40-8964

POWER RESOURCES

Smith Ranch - Highland
Uranium Project
P. O. Box 1210
Glenrock, Wyoming USA 82637
Casper: 307-235-1628
Douglas: 307-358-6541
Fax: 307-358-4533

July 30, 2004

Mr. Lowell Spackman, Acting District 1 Supervisor
Land Quality Division
Wyoming Department of Environmental Quality
Herschler Building
122 West 25th Street
Cheyenne, WY 82002

RE: Permit to Mine No. 633
Smith Ranch Uranium Project
In Situ Uranium Wellfield Release Report

Dear Mr. Spackman:

As reported via email to Mr. Steve Ingle of the Land Quality Division and Mr. John Lusher, NRC Project Manager, on July 23, 2004, Power Resources, Inc. (PRI) had a release of Production Fluid at the Smith Ranch Uranium Project in Converse County, Wyoming. The release was detected on July 22, 2004 in the Mine Unit 4, Headerhouse 1 area. The release occurred when a corroded metal fitting on a 14-inch Production Pipeline leaked fluid. The fitting was at a Valve Station contained within an inverted culvert (manhole). The concentrations of uranium, selenium, and radium in the Production Fluid are above background levels, however the fluid is not considered hazardous material under RCRA, and is not reportable under SARA.

In accordance with Chapter IV, Section 4(a)(iv) of the Water Quality Division rules and Regulations, attached is a report describing the release and the steps taken to prevent recurrence of this nature.

Please call if you have any questions.

Sincerely,

W.F. Kearney
Manager-Health, Safety
& Environmental Affairs

WFK

Cc: John Lusher-NRC Project Manager
M.D. Bryson File 4.3.3.1
R. Knode
File 4.6.4.2
J. Tremel
File 4.6.4.4

LIMS501

Attachment

Power Resources, Inc
Smith Ranch-Highland Uranium Project
URANIUM IN SITU WELLFIELD FLUID RELEASE REPORT

PIPELINE FITTING FAILURE HEADERHOUSE 4-1 VALVE STATION

A. DESCRIPTION OF THE EVENT AND MITIGATIVE ACTIONS TAKEN

On July 22, 2004 at approximately 10:00 am, personnel discovered a Production Fluid leak inside Mine Unit 4 near Headerhouse 4-9. The release occurred when a carbon steel fitting on the Production pipeline failed at the Valve Station that connects the headerhouse to the Main Trunk Line. The Main Trunk Line was immediately shut down and repairs were completed.

The Valve Station consists of a large culvert placed vertically in the ground around the pipeline with an entrance on the top. Most of the spill was contained in the culvert. However, an estimated 2700 to 5000 gallons of Production Fluid overflowed on to the ground. The released fluid flowed approximately 500 feet where it then soaked into the ground. Approximately 200 gallons was recovered with the Vac Truck from a small depression. The fluid that remained contained in the culvert was also recovered. Some of the fluid did enter a small, broad and grassed ephemeral drainage where no natural water was present.

The approximate uranium concentration of the Production Fluid was 11 mg/l. The entire area will be reevaluated during the decommissioning of the wellfield to ensure that applicable decommissioning standards for soils are met. Although no adverse impacts are expected due to the small quantity of fluid involved, soil samples were obtained at two locations within the wetted area and at an adjacent background site. The samples will be analyzed for uranium, radium-226 and selenium.

The release occurred in the NW ¼, SW ¼, Section 35, T36N, R74W and affected approximately 0.6 acres. The exact location and extent of the spill and the locations of the soil samples are shown on the attached map.

B. CAUSE OF THE RELEASE AND THE STEPS TAKEN TO PREVENT RECURRANCE

Cause

The release occurred when a carbon steel fitting on the Production Pipeline located inside the Valve Station failed. Investigation showed that the cause of the failure was due to corrosion of the fitting. The cause for this release was similar to that which occurred on May 3, 2004 at the Headerhouse 4-1 area.

Recurrence Prevention

The fitting was replaced with stainless steel and the pipeline was placed back into service. All Valve Stations at Smith Ranch Project wellfields were inspected to assess whether any similar equipment existed. Any fittings that were found were replaced with stainless steel to ensure that this type of event does not recur. The General Manager of Operations was directly involved with this action to ensure that required corrective actions were completed.