February 27, 2003

Mr. Rory J. O'Kane
Plant Manager
Honeywell Specialty Chemicals
P.O. Box 430
Metropolis, IL 62690

SUBJECT: NRC INSPECTION REPORT 04003392/2003-001(DNMS) AND NOTICE OF VIOLATION - HONEYWELL

Dear Mr. O'Kane:

On February 6, 2003, the NRC completed a routine inspection at the Honeywell Specialty Chemicals 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 on February 6, 2003, the NRC inspector discussed the findings with members of your staff.

The inspection consisted of an examination of activities conducted under the license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of the license. 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, observations of activities in progress, and interviews with personnel.

Based on the results of this inspection, the NRC has determined that one cited violation of regulatory requirements occurred. The violation is cited in the enclosed Notice of Violation (Notice), and the circumstances surrounding the violation are described in the enclosed inspection report. The violation involved a failure to conduct an annual radiation protection program audit, by an individual from outside the plant staff, in calendar year 2002.

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 will be made available electronically for public inspection in the NRC Public Document Room or from the NRC's document system (ADAMS), accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html. To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information so that it can be made available to the Public without redaction.

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

Sincerely,

/RA/

Kenneth G. O'Brien, Chief
Fuel Cycle Branch

Docket No. 04003392
License No. SUB-526

Enclosures: Notice of Violation
Inspection Report 04003392/2003-001(DNMS)

cc w/encls: Gary Wright, Illinois Department of Nuclear Safety

Distribution w/encls:
Docket File
PUBLIC IE-07
M. Raddatz, NMSS
M. Leach, NMSS
W. Schwink, NMSS
J. L. Caldwell, RIII
M. L. Dapas, RIII
RIII Enf. Coordinator
R. Bellamy, RI
D. Ayres, RII
D. B. Spitzberg, RIV

DOCUMENT NAME: G:\SEC\HON2003-001.WPD
To receive a copy of this document, indicate in the box:"**C**" = Copy without enclosure "**E**"= Copy with enclosure"**N**"= No copy

OFFICE	RIII		RIII		RIII			
NAME	Hartland		Berg		O'Brien			
DATE	02/27/03		02/27/03		02/27/03			

OFFICIAL RECORD COPY

NOTICE OF VIOLATION

Honeywell Specialty Chemicals
Metropolis, Illinois

Docket No. 04003392
License No. SUB-526

During an NRC inspection conducted February 3 through 6, 2003, 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, authorized, in part, the use of licensed materials in accordance with the statements, representations, and conditions in Chapters 1 through 7 of the license application.
>
> Chapter 2, Section 2.7, of the license, “Internal Audits and Inspections,” required, in part, that an annual radiation protection program audit be conducted by an individual from outside the plant staff.
>
> Contrary to the above, an annual radiation protection program audit, by an individual from outside the plant staff, was not conducted in calendar year 2002.
>
> 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 27th day of February 2003.

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket No.	04003392
License No.	SUB-526
Report No.	04003392/2003-001(DNMS)
Licensee:	Honeywell International, Inc.
Facility:	Metropolis Works
Location:	P. O. Box 430 Metropolis, IL 62960
Dates:	February 3 through 6, 2003
Inspector:	David J. Hartland, Senior Resident Inspector Portsmouth Gaseous Diffusion Plant
Approved By:	Kenneth G. O'Brien, Chief Fuel Cycle Branch Division of Nuclear Materials Safety

EXECUTIVE SUMMARY
Honeywell International, Inc
NRC Inspection Report 04003392/2003-001(DNMS)

This inspection included aspects of the licensee's operations and radiation protection programs and review of follow-up issues identified during previous inspection reports.

