R2/E41

DADAVID AYRES BI-WEEKLY OPERATIONS STATUS REPORT

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Environment, Health & Safety

Thursday July 27, 2000

OPERATIONS SUMMARY

LAST WEEK (7/17-21)
Conversion = 5 UF_6 lines
Pelleting = 4 lines

LAST WEEKEND (7/22-23)
Conversion = 5 UF_6 lines (Saturday & Sunday)
Pelleting = 4Pellet Lines(Saturday & Sunday)

THIS WEEK (7/24-28)
Conversion = 5 UF_6 lines
Pelleting = 4 lines

THIS WEEKEND (7/29-30)
Conversion = Down
Pelleting = 2 pellet lines (Saturday) and 1 pellet line (Sunday)

UNUSUAL INCIDENTS

UPDATE: We have two uranyl nitrate tanks contaminated with Gadolinium. The source was old archive pellets which were disposed of. Half of one tank was converted to UO_2 before the contamination was detected. The uranyl nitrate and UO_2 powder will be blended off with non-contaminated nitrate and UO_2 powder, respectively.

UPDATE: Three pellet operators were put on restriction due to high airborne at the Pellet Line 3 roll hood. The source of the contamination was the changeout of the granulator screen during that shift. The operators involved were relatively new and were retrained on proper methods for handling this work.

UPDATE: On February 25th, a notification was made to the NRC in accordance with 10CFR70.50(b)(1) due to contamination on a concrete pad outside the plant on the south side (behind the UF6 Bay wall). *All of the 162 sections were "released". The pad is to be sealed and this effort will be complete.*

A 24 hour notification was made to NRC Operations Center on July 26, 2000 as a result of the discovery that a "filter processing procedure was not written in accordance with the Criticality Safety Evaluation." A copy of the report was also made to Region II and to Headquarters. The Incident Review Committee has discussed this incident and althought there was no loss of double contingency protection, this event has been determined to be safety significant and a root cause is being scheduled.

On July 27, 2000, two operators were lifting a fully loaded bulk container when it suddenly fell. An experienced operator was in the process of training a new operator to do this task. The bulk container is lifted by using a device called a "strongback" which allows the overhead crane to lift the container from the floor to the platform above. The experienced operator was operating the overhead crane. He had positioned the operator in training on the platform above in order to "spot" the container on the platform station. The operator raised the full container from the floor and when it had been lifted approximately 8-10 feet from the floor, the "strongback" separated from the crane hook and the container fell to the floor. No injuries occurred. This incident has also been reviewed by the Incident Review Committee and has been determined to be safety significant. Additional actions are being taken prior to allowing restart of the bulk blending area to ensure employee safety. A root cause will be conducted to learn more from this incident and lessons learned will be applied in other areas of the plant, where applicable.

MISCELLANEOUS

7-12