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

April 6, 2006

MEMORANDUM TO: Jay Henson, Leader
Honeywell Special Inspection Team

FROM: William D. Travers, Regional Administrator
/RA by Harold Christensen Acting For/

SUBJECT: SPECIAL INSPECTION TEAM CHARTER FOR HONEYWELL INTERNATIONAL - DOCKET NO. 40-3392 (INSPECTION REPORT NUMBER 40-3392/2006-003)

A Special Inspection Team has been established for Honeywell to inspect and assess the facts and circumstances surrounding the inadvertent leak of UF_6 into the Feed Materials Building on April 4, 2006. The event resulted in Honeywell declaring a Plant Emergency (below NRC emergency classifications) and a telephone report to NRC Region II. The Team composition is as follows:

Team Leader: Jay Henson

Team Members: Jose Jimenez
John Pelchat
Mary Thomas

The objectives of the inspection are to: (1) review the facts surrounding the UF_6 leak into the Feed Materials Building on April 4, 2006; (2) assess the licensee's safety planning and controls, particularly considering the corrective actions that were to be implemented by the licensee as a result of previous events and performance improvements; (3) assess the licensee's response and investigation into the event; (4) assess the safety significance of the event; (5) conduct an independent review of the licensee's extent of condition review; and (6) identify any generic issues associated with the event.

For the period during which you are leading this inspection and documenting the results, you will report directly to me. The guidance in Inspection Procedure (IP) 88003, the applicable provisions of IP 93812, Management Directive 8.3, and Manual Chapter 2600 applies to your inspection.

If you have any questions regarding the objectives of the enclosed Charter, contact Douglas M. Collins at (404) 562-4700.

Enclosure: SIT Charter

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	NMSS					
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NAME	DCollins	GJanosko					
DATE	04/06/2006	04/06/2006	April 7, 2006	April 7, 2006	April 7, 2006	April 7, 2006	April 7, 2006
E-MAIL COPY?	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO

OFFICIAL RECORD COPY DOCUMENT NAME: E:\Filenet\ML060960645.wpd

SPECIAL INSPECTION TEAM (SIT) CHARTER
UF_6 LEAK ON APRIL 4, 2006, AT HONEYWELL INTERNATIONAL

Basis for the Formation of the SIT - On April 4, 2006, there was a UF_6 leak, estimated to be 8 grams of UF_6, into the Honeywell Feed Material Building. The leak occurred while two operators were replacing a gauge on a line from a nitrogen purge gas supply to a distillation column. While removing the gauge, the operators observed a leak apparently from the gauge fittings. There was no indication of release of the UF_6 cloud outside the building. Honeywell declared a "plant emergency" which is a level below that required by the NRC and took actions to stop the leak.

Objectives of the SIT - The objectives of the inspection are to: (1) review the facts surrounding the UF_6 leak into the Feed Materials Building on April 4, 2006; (2) assess the licensee's safety planning and controls, particularly considering the corrective actions that were to be implemented by the licensee as a result of previous events and performance improvements; (3) assess the licensee's response and investigation into the event; (4) assess the safety significance of the event; (5) conduct an independent review of the licensee's extent of condition review; and (6) identify any generic issues associated with the event.

To accomplish these objectives, the following will be performed:

a. Develop a complete sequence of events related to the event.

b. Identify and evaluate the effectiveness of the immediate actions taken by the licensee in response to the event.

c. Evaluate the worker and public safety significance of the event.

d. Evaluate the licensee's process and process implementation for the planning, conduct, control, and oversight of the activities that led to the leak and for actions after the leak was detected, including processes that were revised as a result of previous events.

e. Evaluate the adequacy of and effectiveness of the licensee's safety controls for the work, including safety controls that were revised as a result of previous events.

f. Evaluate the level and effectiveness of the training of the maintenance staff and operators for the actions that led to the release, including training as a result of previous events.

g. Review and evaluate the licensee's root cause analysis for adequacy of scope, depth, and identification of causal factors.

h. Determine if there are any generic issues related to the event.

i. Identify additional actions planned by the licensee as a result of this event and the licensee's resultant extent of condition review, including the time lines for action completion.

j. Document the inspection findings and conclusions in an inspection report within 30 days of the completion of the inspection.