Operations

- The inspector observed that operations were conducted in accordance with the applicable procedures for the specific tasks being performed. Operators were knowledgeable of safe operating parameters, and plant management provided effective oversight of ongoing activities. The inspectors also verified that plant staff was implementing the plant modification process as appropriate. (Section O1.1)

Radiation Protection

- The inspector concluded that the internal dosimetry program was being effectively implemented in accordance with license conditions and 10 CFR Part 20. However, the inspector identified an unresolved item with the effectiveness of the As-Low-As-Reasonably-Achievable (ALARA) Committee in identifying and reversing an apparent adverse trend regarding an increase in personnel whole body exposure. (Section R1.1)

- The inspector concluded that the licensee was effectively implementing the contamination survey program. However, the inspector identified an issue regarding the effectiveness of controls for alerting personnel prior their to entering areas requiring respirators, as well as a need for the licensee to implement such controls prior to initiating activities having a high potential for causing positive air samples. The inspector also identified an unresolved item regarding the licensee's calibration methodology for portable survey instruments. (Section R1.2)

- The inspector concluded that the ALARA Committee's meeting frequency, participation, and internal audits were in accordance with license requirements. However, the inspector identified a violation in that a required annual radiation protection program audit was not conducted, by an individual from outside the plant staff, in calendar year 2002. (Section R1.3)

Report Details

I. Operations

01.1 Conduct of Operations

a. Inspection Scope (TI 2600/003)

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

- cylinder disconnect, weighing, and storage; and
- FMB and control room operations.

b. Observations and Findings

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

The inspector verified that safety controls required by Section 1.5.1 of the license were functional during the filling and handling of liquid uranium hexafluoride (UF_6) cylinders. The safety controls included the use of two separate load cells to monitor cylinder weight during the filling process. In addition, the inspector verified that a separate flow totalizer was used to determine when the cylinder was filled to the plant administrative limit.

The inspector also observed the switching of scrubber trains, an activity that required the fluorination system to be removed from service. The inspector verified that operators appropriately locked out and tagged out equipment, as necessary, manipulated components in accordance with procedural requirements, and returned the fluorination system to service without incident.

During facility tours, the inspector observed housekeeping practices. The inspector noted that the floors of the FMB were clear of obstructions and appeared generally clean.

The inspector also reviewed a sample of appropriation requests. These requests were required for equipment or new installations that exceeded $1000. The inspector verified that Procedure PT-101, “Process Modifications,” was implemented as required by Section 8.8 of the license for those requests that resulted in changes to equipment or processes that potentially impacted safe operations.

c. Conclusions

The inspector observed that operations were conducted in accordance with the applicable procedures for the specific tasks being performed. Operators were knowledgeable of safe operating parameters, and plant management provided effective oversight of ongoing activities. The inspector also verified that plant staff was implementing the plant modification process as appropriate.

O8 Miscellaneous Operations Issues

O8.1 (Closed) IFI 04003392/98001-01: Revisions to the distillation manual to incorporate various smoke alarm window indicators and the expected alarm conditions in the FMB control room. The inspector verified that the revisions to the manual were completed, and this item is closed.

O8.2 (Closed) IFI 04003392/98006-04: Upgrades to the FMB control room monitors and cameras. The inspector verified that video monitors in the FMB that monitored critical liquid UF_6 transfer areas for potential releases had been upgraded and were providing a clear view of affected areas in the control room. The inspector had no further concerns, and this item is closed.

O8.3 (Closed) IFI 04003392/99001-01: Implementation of operations training, annual personnel testing for critical units, and critical procedure checklist programs. The inspector verified that the plant staff had appropriately identified all of the critical procedures, as defined in the operations manuals, and had completed checklists for those procedures. The inspector also verified that the plant staff had implemented an enhanced operations training program which included annual personnel testing for critical units. The inspector had no further concerns, and this item is closed.

O8.4 (Closed) VIO 04003392/2000005-01: Failure to perform required testing on the UF_6 ME-12 cylinder hauler. As immediate corrective action, the plant staff affixed a maintenance “inspection sticker” to the hauler windshield that indicated the due date of the scheduled maintenance inspections. In addition, the plant staff also stenciled a personnel reminder on each outside cab door and on the inside of the cab which stated that the hauler was not to be operated if inspections were not current. A locking device was to be utilized by the maintenance staff to ensure that the hauler was not removed from the shop and placed in service before completion of the required inspections. Inspection cards were also revised to verify installation of the inspection sticker. The inspector verified completion of the corrective actions and that the required inspections had been completed. This item is closed.

