Specialty Materials Honeywell P.O. Box 430 2768 North US 45 Road Metropolis, IL 62960

June 28, 2011

Certified Mail:

Attention: Document Control Desk Director, Office of Nuclear Material Safety Safeguards U.S. Nuclear Regulatory Commission Washington, D.C. 20555-0001

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

> Subject: 30-Day Written Follow-Up Report to NRC Event No. 46915 Reported 06/02/2011 to NRC Operations Center–Medical Treatment Involving Contamination

The Honeywell Metropolis Works facility (MTW) reported to the NRC Operations Center in accordance with 10 CFR 40.60(b)(3) an event that requires unplanned medical treatment at a medical facility of an individual with spreadable radioactive contamination on the individual's clothing or body. This letter is a follow-up report to address specific items required by 10 CFR 40.60(c)(2).

NRC Event Number 46915 dated June 2, 2011

The following information was provided in the 24 Hour NRC Telephone Report:

Description of the Event:

An employee was treated in the site dispensary for irritation to the eye. The employee's coveralls knee area and boots were surveyed and determined to be contaminated (coveralls 2643 dpm/100 sq. cm, boots 3126 dpm/100 sq. cm) Employee stated that they were cleaning out the bottom of the cone on A1 HF filter bowl from the top of the filter when something entered their eye. The individual stated that they saw a small amount of dust in the bottom of the filter bowl, but did not actually see dust by their eye. Other employees were present at the time, but did not notice what had occurred and the affected employee did not tell them what had happened. The individual returned to work after treatment.

Isotope, Quantities and Chemical Form:

Greensalt (UF4)

IE72 NMSS

Personnel Radiation Exposure Data (if applicable):

None.

10 CFR 40.60(c)(2) written 30-day follow up report required sections

(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.

Employee stated that they were cleaning out the bottom of the cone on A1 HF filter bowl from the top of the filter when something entered their eye. They stated that they saw a small amount of dust in the bottom of the filter bowl but, did not actually see dust by their eye. Other employees were present at the time but, did not noticed what had occurred and the affected employee did not tell them what had happened. The supervisor was not aware anything had transpired until 1 hour after the incident occurred and medical treatment had been received.

1515- Employee felt something in their eye and left the area. 1525- Employee went to Health Physics for medical attention. 1615- Supervisor notified of the incident.

Radiological warning lights were already on for precaution on the 6th floor due to the fact that A1 HF filter was being cleaned. Employee left the area and came to the control room and told the Greensalt operator that they thought something got in their eye and sought medical attention through Health Physics.

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

First aid was performed in the plant dispensary which is located within the restricted area boundary.

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

The isotope involved was natural uranium in the form of U_3O_8 , which was in the form of spreadable contamination on the employee's plant issued coveralls and boots. Contamination levels were estimated at approximately 2643 dpm/100 sq. cm for the coveralls and 3126 dpm/100 sq. cm for the boots. There was no detectable contamination on the employee's skin.

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

The incident occurred at approximately 1515 on June 1, 2011 and the 24 hour report was submitted on June 2, 2011 at approximately 1450.

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

The following actions were taken:

1. The dispensary is surveyed daily.

2. The on-site medical facility is cleaned routinely. Additional cleaning can be requested as required.

- 3. An email communicating that when possible decontaminate personnel prior to them being admitted to the dispensary was sent by April 15, 2010.
- Draft regulatory analysis "Application of 10 CFR 40.60(b)(3) Reporting Requirements to MTW" was developed and presented to the NRC Region II on April 12, 2011, to review and discuss facility's 10 CFR 40.60(b)(3) compliance enhancement aspects.
- Honeywell procedure MTW-ADM-HP-0105, Completing Reports to the USNRC, was revised to emphasize applicability of 10 CFR 40.60(b)(3) to on-site unplanned medical treatments of an individual with spreadable radioactive contamination on the individual's clothing or body. Completed: 5/3/2011.
- 6. Training on MTW-ADM-HP-0105, Completing Reports to the USNRC, procedure revision was delivered to appropriate personnel and completed by 5/3/2011.
- 7. Instructions on monitoring potentially contaminated injured individuals in the site's dispensary and documenting associated radioactive contamination surveys were developed and distributed to Health Physics (HP) personnel on 3/22/2011.
- 8. Additional guidance for on-site locations of injury treatment activities was developed and communicated to all Health Physics staff on 4/6/2011.
- 9. Incorporate guidance for documenting of contamination surveys into HP program procedures. Target date: 7/29/2011.
- 10. Lights were already on for precaution on the 6th floor due to the fact that A1 HF filter was being cleaned.



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

N/A.

Please contact Mr. Michael Greeno, Regulatory Affairs Manager, at 618-309-5005, if you have additional comments or questions regarding this matter.

Sincerely, Smith arry 🔒

Plant Manager

cc: Regional Administrator Region II, US Nuclear Regulatory Commission 245 Peachtree Center Ave., NE, Suite 1200 Atlanta, GA 30303-1257