UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
SAM NUNN ATLANTA FEDERAL CENTER
61 FORSYTH STREET, SW, SUITE 23T85
ATLANTA, GEORGIA 30303-8931

January 27, 2006

Mr. David Edwards
Plant Manager
Honeywell Specialty Chemicals
P.O. Box 430
Metropolis, IL 62690

SUBJECT: LICENSEE PERFORMANCE REVIEW (LPR) OF LICENSED ACTIVITIES FOR HONEYWELL SPECIALITY CHEMICALS, DOCKET NUMBER 40-3392

Dear Mr. Edwards:

Managers and staff in our Region II office in Atlanta, Georgia, and the Office of Nuclear Material Safety and Safeguards (ONMSS) in Rockville, Maryland, completed a review of your performance in conducting NRC-licensed activities at the Honeywell Metropolis Plant. The review evaluated your performance during the period beginning November 21, 2004, and ending December 9, 2005. Honeywell's performance was evaluated in four major areas: Safety Operations, Radiological Controls, Facility Support, and Special Topics. This letter and the enclosure provide to you the results of our review, and will be used as a basis for establishing the NRC oversight program for your conduct of licensed activities during the next 12 months.

Honeywell ensured that licensed activities were conducted safely during the review period. However, adherence to procedures related to conduct of operations, management of the corrective action program, and procedure management were identified as areas needing improvement.

We note that the areas needing improvement described in this LPR are essentially identical to some of those documented in the LPR we presented to you February 7, 2005. Management actions to bring about further sustained improvement in these program areas have not been fully effective. To date, your efforts have not resulted in consistent conduct of licensed activities in accordance with regulatory requirements. In addition there have been examples where your staff has not recognized and/or properly responded to conditions that can impact safety.

It has been two years since the site area emergency that prompted your efforts to enhance safety at the Metropolis site through improvements in your facilities, equipment, policies and procedures. You focused your efforts on improvements that would address the root causes and contributing factors and identified numerous short-term and long-term corrective actions to support this effort. We note that as a result of these efforts, you have made significant improvement in your emergency response program. However, you have not been fully successful in implementing your corrective actions program and related performance improvements in a timely, comprehensive and lasting manner.

The numerous changes in personnel, procedures and equipment that have occurred, as well as your ability to manage these numerous changes, may have impacted your performance improvement efforts. As a result, we encourage you to continue to focus on implementation of your previously identified corrective actions, particularly with regards to development and adherence to plant procedures. In addition, you should address ways of improving your ability to manage change and its' impact on the implementation of your performance improvements.

The results of our review will be discussed with you at your facility during a meeting open to the public on February 22, 2006. Areas needing improvement are summarized in the enclosure to this letter. During that meeting, we expect you to discuss your view of your performance in the same major areas that the NRC evaluated. We ask you to specifically discuss why your actions to ensure procedure adherence have not been fully effective, how you will improve adherence in the future, and how you will monitor the effectiveness of these actions. In addition, please describe how you will capture future lessons learned and monitor the implementation of the associated actions in your corrective action program as a part of your long-term performance improvement plan for continued safe operations.

As a result of our review of your performance, the NRC will continue heightened oversight of your licensed operations through inspections beyond those specified by the NRC's core inspection program. These supplemental inspections will be primarily in the areas of plant operations and management organization and controls. We will also monitor your progress in implementing your long-term performance improvement plan.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter and its enclosure 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).

Questions and comments about NRC's review of Honeywell's performance should be referred to Mr. Jay Henson, who can be reached by telephone at 404-562-4731.

Sincerely,

/RA/ J. Henson acting for

Douglas M. Collins, Director
Division of Fuel Facility Inspection

Docket No. 40-3392
License No. SUB-526

Enclosure:
Licensee Performance Review - Summary Outline

cc w/encl: (See page 3)

cc w/encl:
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X PUBLICLY AVAILABLE ☐ NON-PUBLICLY AVAILABLE ☐ SENSITIVE X NON-SENSITIVE

ADAMS: X Yes ACCESSION NUMBER:_____

OFFICE	RII:DFFI	RII:DFFI					
SIGNATURE	JLH 1/27/06	JLH 1/27/06					
NAME	JMPelchat	JLHenson					
DATE	1/ /2006	1/ /2006	1/ /2006	1/ /2006	1/ /2006	1/ /2006	1/ /2006
E-MAIL COPY?	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO

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LICENSEE PERFORMANCE REVIEW FOR HONEYWELL

ASSESSMENT PERIOD: November 21, 2004, to December 9, 2005

PERFORMANCE AREA: SAFETY OPERATIONS

Program Areas Needing Improvement

This area is comprised of chemical safety, plant operations, and fire safety.

