



December 8, 2020
TJT:20:028

U.S. Nuclear Regulatory Commission
Director, Office of Nuclear Material
Safety and Safeguards
Attn: Document Control Desk (03-H8)
One White Flint North
11555 Rockville Pike
Rockville, Maryland 20852-2738

Subject: Follow-up Report to October 20, 2020 Incident Reported Under 10 CFR 70
Appendix A section (c) (NRC Event No. 54962); Framatome Inc. Richland Facility;
License No. SNM-1227; Docket No. 70-1257

On October 21, 2020, the Framatome Inc. Richland facility reported an event per the requirements of 10 CFR 70 Appendix A section (c) because an industrial injury required reporting to the Washington State Department of Labor and Industry.

The initial report (NRC Event Report number 54962) was made consistent with the requirements of 10 CFR 70 Appendix A section (c) which requires the reporting of any event or situation, related to health and safety for which notification to other government agencies has been or will be made.

Attached to this letter is a 60-day follow-up report is being submitted in accordance with 10CFR 70.74 (b).

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

Very truly yours,

A handwritten signature in black ink that reads "T. J. Tate".

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

cc: U.S. Nuclear Regulatory Commission, Region II
Attn: Eric Michel, Chief
Fuel Facility Branch 2
Marquis One Tower, 23 T85
245 Peachtree Center Avenue N.E., Suite 1200
Atlanta, GA 30303-8931

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U.S. Nuclear Regulatory Commission,
Office of Nuclear Material Safety and Safeguards
11545 Rockville Pike
Attn: Osiris Siurano-Perez
Mailstop : TWFN-4A60
Rockville, MI 20852-273

60-Day Follow up Report

Caller Identification

This condition was reported to the NRC Operations Center by Calvin Manning, Framatome Manager of Licensing and Compliance, on October 21, 2020 at 1014 EDT (509-375-8237).

Date, Time, and Exact Location of Incident

The reportable condition occurred on October 20, 2020 at approximately 1130 hours local time in the sites carpenter's shop. This shop is **not** in a radiological control area.

Incident Description

A carpenter working in a clean (non-radiation) area injured his hand and required medical treatment.

There were not radiological or chemical hazards involved in this event.

Other than to the injured employee, there were not health and safety consequences to the workers, the public, or the environment due to this industrial accident.

The sequence of occurrences leading to the event are as follows:

10/20/2020 carpenter's work assignment for the day was to cut and assemble 51/2" blocks for shipping containers. Two hundred and sixty of these blocks were required.

10/20/2020, morning carpenter cuts multiple thick blocks from 2"x6" boards.

10/20/2020, 1120-1130: carpenter begins using the table saw to trim the thick blocks to 51/2" cuts by removing approximately 1/8" strips. A push stick was not used because there was no need to be inside the guard to make the cut.

10/20/2020, approximately 1130: While cutting one of these blocks, a kickback event occurred. A block that had already been cut was caught by the blade and thrown back into the carpenter, before landing approximately 12-15 feet away. The slick floor (slick concrete covered in saw dust may have contributed to the carpenter losing his balance and falling forward. The kickback event caused the guard to lift high enough to expose the blade. The carpenter's right hand came in contact with the blade severely injuring it.

Carpenter contacted his supervisor who summoned first responders who provided care until medical personnel arrived and transported the injured carpenter to an off-site medical care facility.

All remaining structures, systems, equipment, components and activities of personnel relied on to prevent potential accidents or to mitigate their consequences were and remain available and reliable to perform their function.

No external conditions affected this event.

The status of this event is "terminated".

This industrial accident did not require any declared emergency class. The current status of site is normal operations.

Notifications related to this event included the Washington State Department of Labor and Industry and the U.S. NRC.

There was not any press release made due to this event.

Safety Significance of the Incident

Although serious for the individual who was injured, the safety impact of this injury to the plant is low. No radiological emergency condition or radiological or chemical releases resulted from this incident.

Incident Response Actions

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

- EHS&L issued a Stop Work Order.
- A careful review of the event timeline was conducted.
- Appropriate internal and regulatory notifications were made.
- An apparent cause analysis (ACA) was initiated.

Interim and Near-Term Corrective Actions

The table saw was locked out and tagged out pending investigation.

Other similar equipment was inspected for adequate safety devices and guarding.

In-person safety stand down with crafts on this incident.

Incident Cause(s)

The cause of this incident is that the table saw's anti-kickback device was not adequate.

The kick-back event occurred because the distance between the blade and the anti-kickback device was equal to or slightly greater than the width of the block; which resulted in the anti-kickback device not having sufficient "bite" on the material being cut to prevent a kickback.

The saw did not come with a riving knife, a guard that moves along the blade, when it was purchased in 1997. A more modern anti-kickback device was not installed on the table saw because it was not recognized by the employees working on the equipment nor management that this safety feature was available and would have provided proper protection to the worker.

Actions to Prevent Recurrence

Replace the table saw in the carpenter shop with a modern table saw with anti-kickback features including a riving knife.

Evaluate the use of blade stopping technology or light curtain.

Evaluate qualifications and training for carpenters.

Complete a detailed extent of condition review on similar equipment.

Complete a compliance review to assure this type of equipment meets current Washington state safety requirements, as per the Washington Administrative Code.

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bc:

T. J. Tate
R. J. Land
C. D. Manning
C. S. Dreyer
S. C. Powers
S. D. Wright