



**UNITED STATES
NUCLEAR REGULATORY COMMISSION**
REGION II
245 PEACHTREE CENTER AVENUE NE, SUITE 1200
ATLANTA, GEORGIA 30303-1257

January 10, 2014

Mr. Jim Pritchett
Plant Manager
Honeywell Metropolis Works
P.O. Box 430
Metropolis, IL 62960

SUBJECT: HONEYWELL METROPOLIS WORKS – NUCLEAR REGULATORY
COMMISSION INTEGRATED INSPECTION REPORT NUMBER
40-3392/2013-005 AND NOTICE OF VIOLATION

Dear Mr. Pritchett:

This letter refers to the inspections conducted during the fourth quarter from October 1 through December 31, 2013, at the Honeywell Metropolis Works facility in Metropolis, Illinois. The purpose of the inspections was to determine whether activities authorized under the license were conducted safely and in accordance with Nuclear Regulatory Commission (NRC) requirements. The enclosed report presents the results of the inspections. At the conclusion of the inspections, the results were discussed with members of your staff at an exit meeting held on November 7, 2013, for this integrated inspection report.

During the inspections, the staff examined activities conducted under your license, as they relate to public health and safety, in order to confirm compliance with the Commission's rules and regulations and with the conditions of your license. The inspections consisted of facility walk-downs; selective examinations of relevant procedures and records; interviews with plant personnel; and plant observations. Throughout the inspections, observations were discussed with your managers and staff. The inspections covered the following areas: maintenance and surveillance of safety controls and management organization and controls.

Based on the results of these inspections, the NRC has determined that one Severity Level IV violation of NRC requirements occurred. The violation was evaluated in accordance with the NRC Enforcement Policy. The current Enforcement Policy is included on the NRC's Web site at (<http://www.nrc.gov/about-nrc/regulatory/enforcement/enforce-pol.html>).

The violation is cited in the enclosed Notice of Violation (Notice) and the circumstances surrounding it is described in detail in the subject inspection report. The violation is being cited in the Notice because it was self-revealing. You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. If you have additional information that you believe the NRC should consider, you may provide it in your response to the Notice.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, and its enclosures, and your response, will be made available electronically for public inspection in the NRC Public Document Room or from the NRC's document system (ADAMS), accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html>. To the extent possible, your response should not include any personal privacy or proprietary information so that it can be made available to the Public without redaction.

Thank you for your cooperation. If you have any questions, please call me at (404) 997-4628.

Sincerely,

/RA/

James A. Hickey, Chief
Projects Branch 1
Division of Fuel Facility Inspection

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

Enclosure:
NRC Inspection Report No. 40-3392/2013-005
w/Supplemental Information

cc: (See page 3)

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cc: (See page 3)

DISTRIBUTION:

P. Silva, NMSS
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R. Gibson, RII

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cc:

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NOTICE OF VIOLATION

Honeywell Metropolis Works
Metropolis, Illinois

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

During NRC inspections conducted from October 1, 2013 through December 31, 2013, a violation of NRC requirements was identified. In accordance with the NRC Enforcement Policy, the violation is described below:

A self-revealing violation of the SUB-526 license was identified when a release of licensed material occurred from the Fluorination Dust Collector stack. The release was caused by an improperly installed dust collector bag on the secondary Ash Dust Collector that failed, which allowed source material to escape the stack contaminating an area located south of the Feed Material Building.

Section 2.6.1 of the License Application states, in part, that Honeywell shall establish a process to identify those process operations that require procedural guidance to ensure proper execution and require that these process operations be conducted in accordance with approved procedures. The section further states that written procedures shall govern the procedure control process. These procedures shall address operating procedure preparation, review, revision, approval, and implementation. Section 2.6.2.4 states, in part, that Honeywell shall establish procedures governing use of and adherence to written procedures.

Contrary to the above, in June of 2011, the licensee failed to govern the use of and adherence to written procedures. Maintenance workers failed to adhere to the requirements of written procedure MTW-SOP-F2N-0702, "F2N Fluorination Maintenance Support," which resulted in a release of source material from the fluorination stack of the secondary Ash Dust Collector. Specifically, an investigation conducted by the licensee found that only one hose clamp was installed on the bag; however, Section 5.1.35 of the procedure requires, when installing the Fluorination Dust Collector Bag, to place two hose clamps over the top of the bag. Section 5.1.38 requires the placement of one clamp above the ridge on the bag frame and one clamp below the ridge. Subsequently, the dust collector bag became dislodged when the licensee bumped (vibrated) the filters to remove the particulate. The licensee entered the issue into the corrective action program as Incident Report IR-13-1860.

