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February 14, 2004

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U.S. Nuclear Regulatory Commission
Director, Office of Nuclear Material Safety & Safeguards
Attention: Document Control Desk
Mail Stop T-8A33, Two White Flint N, 11545 Rockville Pike
Rockville, MD 20852-2738

Re: Reply to a "Notice of Violation"
License No. SUB-526
Docket No. 040-03392

Dear Sirs:

This letter is our response to the "Notice of Violation" received from the NRC Inspection Report 40-3392/2003-007 dated December 17, 2003. This letter also responds to the request contained in the transmittal letter that in our response to the notice of violations Honeywell Specialty Chemical facility ("Honeywell") address why the corrective actions taken in response to issues identified after a 1998 event were not effective in preventing the more recent problems.

1. Violation No. 40-3392/2003-007-02

Chapter 2, Section 2.6 of the application, dated January 30, 2003, requires that "plant operations shall be conducted in accordance with written Standard Operating Procedure Manuals." Each manual provides detailed instructions for proper operation of each Production unit, and includes information pertaining to, in part, hazardous chemicals handled in the unit.

Contrary to the above, on September 30, 2003, an operation was not conducted in accordance with "Standard Operating Procedure Manuals." Specifically, the licensee's staff conducted an operation to remove a blockage from the Distillation Production unit without detailed instructions provided from "Standard Operating Procedure Manuals."

IEO7

Reason For The Violation

The violation occurred as stated. The Root Causes of the violation from our investigation include the following: the failure to provide a detailed procedure for clearing blockages, the size of Control Valve WIC 404 allowed blockage issues and the failure to provide an effective procedure to leak check pigtail connections prior to use. As a result, some UF6 gas escaped from the system at the No. 4 pigtail connection.

Corrective Actions Taken And Results Achieved

The following procedures were developed and/or enhanced to ensure safe operation:

- Blockage Removal
- Negative Pressure Pigtail Test

The activity addressed in the violation involved clearing blockages for Control Valve WIC-404. WIC-404 was replaced 10-27-03 with a larger valve to reduce blockage issues.

Training was completed on procedural changes.

Corrective Steps That Will Be Taken To Avoid Further Violations

Additional steps to avoid further violations are addressed in Section 3 below.

Completion Date

The Procedure changes were implemented on 10-03-2003.
The Control Valve WIC-404 was replaced 10-27-2003.
Operators were trained to these new procedures after issuance of the new procedures prior to performing shift task activities.
Additional items are addressed in Section 3.

2. Violation 40- No. 40-3392/2003-007-03

Chapter 2, Section 2.6 of the application, dated January 30, 2003, requires that "plant operations shall be conducted in accordance with written Standard Operating Procedure Manuals." The licensee's Standard Operating Procedure Manuals include the Procedure "Continuous Operations."

Step 4.3.23 of Procedure "Continuous Operations," dated February 2003, requires, in part, that evacuation line (PP-8) valves on all fill spots be closed prior to closing the fill spot product (PP-16) valve of the spot presently being filled. The procedure then required that the PP-16 valve be closed and the PP-8 valve opened when the cylinder was filled.

Contrary to the above, on August 31, 2003, licensee staff did not close the evacuation line (PP-8) valve for fill spot No.4 prior to closing the fill spot product (PP-16) valve and opening the PP-8 valve for the spot that was filled (No. 2). As a result, due to a loose pigtail fitting on the No. 4 fill position, a small uranium hexafluoride release occurred.

Reason For The Violation

The violation occurred as stated. The root cause was failure to follow procedures. Additional comments and actions concerning procedural issues are addressed in Section 3 below.

Corrective Actions Taken And Results Achieved

Plant work rules (policy HR-4) was enhanced on 11-20-2003 to emphasize procedural adherence and to provide guidance if a procedure is found to be incorrect or not understood by an operator. Guideline/Expectation for procedure in hand usage was communicated with plant operators prior to startup activities.

Meetings with employees were conducted to explain management's expectations for safety priority and procedural adherence.

Corrective Steps That Will Be Taken To Avoid Further Violations

Additional steps to avoid further violations are addressed in Section 3 below

Completion Date

- The HR-4 policy was issued 11-20-2003.
- The huddle review sessions were completed prior to restart of the UF₆ production activities during November 2003.
- Meetings with employees were held 10-15-2003 and 10-16-2003.

3. Response to Question "Why the corrective actions taken in response to issues identified after the 1998 event were not effective in preventing the more recent problems."

Based on the identified root causes, corrective measures appeared appropriate at the time. However, the root cause determination of the December 22, 2003 event indicates additional corrective measures could have been established to ensure activities are successfully conducted. This specific report has been intentionally brief understanding that the events of December 22 and the report resulting from the

associated AIT Inspection will provide the higher level of detail to ensure we have fully developed the causes and corrective actions necessary for safe operation.

The root causes of the previous events did not recognize the need for the following:

- A formal policy requiring that systems be placed in minimum risk condition prior to conducting evolutions that could involve hazards.
- Procedures to define minimum requirements for planning processes, which would include risk assessment and procedural requirement reviews.
- Procedures for Pre-job brief that would consider a review of all steps, including work scope, potential hazards and contingency plans (this would include supervisory review to determine job impact on total plant operations).
- Improvement in communications to ensure that plant personnel understand management expectations.
- Improve NRC and regulatory commitment tracking and corrective action processes to ensure that corrective actions are implemented and sustained.

Formal measures were not implemented to assure the corrective measures achieved the desired results. Nor were formal measures implemented to assure that the corrective actions had established reinforcement mechanisms so that they were likely to continue in effect. Lack of senior management continuity also contributed to the short-lived corrective action effectiveness.

In response to the December 22, 2003 event, the Plant will establish a performance improvement program that will address short-term items necessary for safe restart of UF₆ operations and longer-term efforts to achieve excellence in operations.

Included in the performance improvement program will be steps to improve corrective actions.

Sincerely,



Rory J. O'Kane
Plant Manager

cc: D. Mays
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