O8.5 (Closed) VIO 04003392/2002003-01: Operators exceeded the safe operating limit for the UF_6 vaporizer weight. The plant staff determined that the violation occurred due to a vapor lock that formed when excess heat was applied during the system start-up. As corrective action, due to the available safety margin, applicable procedures were revised to change affected operational limits from “safe” to “normal.” In addition, procedures were also revised to require operators to take immediate steps to bring conditions back to the normal operating range when these conditions were exceeded. The operators were also required to obtain a temporary process modification if there was a valid reason to exceed a normal operating limit for an extended period of time. The inspector verified the procedure revisions and had no further concerns. This item is closed.

O8.6 (Closed) Event Report No. 36327: Plant fire water deluge system rupture. Repairs to the affected piping were completed in a timely manner. The event did not result in the release of hazardous materials. The inspector had no further concerns, and this item is closed.

O8.7 (Closed) Event Report No. 35646: Failure to have redundant safety equipment available due to loss of power to health physics (HP) vacuum pumps and radiation warning lights. As corrective action, a memo was issued to the production and maintenance departments requiring these departments to notify the HP department of planned maintenance on the standby power system so that appropriate compensatory actions could be taken. The inspector had no further concerns, and this item is closed.

O8.8 (Closed) Event Report No. 38198: Small UF_6 release during a maintenance evolution in the FMB. The plant staff determined that the root cause was that operators did not close the isolation valves with sufficient torque. In addition, the plant staff determined that a line used to maintain a vacuum during the maintenance evolution was partially restricted. As corrective action, instructions were issued to require the use of a valve wrench to ensure that isolation valves were fully seated. In addition, the plant staff revised applicable procedures to provide a means for verifying that UF_6 lines were not under pressure prior to opening the affected systems. The inspector had no further concerns, and this item is closed.

III. Radiation Protection

R1.1 Internal and External Exposure Monitoring Programs

a. Inspection Scope (83822)

The inspector reviewed the plant's internal and external exposure monitoring programs and current bioassay and exposure data for plant personnel.

b. Observations and Findings

Section 3.2.5 of the license established two administrative action levels for routine or special uranium bioassay exposure results. The limits were 15 and 60 micrograms of uranium per liter (μg/L). Bioassay results greater than the 15 μg/L limit required re-sampling. Bioassay results in excess of 60 μg/L required an investigation and an intake restriction evaluation, in addition to daily re-sampling until bioassay results returned to levels below 15 μg/L.

The inspector reviewed investigation reports of bioassay results that exceeded 60 μg/L during calendar year 2002. The inspector determined that the investigations were thorough and extensive in determining the root cause of the uptakes. In all cases, the investigation results showed that the intakes were less than the toxicity limit for soluble uranium of 10 milligrams/week as required by 10 CFR 20.1201(e).

The inspector also reviewed the licensee's whole body exposure data for plant personnel. In addition to the bioassay program, each employee was issued a thermal luminescent dosimeter (TLD) whole-body badge. The TLDs were read on a quarterly basis for all salaried employees and monthly for hourly employees.

Section 11.3 of the license stated that historical data and plant operating experience indicated that employees were unlikely to receive an annual whole body exposure of more than 500 millirem. Table A-1 indicated that 35 exposures of more than 500 millirem had been measured during the five years of plant operation between 1989 and 1993, including two exposures in excess of one Rem. However, during 2000 and 2001, a total of 121 exposures of more than 500 millirem were measured, including 17 exposures in excess of one Rem in calendar year 2001.

