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October 10, 2006

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U.S. Nuclear Regulatory Commission
Director, Office of Nuclear Material Safety and Safeguards
Attention: Document Control Desk
Mail Stop T-8A33, Two White Flint N., 11545 Rockville Pike
Rockville, MD 20852-2738

Subject: 30-Day Written Follow-up Report to NRC Event Number 42836 Reported
September 11, 2006 to Nuclear Regulatory Commission Operations Center
Docket No. 04003392, License No. SUB-526

Honeywell Chemicals, Specialty Materials, Metropolis Works (MTW) facility reported to the Nuclear Regulatory Commission (NRC) Operations Center as per 10CFR40.60 the occurrence of an electrical short to a Nash vacuum pump which caused loss of power to safety support equipment including two Nash vacuum pumps, and the Health Physics vacuum pump. This letter is a required follow-up report to address specific items required by the regulations.

NRC Event Number 42835 dated September 11, 2006, reported:

An electrical short to the wiring of a Nash vacuum pump caused failure of required operating equipment by shorting out the motor control center and blowing a fuse that supplies power to the Nash vacuum pump, and Health Physics vacuum pump which provide flow for building air samplers, and other support equipment and instrumentation. The UF6 processes were shut down and announcements were made to require any personnel who entered any floor in the feed materials building to wear a respirator. There was no release of radioactivity to the environment and power was restored in approximately thirty minutes and process operations were resumed. Air samples were counted on all floors in the Feed Materials Building and no high airborne radioactivity was detected. The floor air samples were collected and counted again in approximately four hours and no airborne radioactivity was detected.

The licensee notified NRC Region II (John Pelchat).

10CFR40.60 (c) (2) Written 30-day follow-up report required:

(2)(i) *A description of the event, including the probable cause and the manufacturer and model number (if applicable) of any equipment that failed or malfunctioned*

An electrical short to the wiring of a Nash vacuum pump caused failure of required operating equipment by shorting out the motor control center and blowing a fuse that supplies power to the Nash vacuum pump, and Health Physics vacuum pump which provide flow for building air samplers, and other support equipment and instrumentation. The UF6 processes were shut down and announcements were made to require any personnel who entered any floor in the feed materials building to wear a respirator. There was no release of radioactivity to the environment and power was restored in

approximately thirty minutes and process operations were resumed. Air samples were counted on all floors in the Feed Materials Building and no high airborne radioactivity was detected. The floor air samples were collected and counted again in approximately four hours and no airborne radioactivity was detected.

The short to one of the operating Nash vacuum pumps caused a fuse to blow in the motor control center which resulted in loss of power to a second Nash vacuum pump and to the Health Physics vacuum pump. Under normal operations three Nash vacuum pumps are operated which provides vacuum for the UF₆ processes. As a result of the short only one Nash vacuum pump remained on line and in addition power was lost to the Health Physics vacuum pump which provides air sampling for all floors in the UF₆ processing building.

(2)(ii) *The exact location of the event.*

The first floor of the feeds material building at Motor Control Center 10.

(2)(iii) *The isotopes, quantities, and chemical and physical form of the licensed material involved.*

No chemicals or radio nuclides were released to the building or environment due to this event.

(2)(iv) *Date and time of the event.*

The event began on 9/10/06 at approximately 15:30 CDT.

(2)(v) *Corrective actions taken or planned and the results of any evaluations or assessments.*

The following actions have been taken or are planned in response to this event:

1. The defective wiring to the Nash vacuum pump was immediately replaced and system operation restored. COMPLETE
2. Inspected wiring in area of the shorted wiring. Condition of wiring was satisfactory. COMPLETE
3. Inspected the Nash vacuum pump for damage – no damage was detected. COMPLETE
4. An evaluation of the electrical system as related to standby power for support equipment will be conducted and, if warranted, changes will be made.

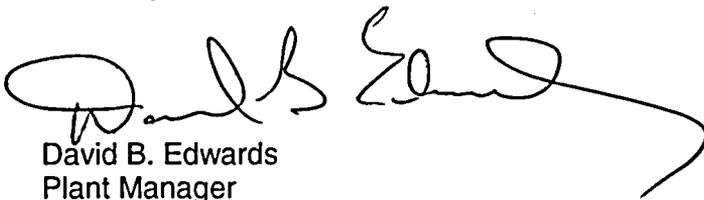
(2)(vi) *The extent of exposure of individuals to radiation or to radioactive materials without identification of individuals by name*

Based on air samples taken immediately after the event and taken four hours later there was no exposure to individuals as result of the event.

NRC Region II (John Pelchat) was notified following the event.

Further questions regarding the above report can be directed to Mr. Jack Riley, Regulatory Affairs Manager, at 618-524-6221.

Sincerely,



David B. Edwards
Plant Manager

cc: Regional Administrator (UPS: 404-562-4701)
Region II, US Nuclear Regulatory Commission
Sam Nunn Atlanta Federal Center
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Jack H. Riley, Regulatory Affairs Manager
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