AREVA

December 2, 2014
TJT:14:017

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

Gentlemen:

Subject: **Thirty-day Follow-up Report to November 2, 2014 Incident Reported Under 10 CFR 70 Appendix A, Criterion (c) (NRC Event No. 50589); AREVA Inc. Richland Facility; License No. SNM-1227; Docket No. 70-1257**

On November 2, 2014, the AREVA Inc. Richland facility reported that an employee had sustained an injury resulting in hospitalization. This injury was reportable to Washington State Department of Labor and Industries in accordance with Washington Administrative Code 296-800-32005. The NRC was notified under the requirements of 10CFR70 Appendix A criterion (c).

The initial report (NRC Event No.50589) was made because the plant condition met the reporting criterion in 10 CFR 70 Appendix A (c) in that "Any event or situation, related to the health and safety of the public or onsite personnel, or protection of the environment, for which a news release is planned or notification of other government agencies has been or will be made, shall be reported to the NRC Operations Center concurrent to the news release or other notifications".

This 30-day follow-up report is being submitted in accordance with 10 CFR 70.50 (c)(2).

Caller Identification

This condition was reported to the NRC Operations Center by Calvin Manning, AREVA Nuclear Criticality Safety Manager, on November 3, 2014 at 11:15 EDT (509-375-8237).

Date, Time, and Exact Location of Incident

The reportable condition was determined to exist on November 2, 2014 at approximately 1400 hours local time. This condition involved an employee within the site's Uranium Dioxide (UO2) Building sustaining an injury that resulted in hospitalization and required notification of Washington State Department of Labor and Industries.

AREVA INC.

2101 Horn Rapids Road, Richland WA 99354
Tel.: 509 375 8100 - www.areva.com

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Incident Description

On November 2, 2014, at approximately 12:47 local time an AREVA Ceramics Operator within the UO2 building had just completed dropping off empty buckets using a motorized ride-one cart. He then proceeded to return the cart to its parking location.

After rounding a corner near a closed off construction zone the operator resumed a straight path. The operator was traveling at the motorized cart's regulated speed and reportedly lost his balance (cause unknown). The operator's hand came off the steering yoke and his right foot came off the right side platform and made contact with the floor. The operator's right foot buckled and rolled under (or was caught near) the rear of the BT cart. The operator then fell to his left with his foot still pinned by the motorized cart. The operator landed on his back with his legs straddling the rear of the motorized cart's platform. This resulted in the operator breaking and dislocating his ankle.

Safety Significance of the Incident

The personnel impact of this incident is significant. The injury resulted in hospitalization of the operator and became a Recordable Event along and Lost Time Accident. No radiological, chemical or product quality impact resulted from this incident.

AREVA notified Washington State Department of Labor and Industries per Washington Administrative Code 296-800-32005 based on the worker requiring hospitalization. A press release was not issued.

Incident Response Actions

A number of actions were taken in direct response to this incident, as follows:

- A careful review of the event timeline was conducted.
- Immediate work stopage and safety stand down for groups involved was conducted.
- Appropriate internal and regulatory notifications were made.
- All ride-on carts were taken out of service.
- An apparent cause analysis (ACA) was initiated.

Interim and Near-Term Corrective Actions

- Operations conducted ride-on cart training with all authorized operators.
- Preventative Maintenance was performed on all ride-on carts and all walk-behind carts to ensure material conditions of the carts were satisfactory.
- Standing Order was issued to require increased supervisor oversight and to assure operation of ride-on carts at reduced speeds.
- Evaluate adjusting speed on all ride-on carts.
- Evaluate side rails for operator containment.
- Evaluate activity-based driving route restrictions.
- Evaluate replacing ride-on carts with walk behinds.
- Evaluate a visual aid for proper foot placement on ride-on cart's platform.
- Evaluate grip surface on both platform and steering yoke.
- Evaluate foot pad limit switch (kill power switch).

Incident Cause

While the cause of this incident has not been definitively determined ride-on carts can become less stable at higher speeds. Ride-on carts can "fishtail" after a curve regardless of speed due to factors such as over steering or speed.

The ride-on cart that was in use at the time of the accident has some physical traits that differ from the other ride-on carts. It has throttle reversal delay and travels at a faster speed. It also has a higher center of gravity due to its standing platform being somewhat higher than the other ride-on carts.

Physical changes in the normal paths of travel were required due to temporary construction curtain walls having been erected to close off a construction zone.

Actions to Prevent Recurrence

Operations management is conducting the evaluation reviews listed as near term corrective actions. In the interim all operators have been evaluated and recertified for operating a ride-on cart. Supervisory oversight has been enhanced to monitor safe travel speeds and proper operation of ride-on carts.

All ride-on carts have had a preventative maintenance inspection to ensure proper working conditions are met. The ride-on cart involved in the accident remains out of service.

If you have questions about this incident or AREVA's associated response, please contact me on 509-375-8550.

Very truly yours,

T. J. Tate, Manager
Environmental, Health, Safety, & Licensing

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c:

U.S. Nuclear Regulatory Commission, Region II
Attn: M. D. Sykes, Chief
Fuel Facility Branch 3
Marquis One Tower, 23 T85
245 Peachtree Center Avenue N.E., Suite 1200
Atlanta, GA 30303-8931

US Nuclear Regulatory Commission
Office of Nuclear Material Safety and Safeguards
Division of Fuel Cycle Safety and Safeguards
Attn: Soly I. Soto
Three White Flint North
Mail Stop 13C64
11601 Landsdown St.
North Bethesda, MD 20852