to alarm at 12,000 pounds actuated. The control room operator acknowledged the annunciator while watching the weight of the vaporizer decrease and then returned his focus to the steam heating coils.

The inspector reviewed the Vaporization Manual section 4.12.6, and determined that exceeding the less than 12,000 pound limit had a consequence of deviation code of "Higher weights may result in vessel overflow." The purpose of the vaporizer was to take relatively cool liquid UF₆ and heat it to near vaporization temperature. Vapor would then flow to the low boiler re-boiler. If too much relatively cool UF₆ was added to the vaporizer and then a steam heating failure occurred, an over pressure condition could result. Too much pressure would cause the rupture disc to fail and for UF₆ to flow to other pressure vessels.

The inspector interviewed the distillation operator to determine whether he was aware of the less than 12,000 pound limit in the UF₆ vaporizer. The operator stated that he was aware of the limit but was busy with the steam heating coils.

License condition 10 of Source Material License SUB-526, Amendment 14, authorized, in part, the use of licensed materials in accordance with the statements, representations, and conditions in Chapter 1 through 7 of the license application. Chapter 5, Section 5.4, "Chemical Safety Plan," required, in part, that plant operations comply with the Chemical Safety Plan as described in Chapter 13.4 of the license application. Chapter 13, Section 13.4.4.3 states, in part, "... each of the operating manuals (including the process containing HF, NH₃, UF₆, or LPG) address upper and lower operational limits for all pertinent process parameters, i.e. temperature, pressure, flow rates concentration, composition, etc." Page 44 of the Distillation Manual, dated April 11, 2002, stated that the safe operating limit for the UF₆ vaporizer weight was less than 12,000 pounds. On May 9, 2002, the inspector observed the UF₆ vaporizer weight read 12,000 pounds in violation of the Distillation Manual. (VIO 04003392/2002-003-01)

c. Conclusions

During routine control room observations the inspector observed the weight of the UF₆ vaporizer exceed the Safe Operating Limit of less than 12,000 pounds. The inspector also observed control room operators, their supervisors, and the cognizant engineer display a casual attitude towards operating within established safe operating limits. The inspector identified one violation for exceeding the Safe Operating Limit weight of the distillation vaporizer.

O1.2 Removal of Control Room Instruments from Service

a. Inspection Scope (TI2600/003)

The inspector assessed the licensee's procedures and practices for identifying and controlling instruments that were inoperable. The assessment focused on those instruments that were in the FMB control room.

b. Observations and Findings

The inspector reviewed operating logs, interviewed control room personnel, reviewed operating procedures, and performed control board walkdowns in order to verify that the licensee was controlling instruments that were out of service in accordance with plant requirements. The inspector noted that the licensee's procedure required that inoperable control room instruments be identified with an instrument out of service tag and be repaired in a timely manner. The inspector observed that the "B" fluorinator instruments were taped over and not marked with tags. The operators stated that the instruments themselves were fully functional but that the "B" fluorinator had been cut out and removed. The inspector noted that the licensee's procedures did not address what actions should be taken to identify instruments related to equipment that had been removed from service but the instruments were otherwise fully operable.

During discussions with the inspector, control room operators stated that operators also used the Disabled Instrument Log (DIL) to track inoperable instruments. The inspector's review of the DIL determined that there were only nine entries since January 14, 1999, and that the last entry was dated February 2, 2001. The inspector determined that the DIL was no longer used and that the DIL was not required by procedure.

c. Conclusions

The inspector determined that the licensee's removal of control room instruments from service was in accordance with procedures. The inspector also determined that the licensee's procedure failed to address the removal of instruments from service when their associated equipment had been removed for maintenance or modification.

