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

October 27, 2006

MEMORANDUM TO: Alphonsa Gooden, Leader
AREVA NP Special Inspection Team

FROM: William D. Travers, Regional Administrator ***/RA/***

SUBJECT: SPECIAL INSPECTION TEAM CHARTER FOR AREVA NP RICHLAND, DOCKET NO. 70-1257 (INSPECTION REPORT NO. 70-12657/2006-010)

This memorandum confirms the establishment of a Special Inspection Team to inspect and assess the facts and circumstances of the hydrogen fluoride leak and worker exposure. The event occurred on October 23, 2006 (Event # 42936) and was reported to the NRC Operations Center on October 26, 2006 (21:09 EST). You are the team leader and should report status directly to me. Your team members are: M. Baker (NMSS), O. Lopez (RII), S. Subosits (RII), and E. Michel (RII).

The inspection and report will be performed in accordance with the guidance of Inspection Procedure (IP) 88003, and the applicable provisions of IP 93812, and will be consistent with Management Directive 8.3 and Manual Chapter 2600. The report will be issued within 30 days of the completion of the inspection.

A copy of the Charter is enclosed for your use. The objective of the team is to gather information and make appropriate findings and conclusions in the areas listed in the Charter. These will then be used as a basis for any necessary followup. As indicated in the Charter, the foremost objective is to determine the safety implications and adequacy of licensee corrective actions for the sequence of events which resulted in the workers exposure to HF release.

If you have any questions, please contact me.

Enclosure: Special Inspection Charter

cc w/encl:
W. Travers, RII
J. Strosnider, NMSS
R. Pierson, FCSS
D. Ayres, RII

X☐ PUBLICLY AVAILABLE ☐ NON-PUBLICLY AVAILABLE ☐ SENSITIVE **X**☐ NON-SENSITIVE

ADAMS: **X**☐ Yes ACCESSION NUMBER:_____

OFFICE	RII:DFFI	RII:DFFI	NMSS	RII:ORA			
SIGNATURE	***/RA/***	/RA/	/RA/				
NAME	DAyres	DCollins	RPierson	VMcCree			
DATE	10/27/2006	10/27/2206	10/27/2006				
E-MAIL COPY?	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO

OFFICIAL RECORD COPY DOCUMENT NAME: C:\FileNet\ML063060232.wpd

Special Inspection Charter
AREVA NP, Inc.
Hydrogen Fluoride (HF) Exposure

Basis

On Monday, October 23, 2006, two workers entered the dry conversion process area and noted an unusual odor. Upon discovery of this condition, workers immediately evacuated the area. The workers obtained respiratory protection and returned to the process area for collecting air samples. Samples were collected for both chemical and radioactive determination to assist in the identification of what may have been leaking and the location for leak. During chemical sampling using a draeger gas collection instrument, it was observed that HF levels in the vicinity of the conversion line 3 reactor was 30 parts per million (ppm). No elevated radiation measurements were recorded. The leak was determined to be a hair-line crack within the weld around a plug on the reactor off-gas system. Line 3 operations were terminated and actions were initiated to inspect weld joints on the second of two reactors for line 3 and other associated line 3 process equipment to verify that there was no breach of containment, or significant physical damage. Lines 1 and 2 were subsequently shutdown for examination.

The workers were unaware of the HF release at the time of the initial entry to the process area. As a result, a short duration exposure to HF occurred. No reports or requests were filed with site health and safety personnel to assess the significance of the employees exposure or physical condition. The workers did not experience any immediate effects from the exposure. However, after arriving at home from shift work, one of the workers complained to his wife that he was experiencing a tingling sensation and physically did not feel well. In response, the individual was transported to the hospital by his wife and remained hospitalized until Wednesday, October 25, 2006.

Scope

In order to develop the safety significance of the event, the team should focus on the areas listed below. They are listed in order of importance.

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

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

3. Evaluate the potential for an acute chemical exposure to HF at the time of discovery by the workers. This should consider the sequence of events following the recognition by workers of an unusual odor (how long in the area without personal protective equipment, was the proper equipment used for sampling the environment, was the workers properly trained on how to use the Draeger equipment, and did workers follow reporting procedures).

4. Evaluate the risk significance to other workers, the public, and environment.

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

6. Evaluate the adequacy of the licensee's response. Determine adequacy of internal and external licensee event reporting. This should include a review of the information available to the licensee to use as indicators of a problem, timeliness of reporting to offsite agencies (NRC, OSHA, State, DOL) and the response to safety issues. Safety issues include chemical and radiological areas.

7. Determine the probable contributing and root causes for the failure to perform an assessment of the worker's health following the exposure.

8. Evaluate the adequacy of the licensee's training program and procedures for responding to HF events.

9. Determine the adequacy of the licensee's actions to prevent recurrence.

10. Determine to what standard the chemical reactor vessel was constructed (i.e. ASME Boiler and Pressure Vessel Code). Determine the adequacy of any maintenance requirements for the chemical reactor vessel and/or periodic-in-service inspection program that check the welds for flaws.

Documentation

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