

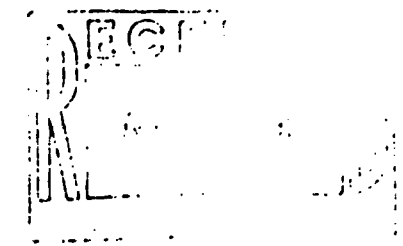
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August 20, 1991

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Robert D. Martin
Regional Administrator
Region IV
U.S. NUCLEAR REGULATORY COMMISSION
611 Ryan Plaza Drive, Suite 1000
Arlington, Texas 76011

RE: License No. SUB-1010, Docket No. 40-8027
Unusual Event of August 2, 1991
10 CFR 20.405 Report

Dear Mr. Martin:

On August 2, 1991 Sequoyah Fuels Corporation (SFC) notified the NRC Operations Center duty officer and NRC Region IV that an incident had occurred.

At 0739 on August 2, 1991 a small puff of powder was observed to have discharged from the packaging enclosure in the UF₆ Reduction Facility. The operator at the enclosure pushed the emergency stop button and left the building. The control room operator shut down the rest of the process. An Unusual Event was subsequently declared. While the area was being surveyed a second puff was observed to be discharged from the packaging enclosure. During cleanup of the area a third puff was observed to be discharged from the packaging enclosure.

A subsequent investigation indicated that each discharge was associated with completion of a dust collector blowback cycle. The air supply for the blowback system was isolated. It was later determined that the powder level in the dust collector hopper was too high. The dust collector was emptied to provide an immediate remedy to the condition. It was also discovered that the rotary feeder to the dust collector required repair. A 10 CFR 20.403(b)(3) notification was made due to the potential of exceeding 24 hours down time for repair.

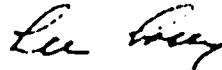
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Robert D. Martin
August 20, 1991
Page Two

The attached report is submitted pursuant to the requirements of 10 CFR 20.405(a)(1)(iv). Should you have any questions on this matter, please contact me at 918/489-3207.

Sincerely,



Lee R. Lacey
Vice President
Regulatory Affairs

LRL:nv

Attachment

xc: Keith E. Asmussen, General Atomics
Charles J. Haughney, NRC - NMSS

SEQUOYAH FUELS CORPORATION

UNUSUAL EVENT OF AUGUST 2, 1991

(10 CFR 20.405)

1. Estimate of each individual's exposure:

The SFC Health and Safety staff has evaluated the situation and determined that it did not contribute any exposure to personnel above normal operating conditions.

2. Levels of radiation and concentrations of radioactive materials involved:

The following air concentrations (re: dUF_4) were recorded in association with the incident:

- Fifth level reactor cooling exhaust = 2.89 MPC,
- Roof exhaust fans = 2.03 MPC,
- Area air samples:
 - Shift 1 (0000-0800) maximum = 0.57 MPC,
 - Shift 2 (0800-1600) maximum = 2.50 MPC,
 - Shift 3 (1600-0000) maximum = 0.27 MPC,
- Breathing zone samples during cleanup = 0.5 and 0.6 MPC.

3. The cause of the exposure, levels, or concentrations:

The cause of the discharges is attributed to the dust level in the dust collector hopper being too high. This condition arose due to a faulty level probe in the dust collector hopper.

4. Corrective steps taken or planned to prevent recurrence:

Immediate corrective actions included cleaning of the area, emptying of the dust collector hopper, running the dust collector while empty to clean the feed lines of powder, and repair of the existing high-level indicator in the hopper.

Actions to be taken to prevent recurrence are revision of Procedure N-800-9 "Operation of the Dust Collection and Vacuum Cleaning Systems - Depleted UF_4 Facility" to call for a periodic manual check of the powder level in the dust collector hopper and to require the dust collector hopper to be emptied on a routine basis. Also, the use of a backup level indicator is being investigated.