In accordance with the NRC Enforcement Policy, this violation is characterized as a Severity Level IV violation for failure to govern the use and adherence to written procedures which resulted in a safety system failing leading to a release of source material through the stack of the secondary Ash Dust Collector (Section 6.2.d.2).

Pursuant to the provisions of 10 CFR 2.201, Honeywell Metropolis Works is hereby required to submit a written statement or explanation to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001, with a copy to the Regional Administrator, Region II, within 30 days of the date of the letter transmitting this Notice of Violation (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation"; and should include for each violation: (1) the reason for the violation, or, if contested, the basis for

Enclosure 1

disputing the violation or severity level, (2) the corrective steps that have been taken and the results achieved, (3) the corrective steps that will be taken, and (4) the date when full compliance will be achieved. Your response may reference or include previous docketed correspondence, if the correspondence adequately addresses the required response. If an adequate reply is not received within the time specified in this Notice, an order or a Demand for Information may be issued as to why the license should not be modified, suspended, or revoked, or why such other action as may be proper should not be taken. Where good cause is shown, consideration will be given to extending the response time. If you contest this enforcement action, you should also provide a copy of your response, with the basis for your denial, to the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001.

Because your response will be made available electronically for public inspection in the NRC Public Document Room or from the NRC's document system (ADAMS), accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html> to the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be made available to the public without redaction. If personal privacy or proprietary information is necessary to provide an acceptable response, then please provide a bracketed copy of your response that identifies the information that should be protected and a redacted copy of your response that deletes such information. If you request withholding of such material, you must specifically identify the portions of your response that you seek to have withheld and provide in detail the bases for your claim of withholding (e.g., explain why the disclosure of information will create an unwarranted invasion of personal privacy or provide the information required by 10 CFR 2.390(b) to support a request for withholding confidential commercial or financial information). If safeguards information is necessary to provide an acceptable response, please provide the level of protection described in 10 CFR 73.21.

In accordance with 10 CFR 19.11, you may be required to post this Notice within two working days.

Dated this 10th day of January, 2014

U.S. NUCLEAR REGULATORY COMMISSION
REGION II

INSPECTION REPORT

Docket No.: 40-3392

License No.: SUB-526

Report No.: 40-3392/2013-005

Licensee: Honeywell International, Inc.

Facility: Metropolis Works (MTW)

Location: Metropolis, IL 62960

Dates: October 1 through December 31, 2013

Inspector: Richard Gibson, Senior Fuel Facility Inspector

Approved by: James A. Hickey, Chief
Projects Branch 1
Division of Fuel Facility Inspection

Executive Summary

Honeywell Metropolis Works NRC Integrated Inspection Report 40-3392/2013-005

Routine, announced inspections were conducted by a regional inspector during normal shifts in the areas of maintenance and surveillance of safety controls and management organization and controls. The inspector performed a selective examination of licensee activities that were accomplished by direct observation of safety-significant activities and equipment, tours of the facility, interviews and discussions with licensee personnel, and a review of facility documents. The inspections addressed the following aspects of the program as outlined below.

Facility Support

- The Maintenance and Surveillance of Safety Controls program was implemented in accordance with the license application and regulations. One violation was identified for failure to govern the use of and adherence to written procedures which resulted in a safety system failing leading to a release of source material through the stack of the secondary Ash Dust Collector. (Paragraph A.1).
- The Management Organization and Controls program was implemented in accordance with the license and regulatory requirements. (Paragraph A.2)

Other Areas

- The inspector performed follow-up inspections of several incidents that occurred during this quarter. No violations of NRC requirements were identified. (Paragraph B.1)

Attachment:

Key Persons Contacted

Inspection Procedures Used

List of Items Opened, Closed, and Discussed

List of Documents Reviewed

REPORT DETAILS

Summary of Plant Status

The Honeywell Metropolis Works (licensee) uranium conversion facility is located on a 1,100 acre site (60 acres within the fence line) near Metropolis, IL. The licensee is authorized to possess 150 million pounds of natural uranium ore and to convert this material to uranium hexafluoride (UF₆). The uranium conversion process occurs in the Feed Materials Building (FMB). During the quarter, routine operations were on-going.