O8 Miscellaneous Operations Issues

O8.1 Miscellaneous Open Item Closures (92701)

- 8.1.1 (Closed) Inspection Followup Item (IFI) 04003392/2001-004-01: Evaluation of uranium hexafluoride (UF₆) smoke detectors as critical equipment. The inspector verified that the licensee had added the UF₆ smoke detectors to the critical equipment list. This item is closed.
- 8.1.2 (Closed) Violation 04003392/1996-007-001: Failure to shut off fluidizing air to the fluorinators. The licensee had completed corrective actions to address the causes for and prevent a recurrence of a release of material. The only portion of the corrective actions not addressed in NRC Inspection Report No. 04003392/1996007 was the performance of a long term review of the structure and guidance in the loss of power procedure. The inspector's review of the fluorination procedure determined that the procedural ambiguity contributing to the release had been corrected. This item is closed.
- 8.1.3 (Closed) IFI 04003392/1997-001-001: Review of license condition regarding two independent methods for determining the amount of UF₆ poured into a cylinder. The IFI was originally written to track the licensee's proposed submittal of a request for clarification regarding the use of the flow totalizer as an independent method for determining the amount of UF₆ added to a cylinder. The licensee had not submitted a request for clarification regarding the flow totalizer. Instead, the licensee had altered the

fill method of the product cylinders. The altered fill method resulted in a more stable flow rate and a consequent reduction in flow totalizer inaccuracies. License condition 13.3.8.14.3 recognized that deviations between the flow totalizer and the load cells could occasionally be expected; however, at the time the IFI was initiated, deviations would occur five or more times per month. Since the altered fill method had been introduced, deviations have occurred once every two or three months. The licensee was evaluating the use of independent load cells to replace the flow totalizers but the project did not have a high priority. This item is closed.

8.1.4 (Closed) Violation 04003392/2001-006-001 and NRC notifications EN 38580, EN 38296, and EN 37320: Failure to implement change process for the use of a temporary standby generator. The licensee's initial response to the Notice of Violation was inadequate in that it was narrowly focused on the failure to log start times. Subsequent licensee responses included corrective actions to counsel the engineer involved in the failure to initiate the change process, e-mail to plant personnel to emphasize the management of change policy, and the use of the lock out/tag out program to help control temporary alterations to the facility. The inspector concluded that the corrective actions were adequate and these items are closed.

8.1.5 (Closed) IFI 04003392/1996-003-001: Licensee's program for accomplishing procedure reviews is weak. The inspector reviewed the Distillation Manual and the Fluorination Manual and verified that the manuals reflected current operating practices as observed in the FMB control room. Since the IFI had been issued several other examples of weak procedure had been identified. Examples included closed violation 04003392/1996-007-001 discussed above and the issue discussed in Section 8.4 of Inspection Report No. 04003392/1997-001. Licensee management had tasked a committee to review all plant manuals and procedures for accuracy and adequacy. The review performed by the committee had been completed in early 1997. No significant problems had been identified since that review had been completed. This item is closed.

III. Plant Support

R2 Status of Radiological Protection Facilities and Equipment

R2.1 Instruments and Equipment

a. Inspection Scope (83822)

The inspector verified the performance of radiation protection instruments and equipment was in accordance with license requirements and licensee procedures.

b. Observations and Findings

The inspector randomly selected instruments of each major type and examined them in order to verify operability and proper alarm settings. The inspector also reviewed calibration records and verified that the selected instruments were within the required calibration frequency.

The inspector accompanied licensee personnel during the routine, weekly retrieval of sampling media in on-site and off-site air monitors. During the change out of the media paper the inspector verified that the air monitors were in good repair and were functioning properly.

The inspector verified that the licensee calibrated the rotometers for regulating sampler air flows for continuous air monitors on a quarterly basis, using a secondary standard rotometer calibrated by a dry test meter. In response to a previous finding, the licensee had committed to a more frequent and regular calibration of the rotometer, and to ensure that the dry test meter was traceable to national standards. The licensee had purchased a new dry test meter with documented traceability.

The inspector toured the facility and observed the status and condition of instrumentation and sampling equipment. Equipment was in good working order and was within the required calibration frequency. Also during the facility tours, the inspector noted that radioactive material, radiation, and airborne radioactivity areas were adequately posted in accordance with the requirements of 10 CFR Part 20. Labeling of radioactive materials and containers were consistent with 10 CFR Part 20, and the exemptions allowed by Part I, Chapter 1, of the license for radioactive materials and containers.

c. Conclusions

The licensee effectively implemented the contamination survey and instrument calibration programs. Equipment was in good working order and within the required calibration frequency. Documentation was maintained supporting the calibration of the equipment.