Section 11.11 of the license required that the As-Low-As-Reasonably-Achievable (ALARA) Committee perform a detailed evaluation of personnel exposures to identify undesirable trends. An investigation could then be utilized in reversing significant increases observed in the exposure trend analyses. The inspector's further review of the effectiveness of the ALARA Committee in identifying and reversing an apparent adverse trend regarding an increase in personnel whole body exposure is an unresolved item. (URI 04003392/2003001-01).

c. Conclusions

The inspector concluded that the internal dosimetry program was being effectively implemented in accordance with license conditions and 10 CFR Part 20. However, the inspector identified an unresolved item with the effectiveness of the ALARA Committee in identifying and reversing an apparent adverse trend regarding an increase in personnel whole body exposure.

R1.2 Radiological Surveys and Survey Instrumentation

a. Inspection Scope (83822)

The inspector reviewed records of daily, weekly and monthly contamination surveys. The inspector also reviewed records of instrument calibrations.

b. Observations and Findings

The inspector noted that routine facility contamination surveys were being performed in accordance with the frequency and action levels specified in the license. Also during the facility tours, the inspector noted that radioactive material and radiation areas were adequately posted in accordance with the requirements of 10 CFR Part 20.

On February 5, 2003, while observing ongoing activities, the inspector, health physics (HP) staff, and operations personnel inadvertently entered an area requiring respiratory protection on the fourth floor of the FMB. The plant staff had previously activated the respirator lights for that floor as a precautionary measure after filters from fixed area samplers had readings in excess of 30 percent of the derived air concentration (DAC) for uranium. The individuals accompanying the inspector did not see that the lights had been activated until they were leaving the area. In response, the HP staff counted the filter on the air sampler in the immediate area where the individuals were located and determined that airborne levels were not exceeded. The source of the elevated airborne levels was in another area of the room.

Section 11.9, "Respiratory Protection," of the license required, in part, that respirators shall be worn in areas for which measured air concentrations of uranium exceed 30

percent of the DAC for uranium. Although the failure on February 5, 2003, to wear respirators on the fourth floor of the FMB was corrected, it constituted a violation of minor significance that was not subject to enforcement action in accordance with Section IV of the NRC's Enforcement Policy.

During follow-up, the inspector determined that the source of the airborne radioactivity was a result of cleaning a "mudballer," where ore concentrates were blended and agglomerated to obtain the optimum size for fluid bed operations. The HP staff indicated it was not unusual for airborne levels to exceed administrative limits during performance of this activity. The inspector then questioned why the respirator lights for the floor were not activated prior to beginning the activity rather than waiting for a positive air sample to be received. The inspector verified that the individuals performing the maintenance activity were required to wear respiratory protection by the radiation work permit.

The inspector also questioned whether the existing controls for preventing personnel from entering an area where respiratory protection was required, namely the lights, were sufficient. The plant staff determined that some enhancements were needed and, as an immediate action, intended to post entry points into those areas to alert personnel. The licensee's efforts to develop enhanced controls for alerting personnel prior to their entering areas requiring a respirator, including activating such controls prior to initiating activities having a high potential for causing positive air samples, will be tracked as an inspector follow-up item. (IFI 004003392/2003001-02)

The inspector noted that the frequency of calibration and instrumentation operability was adequately tracked by the HP staff. During facility and HP laboratory tours, the inspector observed that survey instruments in use were operational and within the current calibration period. The inspector noted that the HP staff performed a monthly calibration check of survey instruments used to by personnel to monitor for contamination prior to leaving the site. The monthly check consisted of the staff's calculating instrument efficiency using a uranium-238 source and adjusting the alarm setpoint to 1000 dpm/100 cm^2.

The inspector noted that, although the licensee's calibration frequency was consistent with license requirements, the methodology was not consistent with typical industry standards, including ANSI N323A-1997, "American National Standard Radiation Protection Instrumentation Test and Calibration, Portable Survey Instruments." The licensee did not perform daily source checks to ensure proper operation of the instruments between calibrations. In addition, the licensee did not perform annual calibrations involving the adjustment of the instruments relative to a series of conventionally true values for radiation sources (multiple points/scales), which would have included documented as-found readings. The inspector's further review of the licensee's calibration methodology in relation to industry standards is an unresolved item. (URI 04003392/2003001-03)

c. Conclusions

The inspector concluded that the licensee was effectively implementing the contamination survey program. However, the inspector identified an issue regarding the effectiveness of controls for alerting personnel prior their to entering areas requiring respirators, as well as a need for the licensee to implement such controls prior to

initiating activities having a high potential for causing positive air samples. The inspector also identified an unresolved item regarding the licensee's calibration methodology for portable survey instruments.