A. Facility Support

1. Maintenance and Surveillance (IP 88025)

a. Inspection Scope and Observations

The inspector interviewed the operations and maintenance managers to verify that maintenance and surveillance program activities for safety equipment were adequate to assure that the safety controls were available and reliable to perform their safety function when needed. The inspector concentrated efforts on evaluating work activities associated with projects involving heavily contaminated equipment including: (1) replacing the gasket on the wind box to the A-hydrofluorinator per work order 100926197, (2) repairing a crack in the piping to the A-fluorinator old screw per work order 100926762, and (3) an annual preventative maintenance wash out to the #2 Low Boiler Condenser per work order 100918695. The inspector determined that the maintenance workers involved were in compliance with the safety requirements and demonstrated knowledge of the requirements contained in the work packages.

The inspector verified that the licensee's work control program had provisions to ensure adequate pre-job planning and preparation of work packages in support of maintenance and surveillance activities. The inspector reviewed maintenance and surveillance work packages for accuracy. The review also ensured that the work packages challenged and verified operability of the safety controls within the required frequency.

The inspector reviewed the licensee's program for tracking and managing maintenance activities, and for maintaining equipment and component reliability including safety related Plant Features and Procedures (PFAPS). In addition, the inspector reviewed the licensee's corrective action program (ITCA – Incident Tracking and Corrective Actions) to verify that performance issues relating to the maintenance and surveillance of safety controls were entered into the corrective action program and evaluated the adequacy of corrective actions taken.

The inspector performed a follow-up inspection of an incident that involved a release of fine bed material (source material) from the stack of the secondary Ash Dust Collector for the A-Fluorinator that occurred on September 22, 2013. The licensee was bumping the secondary filters for the dust collector in order to remove the accumulation of particulates that were causing a pressure increase across the filters. The dust collector bag became dislodged from the frame of the Ash Dust Collector which resulted in a release of source material through the ventilation stack. The release caused spreadable contamination to an area located south of the FMB contaminating UF₆ cylinders on the ground, the road, and a vehicle located in the area.

The area and equipment were decontaminated and surveyed to less than the administrative limit for the area. The initial investigation by the licensee determined that during the last re-bagging back in June of 2011, the dust collector bag was installed with only one hose clamp. However, the maintenance support procedure requires installing two hose clamps.

Section 2.6.2.4, Procedural Adherence of the license application, states, in part, that Honeywell shall establish procedures governing use of and adherence to written procedures. Section 5.1.35 of the licensee's procedures, MTW-SOP-F2N-0702, "F2N Fluorination Maintenance Support," requires placing two hose clamps over the bag at the top. Section 5.1.38, requires placing one clamp above the ridge on bag frame and one clamp below the ridge. Fluorination ash dust collector bags are on wire frames that are clamped to the tube sheet at the top with two hose clamps. During the last bag changed out in June of 2011, maintenance workers failed to install two hose clamps as required by the written procedure. Subsequently, the dust collector bag became dislodged when the licensee bumped (vibrated) the filters to remove the particulate. The investigation by the licensee determined that the dust collector bag was secured by only one hose clamp. The licensee entered the issue into the corrective action program as Incident Report IR-13-1860. The failure to adhere to the licensee's written procedure, in accordance with Section 2.6.2.4, is considered to be a violation of the NRC license application (VIO 40-3392/2013-005-01).

b. Conclusion

One violation was identified involving maintenance personnel failing to adhere to the written requirements of a procedure resulting in a safety system failing leading to source material being release through the stack of the secondary Ash Dust Collector for the A-fluorinator.

2. Management Organization and Controls (IP 88005)

a. Inspection Scope and Observations

The inspector interviewed senior managers, managers, and supervisors to verify that the licensee management team understood and implemented governing policies for safety programs and were cognizant of their responsibilities under these policies. The inspector reviewed changes in personnel responsibilities and functions that occurred within the past year. The inspector verified that the personnel selected met the qualifications as required by the license application.

The inspector verified the licensee's control of procedures through discussions with licensee staff. The inspector reviewed procedures which had been revised since the last inspection to ensure that they were reviewed and approved in accordance with approved procedures. The inspector verified that the licensee's corrective action program was commensurate with safety significant issues identified by employees and that those issues were tracked to completion. The inspector reviewed multiple samples of ITCA reports related to safety issues and determined that the findings were appropriately documented in accordance with the licensee's program and established procedures.

The inspector verified that the Quality Assurance Program was comprehensive in conducting audits of the safety programs and provided helpful recommendations that were appropriately documented in the corrective actions program. The inspector determined that the reviewed internal audits were thorough and reflected a low threshold for identification and documentation of discrepancies.

