UNITED STATES NUCLEAR REGULATORY COMMISSION OFFICE OF NUCLEAR MATERIAL SAFETY AND SAFEGUARDS WASHINGTON, D.C. 20555-0001

July 31, 1997

NRC INFORMATION NOTICE 97-58: MECHANICAL INTEGRITY OF IN-SITU LEACH INJECTION WELLS AND PIPING

Addressees

Holders of and Applicants for Licenses for In-Situ Leach Facilities.

Purpose

The U.S. Nuclear Regulatory Commission (NRC) is issuing this information notice to alert licensees to leaks related to faulty coupling and configuration of piping at in-situ leach facilities. Recipients should review the information notice for applicability to their facilities and consider actions, as appropriate, to prevent similar problems. However, recommendations contained in this information notice are not NRC requirements; therefore, no specific action or written response is required.

Description of Circumstances

In one case, an injection well (IW) leak, detected during routine 5-year mechanical integrity testing (MIT), caused an excursion above the ore zone. In a separate incident, a failure occurred in an injection trunk line, resulting in a spill of barren lixiviant.

1. IW Leak:

A leak in an IW was detected during routine 5-year MIT work. Further testing identified a faulty coupling 12 meters (40 feet) below the ground as the source of the leak. Initial operation of the leaking IW occurred from March 1992 to September 1994. The well was then dormant from October 1994 to October 1995. A lixiviant re-circulation, using extraction water that had not passed through the ion exchange facility, was initiated in November 1995 and lasted until January 1996. The well was then dormant until the MIT of March 1996.

After the MIT results, a monitoring well (air drilled) was installed to the proper depth interval to monitor around the IW for groundwater contamination in the shallow fresh water aquifer. An excursion was detected in a monitoring well, 3 meters (10 feet) from the IW. The sample from this well had a conductivity of 5540 uMho/cm and 27.6 ppm uranium oxide ($\rm U_3O_8$). Normal aquifer conductivity is 300 Umho/cm. Pursuant to conditions in the license agreement, the licensee informed NRC of the excursion within 24 hours of detection. Additional shallow monitoring wells were installed around the IW to

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begin delineation of the excursion. Monitoring wells 30 to 42 meters (100 to 138 feet) from the IW were at normal background levels for conductivity and uranium concentrations.

The licensee is taking corrective action by pumping the contaminated shallow monitoring wells to recover the excursion. The effectiveness of the fluid recovery operation will be monitored by weekly sampling of the contaminated shallow monitoring wells and the shallow monitoring wells outside the excursion limits. These weekly groundwater samples will be analyzed for sodium, chloride, sulfate, alkalinity, and conductivity. The licensee has concluded that a pressure buildup, caused by the downhole oxygen (O₂) injection system, led to the loss of integrity at the casing coupling in the IW, and that minor excursions occurring in other IWs have similar causes. The licensee plans to remove the O₂ stingers from injection wells.

2. Trunk Line Failure:

A leak was detected in a primary injection trunk line which supplies barren lixiviant to the well fields. The trunk line system consists of two 30-cm (12-in) diameter high density polyethylene buried lines (one injection line, one recovery line) that carry lixiviant to and from the plant to the various well fields. The failure consisted of a separation at a fusion weld, where a 30-cm to 20-cm (12-in to 8-in) short reducer was welded onto the 30-cm (12-in) line.

The licensee believes the failure of the fusion weld was caused by the configuration of the line reducer and 90-degree tee at this point in the system. The full injection flow placed a large stress on the short reducer, before making the 90-degree turn toward the well fields. The trunk line has been repaired, with the 90-degree tee replaced with a 30-cm (12-in) steel elbow with threaded ends and a gentler bend. An investigation of the trunk line systems found this configuration, where the failure occurred, unique.

Discussion

The licensees are addressing corrective action and cleanup for these incidents pursuant to clean-up and restoration license conditions and/or site procedures. No new NRC requirements have been established for the involved licensees or other licensees as a result of these incidents. Excursions from losses of mechanical integrity in wells are generally preventable since they are often manifested by structural weaknesses induced by improper well construction. Licensees with similar IW arrangements should be aware that more frequent integrity testing may be necessary to prevent this type of excursion in the future. Likewise, licensees should avoid piping configurations similar to the 90-degree bend in the trunk line. The staff plans to thoroughly review data associated with similar piping/injection arrangements at other licensee facilities during future inspections.

This information notice requires no specific action or written response. If you have any questions about the information in this notice, please contact the technical contact listed below.