R4 Staff Knowledge and Performance in Contamination Control

R4.1 Contamination Monitoring

a. Inspection Scope (83822)

The inspector observed employees, visitors, and contractors performing self-monitoring for contamination prior to leaving the Restricted Area.

b. Observations and Findings

Radiological survey instrumentation for exiting the plants restricted area was located by the employee exits and also by the security guard post, where visitors and some employees exited. Survey instrumentation used for exit monitoring was sampled and the inspector verified the instrumentation was within the required calibration frequency. Observations of employee practices for performing self-monitoring indicated that radiological training in the use of radiation detection equipment was adequate. The inspector interviewed several employees at the exit stations and concluded that the employees were familiar with the appropriate actions and procedure to contact HP in a contamination event.

Based on the inspector's observations and interviews of security personnel, the inspector concluded that the HP program for training security personnel on

contamination surveys was effective. The inspector observed security personnel perform routine surveys of several vehicles. Security personnel provided verbal guidance regarding the HP decontamination procedure and oversaw the performance of self-monitoring of delivery persons and visitors to ensure proper self monitoring was performed. In addition, the inspector observed security personnel conducting radiological surveys of vehicles leaving the restricted area. The inspector interviewed selected security personnel and determined that they were knowledgeable in the use of radiation detection equipment and the appropriate procedure to follow in the event of either a personnel or vehicle contamination. In addition, the security personnel were knowledgeable in ensuring that proper exit monitoring was conducted by visitors and employees.

c. Conclusions

Employee and security personnel demonstrated adequate knowledge of contamination monitoring, radiation detection equipment usage, and the appropriate procedure to follow in the event of either a personnel or vehicle contamination. All surveys observed by the inspector were performed in accordance with licensee requirements.

R8 Miscellaneous Radiological Protection and Contamination Control Issues

R8.1 Miscellaneous Open Item Closures (92701)

8.1.1 (Closed) IFI 040-03392/2000-005-02: Repackaging of leaking hard uranium ore concentrate from deteriorated 55-gallon drums. The inspector verified through a review of records and tours of the facility that leaking hard uranium ore concentrate from a sister facility had been repackaged. The licensee had placed the leaking 55-gallon drums into overpacks and had cleaned up the existing spills. The inspector's tour of the storage areas for hard uranium ore concentrate received from another uranium conversion plant verified cleanup activities were completed. This IFI is closed.

8.1.2 (Closed) IFI 04003392/2001-004-02: Improvements in the calibration program for airborne radioactivity measurement instruments. The inspector verified that the licensee had procured instruments which were traceable and that the improvements in the calibration program had been implemented. This IFI is closed.

P2 Status of Emergency Preparedness Facilities, Equipment, and Resources

P2.1 Assessment of Emergency Preparedness Equipment and Facilities

a. Inspection Scope (88050)

The inspector assessed the licensee's emergency equipment and facilities specified in the emergency preparedness program in order to verify they were operable and properly maintained.

b. Observations and Findings

The inspector selectively examined the emergency equipment and kits specified in the emergency plan, including the onsite medical facilities. The inspector verified that the emergency equipment and kits were checked and service at the required intervals and

that proper inventory levels were maintained. All equipment examined was operable and maintained in good condition.

The inspector examined onsite rendezvous areas where personnel would go for given accidents. The inspector determined that the areas were readily accessible and contained adequate communications or other equipment specified in the licensee's emergency plan.

c. Conclusions

The inspector verified that the licensee's emergency equipment and facilities specified in the emergency preparedness program were operable and properly maintained. All equipment examined was operable and maintained in good condition.

