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November 17, 2006 UPS: 301-415-8147

US Nuclear Regulatory Commission
Director, Office of Nuclear Material Safety & Safeguards
Attention: Document Control Desk
Mail Stop T8A33, Two White Flint N, 11545 Rockville Pike
Rockville, MD 20852-2738

Docket No. 40-3392
License No. SUB-526

RE: "NRC Inspection Report 40-3392/2006-008 and Notice of Violation dated November 1, 2006"

Dear Sirs:

This letter is our response to the NRC Inspection Report 40-3392/2006-008 and Notice of Violations

During an NRC inspection conducted from September 18-22, 2006, three violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600, the violations are listed below:

> Violation A involved the failure to post a radiation area; Violation B involved the failure to wear appropriate protective clothing during a UF_6 line break; and Violation C involved the failure of personnel to follow procedures during inspection of UF_6 cylinders prior to shipment.
>
> These are Severity Level IV violations.
>
> **Violation A – Failure to wear appropriate protective clothing during a UF_6 line break.**
>
> Contrary to license and procedural requirements, on April 4, 2006, licensee employees did not wear the specified personal protective equipment while performing a line break to clear a blockage in a utility air line that was known to contain uranium hexafluoride.

IE07

As discussed in the referenced letter, actions taken to correct and prevent recurrence are already documented in the subject NRC Inspection Report and are accurate. Therefore, no further information is provided.

Violation B – Failure to post a radiation area.

License Condition 10 of NRC License No. SUB-526, Amendment No. 15, authorizes, in part, the use of licensed materials in accordance with the statements, representations, and conditions in Chapters 1 through 7 of the license application dated January 30, 2003.

Chapter 3, Section 3.2.5 of the application, requires, in part, that process vessels be posted as "Caution – Radiation Area" if the exposure rate exceeds 5 milliroentgens per hour (mR/hr) at 30 centimeters from the source. In addition, magenta and yellow floor stripes are to be provided around the equipment to provide an additional buffer zone and warning device for employees.

Contrary to the above, as of September 21, 2006, the vicinity of the filter housing adjacent to the E-413 secondary cold trap on the 5th floor of the Feed Materials Building was not posted with a "Caution – Radiation Area" sign, an area where measured exposure rates were 7 mR/hr at a distance of 12 inches (30 centimeters). Also, contrary to the above, magenta and yellow floor stripes were not provided around the area to provide an additional buffer zone and warning for individuals present in the area.

Reason for this Violation:

We have determined that a previously unidentified radiation area existed in the vicinity of the filter housing adjacent to the E-413 secondary cold trap on the 5th floor of the Feed Materials Building.

Extent of Condition:

Spot surveys of other areas in the Feed Materials Building did not identify additional unposted radiation areas.

Corrective steps that have been taken and the results:

The following corrective actions have been taken:
1. The area was roped off to notify employees that a radiation area exists.
2. Work notification #521172 was created to install floor stripes to denote the radiation area.
3. Evaluated the potential of like equipment to exceed 5 mR/hr.

Corrective Actions Planned to prevent a recurrence:

The following corrective actions have been taken to prevent recurrence:

1. Extensive survey is planned for the week of November 27, 2006 for all process areas.
2. Increased radiation surveys are planned to identify intermittent conditions.

Date When Full Compliance Will Be Achieved:

Full compliance was achieved on September 28, 2006.

Violation C – Failure to properly inspect UF_6 cylinder prior to shipment.

License Condition 10 of NRC License No. SUB-526, Amendment No. 15, authorizes, in part, the use of licensed materials in accordance with the statements, representations, and conditions in Chapters 1 through 7 of the license application dated January 30, 2003.

Chapter 2, Section 2.6 of the license application, dated January 30, 2003, requires that plant written procedures shall be reviewed, revised, approved, and implemented in accordance with Plant Policy titled, "Procedure Control Policy."

Procedure Control Policy AD-7 (now MTW-POL-AD-0007), states, in part, that procedures written after March 1, 2004, shall be reviewed, revised, approved, and implemented in accordance with Procedure MTW-ADM-PRO-0100, "Development and Implementation of Policies and Administrative Procedures." Step 4.11.2 of procedure MTW-ADM-PRO-0100 requires that policies and procedures be followed as written.

Section 17.2.4, Cylinder Condition, of the procedure, (MTW-QAM-UF6-0217) "Uranium Hexafluoride (UF_6) Cylinder Shipping and Receiving Inspection," Revision 5, dated December 2005, states in part, that prior to shipment and receipt, each cylinder will be inspected for any physical damage including but not limited to dents, bulges, gouge and cuts.

Contrary to the above, on January 5, 2006, a UF_6 cylinder (serial number 172481) was not adequately inspected for physical damage prior to shipment. Specifically, the inspection of the cylinder failed to detect the presence of eight areas on the cylinder's exterior that exhibited dents and gouges prior to its shipment to another facility. The licensee's record of the pre-shipment inspection indicated that there was no damage, when in fact, there were dents and gouges on the exterior of the cylinder.

Reason for this violation: Personnel Error -The operator did not follow the cylinder inspection procedure which required reporting of any visual defects on the exterior of the cylinder. The cylinder had eight visual defects that should have been reported.

Extent of condition: No further cylinder incidents have been identified.

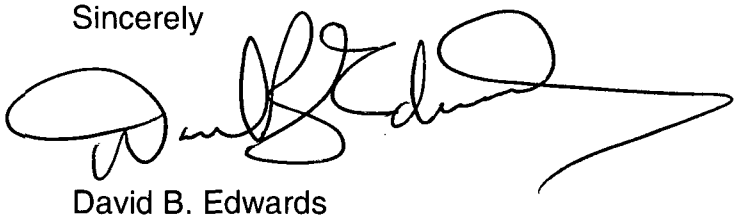
Corrective steps that have been taken and the results achieved: An Apollo (Root Cause Investigation) was conducted. Training was conducted for personnel who perform inspections. Supervisors performed increased surveillance of cylinders ready for shipment. This specific event including lessons learned was discussed with personnel who perform inspections.

Corrective steps that have been taken to prevent recurrence:
As a result of the Apollo investigation, inspection procedures were updated and requirements made more specific. Retraining of all personnel who perform cylinder inspections was conducted, and the training included review of ANSI N14.1 as related to cylinder external conditions. Management expectations as related to procedure compliance were reemphasized to all personnel who perform cylinder inspections. Appropriate disciplinary action was taken with the personnel involved. Since the event, over 1100 cylinders have been shipped without further incident.

Date when full compliance was achieved:
Full compliance was achieved on January 10, 2006.

Questions regarding this correspondence can be addressed with Jack Riley at 618-524-6221.

Sincerely



David B. Edwards
Plant Manager

cc: File – RMDC

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