(original signed by)

John T. Greeves, Director Division of Waste Management Office of Nuclear Material Safety and Safeguards

Technical contact: J. Robert Tinsley, NMSS

(301) 415-6251 E-mail: jrt1@nrc.gov

Attachments:

1. List of Recently Issued NMSS Information Notices

2. List of Recently Issued NRC Information Notices

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DATE	7/02/97	7/02/97	7/02/	97 7/06/97	723/97

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LIST OF RECENTLY ISSUED NMSS INFORMATION NOTICES

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Date of Notice No.	Subject	Issuance	Issued to
97-57	Leak Testing of Packaging Used in the Transport of Radioactive Material	07/30/97	Suppliers and users of packaging for the transportation of radioactive material required to perform packaging leak tests
97-56	Possession Limits for Special Nuclear Material at the Environcare of Utah Low-Level Radioactive Waste Disposal Facility	07/28/97	All licensees authorized to possess special nuclear material
97-55	Calculation of Surface Activity for Contaminated Equipment and Materials	07/23/97	All Uranium Recovery Licensees
97-51	Problems Experienced with Loading and	07/11/97	All holders of OLs or CPs for nuclear power reactors
	Unloading Spent Nuclear Fuel Storage and Trans- portation Casks		Designers and fabricators of independent spent fuel storage installations
			All holders of or applicants for licenses to operate ISFS
97-50	Contaminated Lead Products	07/10/97	All U.S. Nuclear Regulatory Commission licensees
97-47	Inadequate Puncture Tests for Type B Packages Under 10 CFR 71.73(c)(3)	06/27/97	All "users and fabricators" of type B transportation packages [as defined in 10 CFR 171.16(10(B)]

Attachment 2 IN 97-58 July 31, 1997 Page 1 of 1

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97-55	Calculation of Surface Activity for Contaminated Equipment and Materials	07/23/97	All Uranium Recovery Licensees
97-54	NRC Licensed Operators at Six Non-Power Reactor Facilities Allow their Operator Licenses to Expire	07/18/97	All holders of OLs or CPs for test and research reactors and all licensed operators at test and research reactor facilities
97-53	Circuit Breakers Left Racked Out in Non-Seismically Qualified Positions	07/18/97	All holders of OLs or CPs for nuclear power reactor
97-52	Inadvertent Loss of Capability for Emer- gency Core Cooling System Motors	07/17/97	All holders of OLs or CPs for nuclear power reactor

OL = Operating License CP = Construction Permit

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John T. Greeves, Director
Division of Waste Management
Office of Nuclear Material Safety
and Safeguards

CONTACT: J. Robert Tinsley, NMSS (301) 415-6251

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outside the excursion limits. These weekly groundwater samples will be analyzed for sodium, chloride, sulfate, alkalinity, and conductivity. The licensee has concluded that a pressure buildup, caused by the downhole oxygen (O₂) injection system, led to the loss of integrity at the casing coupling in the IW, and that minor excursions occurring in other IWs have similar causes. The licensee plans to remove the O₂ stingers from injection wells.

2. Trunk Line Failure:

A leak was detected in a primary injection trunk line which supplies barren lixiviant to the well fields. The trunk line system consists of two 30-cm (12-in) diameter high density polyethylene buried lines (one injection line, one recovery line) that carry lixiviant to and from the plant to the various well fields. The failure consisted of a separation at a fusion weld, where a 30-cm to 20-cm (12-in to 8-in) short reducer was welded onto the 30-cm (12-in) line.

The licensee believes the failure of the fusion weld was caused by the configuration of the line reducer and 90-degree tee at this point in the system. The full injection flow placed a large stress on the short reducer, before making the 90-degree turn toward the well fields. The trunk line has been repaired, with the 90-degree tee replaced with a 30-cm (12-in) steel elbow with threaded ends and a gentler bend. An investigation of the trunk line systems found this configuration, where the failure occurred, unique.

Discussion

The licensees are addressing corrective action and cleanup for these incidents pursuant to clean-up and restoration license conditions and/or site procedures. No new NRC requirements have been established for the involved licensees or other licensees as a result of this incident. Excursions from losses of mechanical integrity in wells are generally preventable since they are often manifested by structural weaknesses induced by improper well construction. Licensees with similar IW arrangements should be aware that more frequent integrity testing may be necessary to prevent this type of excursion in the future. Likewise, licensees should avoid piping configurations similar to the 90-degree bend failure. The staff plans to thoroughly review data associated with similar piping/injection arrangements at other licensee facilities during future inspections.

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The licensee has concluded that a pressure buildup, caused by the downhole oxygen (O_2) injection system, led to the loss of integrity at the casing coupling in the IW, and that minor excursions occurring in other IWs have similar causes. The licensee plans to remove the O_2 stingers from injection wells.

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