P5 Staff Training and Qualification in Emergency Preparedness

P5.1 Assessment of Emergency Preparedness Training

a. Inspection Scope (88050)

The inspector assessed the licensee's emergency preparedness training to verify that the licensee provided training that was consistent with the frequency and performance objectives outlined in the emergency plan.

b. Observations and Findings

The inspector reviewed licensee training records and interviewed personnel to verify that training was provided to licensee personnel to cover the following areas:

- site-specific emergency procedures;
- use of self-contained breathing air packs;
- chemical resistant suits;
- respirators;
- monitoring devices for hazardous materials; and
- fire fighting equipment.

The inspector reviewed licensee fire pre-plans and emergency procedures to verify they were current and reflected special considerations such as the chemical hazards at the facility. All pre-plans and procedures reviewed were current and reflected the appropriate special considerations.

c. Conclusions

The licensee's emergency preparedness training was consistent with the frequency and performance objectives outlined in the emergency plan. All fire pre-plans, training

records, and procedures reviewed by the inspector were current and reflected appropriate special considerations.

P8 Miscellaneous Open Item Closures (92701)

P8.1 (Closed) IFI 04003392/2001-005-03: Implementation of a plant-wide database to track action items. Nuclear Regulatory Commission Inspection Report 04003392/2001-005 identified the lack of a plant-wide database as a weakness in the documentation of action items and associated corrective actions. Nuclear Regulatory Commission Inspection Report 04003392/2001-006 also discussed this item but as the implementation was not yet completed the item was not closed. During this inspection period the inspector verified that a plant-wide database to track open items was being utilized. This item is closed.

VI. Management Meetings

X1. Exit Meeting Summary

The inspector presented the inspection results to a member of the plant staff and management at the conclusion of the inspection on May 10, 2002. 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

- * W. Lessig, Plant Manager
- * H. Roberts, Health Physics Manager
- M. Shephard, Regulatory Affairs Manager
- J. Pratte, Maintenance Manager

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

* Denotes those attending the exit meeting on May 10, 2002.

INSPECTION PROCEDURES USED

IP 88050:	Emergency Preparedness
IP 83822:	Radiation Protection
Temporary Instruction 2600/003:	Operational Safety Review
IP 92701:	Followup

ITEMS OPENED, CLOSED, AND DISCUSSED

<u>Opened:</u>	<u>Type</u>	<u>Summary</u>
04003392/2002-003-001	VIO	Failure to maintain the weight of the UF ₆ vaporizer below the safe operating limit of less than 12,000 pounds.

Closed:

04003392/1996-003-001	IFI	Review distillation procedure.
04003392/1996-007-001	VIO	Failure to shut off bed fluidizing air.
04003392/1997-001-001	IFI	Lack of clarity in what constitutes two independent methods for determining cylinder fill.
EN37320	LER	NRC Report regarding the failure of the standby generator to start.
04003392/2000-005-002	IFI	Address breaching natural uranium ore from 55-gallon drums.
04003392/20001-004-002	IFI	Track improvements in the licensee's calibration program.
04003392/20001-004-001	IFI	Evaluation of UF ₆ smoke detectors as critical equipment.
04003392/20001-005-003	IFI	Implementation of a plant wide database to track action items.
EN38296	LER	NRC Report regarding the failure of the standby generator to start.
04003392/20001-006-001	VIO	Failure to implement PT-101 modification for the use of the temporary standby generator.
EN38580	LER	NRC Report regarding the failure of the standby generator to start.

Discussed:

None

LIST OF ACRONYMS USED

ADAMS	Agencywide Document Access and Management System
ALARA	As-Low-As-Reasonably-Achievable
CFR	Code of Federal Regulations
D/G	Diesel Generator
DIL	Disabled Instrument Log
DNMS	Division of Nuclear Material Safety
FMB	Feed Materials Building
HP	Heath Physics
IFI	Inspection Followup Item
IP	Inspection Procedure
LER	Licensee Event Report
NRC	Nuclear Regulatory Commission
PARS	Publicly Available Records
PDR	Public Document Room
PERR	Public Electronic Reading Room
UF ₆	Uranium Hexafluoride
VIO	Violation