R1.3 Audits and Committees

a. Inspection Scope (83822)

The inspectors reviewed the ALARA Committee's meeting agendas, meeting frequency, and meeting attendees for compliance with the requirements established in Chapter 2.3 of the license. The inspectors also reviewed audits and inspections for compliance with Chapter 2.7 of the license.

b. Observations and Findings

Chapter 2.3 of the license application required, in part, that an ALARA Committee shall be utilized by management to ensure that exposures and effluent releases were effectively controlled. The inspector reviewed meeting minutes for 2002 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 illustrated radiation exposures to workers and the closest resident and uranium losses to the environment.

The inspector noted that the licensee was in compliance with the requirements specified in Chapter 2.3 of the license regarding meeting frequency and participation. However, the inspector identified an issue regarding effectiveness of the ALARA Committee in identifying and addressing an apparent adverse trend in whole body personnel exposure as discussed in Section R1.1 of this report.

The inspector also verified that the HP department was performing formal audits of plant operations involving source materials, as required by Chapter 2.7 of the license, to determine compliance with regulations, license conditions, and licensee procedures. The audits were conducted quarterly, with all areas involving source materials reviewed annually. Periodic audits of the HP department were also performed by the Management Assurance organization. Findings and deficiencies from the audits were documented in formal reports to plant management.

The inspector noted that an annual radiation protection audit to be conducted by an individual from outside the plant staff, as required by Chapter 2.7 of the license, was not performed in calendar year 2002. Plant staff submitted a change to the license in

November 2002 to make the requirement optional, but the change did not become effective until January 30, 2003.

License Condition 10 of Source Materials License SUB-526, Amendment 14, authorized, in part, the use of licensed materials in accordance with the statements, representations, and conditions, in Chapters 1 through 7 of the license application. Chapter 2, Section 2.7 of the license, "Internal Audits and Inspections," required, in part, that an annual radiation protection program audit be conducted by an individual from outside the plant staff. Contrary to the above, an annual radiation protection program audit was not conducted by an individual from outside the plant staff in calendar year 2002. This is a violation. (VIO O4003392/2003001-04)

c. Conclusions

The inspector concluded that the ALARA Committee's meeting frequency, participation, and internal audits were in accordance with license requirements. However, the inspector identified a violation in that a required annual radiation protection program audit was not conducted, by an individual from outside the plant staff, in calendar year 2002.

R8 Miscellaneous Plant Support Issues

R8.1 (Closed) VIO 04003392/98006-02: Failure to conduct immediate decontamination activities of visible accumulation of uranium on various pieces of process equipment and floor areas in the FMB. As corrective action, plant staff revised an HP procedure, "Contamination Control," to require a visual inspection by the FMB foreperson and the HP department following a spill or release to determine if immediate decontamination is required. The inspector verified that the procedure was revised, and this item is closed.

R8.2 (Closed) IFI 04003392/99003-01: Development of a written management assurance program. The inspector verified that a written document was developed that involved the specific elements of a management assurance program, and this item is closed.

R8.3 (Closed) VIO 04003392/2001003-01: Failure to submit complete nuclear material transaction reports by the close of business of the next working day for shipments leaving the facility as required by 10 CFR 40.64. As corrective action, applicable plant staff were trained on all responsibilities necessary for filing the necessary reports in the required time frame. The inspector determined that nuclear material transaction reports were being submitted as required and had no further concerns. This item is closed.

R8.4 (Closed) VIO 04003392/2002004-01: Failure to submit semi-annual effluent monitoring report as required by 10 CFR 40.65. As corrective action, the plant secretary will follow up with a computer reminder flagging the due date for reports required by the license to be submitted to the NRC. The inspector determined the corrective actions had been implemented and that recent reports had been submitted as required. The inspector had no further concerns, and this item is closed.