- Adherence to procedures related to the conduct of operations, especially those involving cylinder operations:

  - (2005-006) One violation, with three examples, for failure to follow procedures (Torque and Teflon on Cylinders, and Leak event for failing to judge valve position).

  - (2004-011) A violation for failure to properly perform uranium hexafluoride cylinder pre-filling checks, allowing cylinders equipped with Hunt valves to be filled and ultimately shipped.

  - (2005-004) A violation for failure to implement procedural requirements for an inoperative control room alarm.

  - (2005-005) A violation for failure to implement procedural requirements for restricting access to a visibly contaminated area.

Recommended NRC Effort in Safety Operations

- ***Maintain elevated inspection effort in plant operations, with emphasis on licensee management of change.***

PERFORMANCE AREA: RADIOLOGICAL CONTROLS

This area is comprised of radiation protection, environmental protection, waste management, and transportation.

Program Areas Needing Improvement

- No specific areas needing improvement were identified for Radiological Controls.

Recommended NRC Effort in Radiological Controls

- ***Maintain core inspection effort.***

PERFORMANCE AREA: FACILITY SUPPORT

This area is comprised of maintenance/surveillance, training, emergency preparedness, and management organization and controls.

Program Areas Needing Improvement

- Management of the corrective action program to ensure that corrective actions are prioritized, implemented, sustained, and achieve the desired results.

  In a February 14, 2004, letter responding to a "Notice of Violation" dated December 17, 2003, Honeywell indicated that one of the root causes of the events that occurred in August and September of 2003 was the fact that they did not recognize the need to "improve NRC and regulatory commitment tracking and corrective action processes to ensure that corrective actions are implemented and sustained." Honeywell further stated that "formal measures were not implemented to assure the corrective measures achieved the desired results. Nor were formal measures implemented to assure that the corrective actions had established reinforcement mechanisms so that they were likely to continue in effect. Lack of senior management continuity also contributed to the short-lived corrective action effectiveness."

  Honeywell stated that, "In response to the December 22, 2003 event, the Plant will establish a performance improvement program that will address short-term items necessary for safe restart of UF6 operations and longer-term efforts to achieve excellence in operations. Included in the performance improvement program will be steps to improve corrective actions."

  In subsequent public meetings regarding the December 22, 2003 event, Honeywell continued to state that they would assess the corrective action program to address problem identification and reporting, apparent root cause analysis, root cause analysis, trending, completion of corrective actions, and effectiveness reviews.

  Honeywell's efforts to improve its corrective action program have not been effective as noted in the following NRC inspector observations:

  - (2004-011) Inspectors noted that the *corrective action* system was being used as an action tracking tool rather than as a mechanism for assessing significance of items, prioritizing and initiating investigations, and performing adverse trend analyses.

  - (2005-003) The *corrective action* tracking system was observed to be difficult for personnel to use, and entries in the system did not always provide adequate information needed for tracking purposes.

  - (2005-004) The inspectors identified that some short-term corrective actions taken in response to issues previously identified regarding operator attentiveness were not adequately addressed.

- (2005-006) The licensee's corrective actions program was noted to have a weakness in the management and evaluation of corrective actions, resulting in incorrect status indicators regarding the completion of upgrades.

- Assurance of procedure control in the FMB control room:

  - (2005-003) A violation was identified for failure to remove several standard operating procedures from service and immediately placing them into the periodic review cycle after an extension for the periodic review expired.

  - (2005-006) One violation with two examples was identified for the failure to control procedures in the Feeds Material Building control room. Specifically, the failure to properly replace an expired temporary procedure and the failure of posting an operator aid that required procedural steps without having a permanent or temporary procedure written.

Recommended NRC Effort in Facility Support

- ***Maintain elevated inspection effort in facility support with emphasis on management of the corrective action program.***

PERFORMANCE AREA: SPECIAL TOPICS

This area comprises safety licensing.

Program Areas Needing Improvement

- No specific areas needing improvement were identified for Special Topics.