

R2/E41

**DADAVID AYRES BI-WEEKLY OPERATIONS STATUS REPORT**Don Goldbach, Manager  
Environment, Health & Safety

Thursday July 27, 2000

**OPERATIONS SUMMARY****LAST WEEK (7/17-21)**Conversion = 5 UF<sub>6</sub> linesPelleting = 4 lines**LAST WEEKEND (7/22-23)**Conversion = 5 UF<sub>6</sub> lines (Saturday & Sunday)Pelleting = 4 Pellet Lines (Saturday & Sunday)**THIS WEEK (7/24-28)**Conversion = 5 UF<sub>6</sub> linesPelleting = 4 lines**THIS WEEKEND (7/29-30)**Conversion = DownPelleting = 2 pellet lines (Saturday) and 1 pellet line (Sunday)**UNUSUAL INCIDENTS**

UPDATE: We have two uranyl nitrate tanks contaminated with Gadolinium. The source was old archive pellets which were disposed of. Half of one tank was converted to UO<sub>2</sub> before the contamination was detected. The uranyl nitrate and UO<sub>2</sub> powder will be blended off with non-contaminated nitrate and UO<sub>2</sub> powder, respectively.

UPDATE: Three pellet operators were put on restriction due to high airborne at the Pellet Line 3 roll hood. The source of the contamination was the changeout of the granulator screen during that shift. The operators involved were relatively new and were retrained on proper methods for handling this work.

UPDATE: On February 25<sup>th</sup>, a notification was made to the NRC in accordance with 10CFR70.50(b)(1) due to contamination on a concrete pad outside the plant on the south side (behind the UF6 Bay wall). All of the 162 sections were "released". The pad is to be sealed and this effort will be complete.

A 24 hour notification was made to NRC Operations Center on July 26, 2000 as a result of the discovery that a "filter processing procedure was not written in accordance with the Criticality Safety Evaluation." A copy of the report was also made to Region II and to Headquarters. The Incident Review Committee has discussed this incident and although there was no loss of double contingency protection, this event has been determined to be safety significant and a root cause is being scheduled.

On July 27, 2000, two operators were lifting a fully loaded bulk container when it suddenly fell. An experienced operator was in the process of training a new operator to do this task. The bulk container is lifted by using a device called a "strongback" which allows the overhead crane to lift the container from the floor to the platform above. The experienced operator was operating the overhead crane. He had positioned the operator in training on the platform above in order to "spot" the container on the platform station. The operator raised the full container from the floor and when it had been lifted approximately 8-10 feet from the floor, the "strongback" separated from the crane hook and the container fell to the floor. No injuries occurred. This incident has also been reviewed by the Incident Review Committee and has been determined to be safety significant. Additional actions are being taken prior to allowing restart of the bulk blending area to ensure employee safety. A root cause will be conducted to learn more from this incident and lessons learned will be applied in other areas of the plant, where applicable.

**MISCELLANEOUS**

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