



Smith Ranch - Highland
Uranium Project
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March 2, 2005

Docket No. 04008964

Mr. Lowell Spackman, 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. 603
Highland 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 February 26, 2005, Power Resources, Inc. (PRI) had a release of Production Fluid at the Highland Uranium Project in Converse County, Wyoming. The release was detected on February 26, 2005 at 10:00 a.m. The release occurred at a main Production Header in Headerhouse F-5. The concentrations of uranium, selenium and radium in 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 a recurrence of this nature.

Please call if you have any questions.

Sincerely,

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

WFK/klm

Cc: John Lusher – NRC Project Manager C. Foldenauer K. Milmine
M.D. Bryson File HUP 4.3.3.1 File HUP 4.6.4.1 File HUP 4.6.4.4



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Attachment

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

**HEADERHOUSE F-5 MAIN PC HEADER RELEASE OF PRODUCTION
FLUID**

A. DESCRIPTION OF THE EVENT AND MITIGATIVE ACTIONS TAKEN

On February 26, 2005 at approximately 10:30 p.m., a release of Production Fluid was discovered by a Satellite Operator at Headerhouse F-5. The cause of the release was failure of the main Production (PC) Header due to excessive pressure. The excessive pressure was caused when the Production (PC) bypass valve at Satellite No. 3 was not opened prior to starting the wellfield after an unscheduled shutdown. The Headerhouse was immediately shut down and repairs to the main PC header were completed on February 27, 2005 at approximately 12:00 p.m.

An estimated 3,000 gallons of Production Fluid was released and flowed down an ephemeral draw for approximately 475 feet. The production fluid settled in several low areas, which contained runoff water from snowmelt. Approximately 4,500 gallons of production fluid combined with runoff water was recovered from these low-lying areas with a Vac Truck. The approximate uranium concentration of the Production Fluid was 11.5 mg/L. No adverse impacts are expected due to the relatively small quantity of fluid involved, the low uranium concentrations of the Production Fluid, and a significant amount of the release was recovered

The release occurred in the SE ¼, NE ¼, Section 21, T36N, R74W and affected approximately 0.1 acres. The exact location and extent of the spill is shown on the attached map.

~~Soil samples were taken and analyzed for uranium, selenium, and radium-226 at the upstream, downstream, and background locations shown on the attached map. The entire area will be reevaluated during the decommissioning of the wellfield to ensure that applicable decommissioning standards for soils are met.~~

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

Cause

The cause of the release was attributed to Operator error. The Operator failed to open the Production (PC) bypass valve at Satellite No. 3 prior to starting the wellfield after an unscheduled shutdown. There is another valve located directly next to the Production (PC) bypass valve, which was mistakenly opened instead of the Productio (PC) bypass valve. The failure to open the proper valve caused

the main Production (PC) Header at the headerhouse to burst under the pressure created by the shut valve and the startup of the downhole pumps.

Recurrence Prevention

The main Production (PC) Header in Headerhouse F-5 was repaired and place back into service. The Production (PC) bypass valve at Satellite No. 3 has been painted and marked to distinguish it from the adjacent valve to avoid future errors of this kind. The Satellite Operator was counseled on the proper wellfield startup procedures and all other Satellite Operators will be refreshed on these procedures.