R8.5 (Closed) 10 CFR Part 20 Written Report: On August 7, 2000, the plant staff reported a potential intake in excess of the weekly limit (10 milligrams) for Class "D" uranium. As a follow-up, the plant staff determined that the employee's urinary excretion data did not fit any known curve for bioassay modeling for an acute exposure and that a chronic

inhalation did not occur due to employee work restrictions. Therefore, the plant staff determined that the urine samples were contaminated, and the employee did not exceed the weekly 10 milligram uranium intake limit. The inspector agreed and had no further concerns. This item is closed.

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 February 6, 2003. 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

* P. Bryan, Nuclear Services Leader
* M. Davis, Health Physics Supervisor
* M. Ginzel, Health Physics Manager
* D. Mays, Safety Manager
* M. Shepherd, Environmental and Regulatory Affairs Manager

* Denotes those present at the exit meeting on February 6, 2003.

INSPECTION PROCEDURES USED

TI 2600/003	Operational Safety Review
IP 83822	Radiation Protection

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened:

04003392/2003001-01	URI	Inspector review of the effectiveness of the ALARA Committee in identifying and reversing an apparent significant increase in personnel whole body exposure.
04003392/2003001-02	IFI	Inspector review of the licensee's efforts to enhance controls for alerting personnel prior to entering areas requiring a respirator, as well activating such controls prior to initiating activities having a high potential for causing positive air samples to be received.
04003392/2003001-03	URI	Inspector review of the licensee's calibration methodology in relation to industry standards.
04003392/2003001-04	VIO	An annual radiation protection program audit was not conducted by an individual from outside the plant staff in 2002 as required by license requirements.

Closed:

04003392/98001-01	IFI	Revisions to the distillation manual to incorporate various smoke alarm window indicators and the expected alarm conditions in the FMB control room.
04003392/98006-02	VIO	Failure to conduct immediate decontamination activities of visible accumulation of uranium on various pieces of process equipment and floor areas in the FMB.
04003392/98006-04	IFI	Upgrades to the FMB control room monitors and cameras.
04003392/99001-01	IFI	Implementation of operations training, annual personnel testing in critical units, and critical procedure checklist programs.
04003392/99003-01	IFI	Development of a written management assurance program.
04003392/2000005-01	VIO	Failure to perform required testing on the UF_6 ME-12 cylinder hauler.
04003392/2001003-01	VIO	Failure to submit complete Nuclear Material Transaction reports by the close of business the next working day for shipments leaving the facility as required by 10 CFR 40.64.
04003392/2002003-01	VIO	Operators exceeded the safe operating limit for the UF_6 vaporizer weight
04003392/2002004-01	VIO	Failure to submit semi-annual effluent monitoring report as required by 10 CFR 40.65.
36327	LER	Plant fire water deluge system rupture.
35646	LER	Failure to have redundant safety equipment available due to loss of power to HP vacuum pumps and radiation warning lights.
38198	LER	Small UF_6 release during a maintenance evolution in the FMB.
10 CFR Part 20 Written Report		On August 7, 2000, plant staff reported a potential intake in excess of weekly limit (10 mg) for Class “D” uranium.

Discussed:

None

LIST OF ACRONYMS USED

ADAMS	Agency Document Access and Management System
ALARA	As Low As Reasonably Achievable
ANSI	American National Standards Institute
CFR	Code of Federal Regulations
DAC	Derived Air Concentration
DNMS	Division of Nuclear Material Safety
FMB	Feed Materials Building
HP	Heath Physics
IFI	Inspector Follow-up Item
IP	Inspection Procedure
NRC	Nuclear Regulatory Commission
PARS	Publicly Available Records
TI	Temporary Instruction
TLD	Thermal Luminescent Dosimeter
UF_6	Uranium Hexafluoride
μg/L	micrograms per liter
URI	Unresolved Item
VIO	Violation