The inspector reviewed the minutes from the plant Health Safety and Environmental Committee and the "B" Council meetings for the year 2012. Based on this review, the inspector determined that the meetings were chartered and the members met the terms and conditions stipulated in the license. The inspector also determined that safety recommendations from the meetings were entered in the corrective action program for tracking.

b. Conclusion

No violations of NRC requirements were identified.

B. Other Areas

1. Ore Concentrate Drum Storage

a. Inspection Scope and Observations

The inspector performed an inspection of the concrete pads used for storing 55-gallon drums of ore concentrate. The inspector verified that the drums were properly stored and inventoried on the pads. The inspector also verified that housekeeping was adequately maintained on the pads. The inspector interviewed the licensee's Site Services Manager and determined that the licensee performs ore pad inspections daily to note any defects with the drums. If a drum on the pad is found to be compromised, the licensee immediately addresses it. Also, the licensee performs a wall-to-wall monthly inventory where nearly all the drums are identified for content.

The inspector walked down the areas of the ore pads and noted that the 55-gallon drums containing uranium feed ore stored outside were free of physical defects and in good physical condition. The inspector determined that each 55-gallon drum of ore weighs approximately 800 to 1000 pounds and were stacked three drums high in accordance with the drum manufacturer storage requirements for stacking chemical drums. The inspector did not identify any ore drums leaking yellow cake onto the pads and as a result, the inspector determined that housekeeping of the pads was adequate. The inspector did not observe any defects to the concrete pads.

b. Conclusion

No violations of NRC requirements were identified.

2. HF Rail Car Unloading Operations

a. Inspection Scope and Observations

The inspector performed a follow-up inspection of an incident that occurred on October 8, 2013, at the hydrogen fluoride (HF) Rail Car unloading platform. While moving the used HF Rail Car from the unloading platform, the unloading hose became entangled on the rail car dome railing causing the breakaway coupling on the hose to break. The inspector determined from interviews and reviews of records that the operators had just completed discharging HF from the rail car to the Feed Materials Building and were in the process of switching out the used rail car for a full one. Once the hose lines were evacuated, they were unhooked from the rail car and inspected by the operators.

The used rail car was being moved from the unloading platform and, while moving the car, the unloading hose caught on the railing around the dome on the car causing the unloading hose to break at the breakaway coupling.

The licensee's procedure "HF Unloading Operations," MTW-SOP-TFO-0210, requires two tank farm personnel when unloading anhydrous HF and during connection/disconnection to a tank car/truck. Also, there is a checklist requirement to initial and date the time that the catwalk with the unloading hoses was raised and secured. While moving the used HF Rail Car from the unloading station, the operator (spotter) did not ensure that the unloading hoses were adequately secured to the platform. The inspector determined that the unloading operations of the HF Rail Car did not involve licensed source material and the discharging of HF to the FMB was prior to the processing of licensed material. The licensee entered the issue into the corrective action program as Incident Report IR-13-1956.

b. Conclusion

No violations of NRC requirements were identified.

3. Sulfuric Acid Unloading Operations

a. Inspection Scope and Observations

The inspector performed a follow-up inspection of an incident that occurred at the sulfuric acid storage tank on October 18, 2013. A truck of sodium hydroxide was connected to the sulfuric acid unloading station when approximately 5000 pounds of sodium hydroxide was added to the sulfuric acid tank before the operator realized the error. The addition of sodium hydroxide to sulfuric acid caused an exothermic reaction inside the tank. There was no pressure buildup in the tank because the tank was vented during the unloading process. However, the tank temperature did reach 265 degrees Fahrenheit at the interface zone due to the exothermic reaction. The licensee cooled the tank externally with the mitigation spray towers to lessen the effects of the reaction.

The inspector interviewed licensee personnel and reviewed records and determined from the investigation that, according to their shipping metrics for the day, the operators had expected a truck containing sulfuric acid and not sodium hydroxide. However, a shipment of sodium hydroxide was delivered and partially unloaded into the sulfuric acid tank. According to the licensee, the exothermic reaction did cause a small amount of degradation to the internal walls of the tank, but the tank was not compromised and is still in use for storage of sulfuric acid. The inspector reviewed records of penetration tests performed on the tank by the licensee and agreed with the results.

The licensee's procedure "Sulfuric Acid Truck to Process Operations," MTW-SOP-TFO-0215, requires the operators to initiate the inspection sheet Form A prior to sulfuric acid run to process. The inspection sheet has a line item to ensure the material identification (UN) number for the chemical agent prior to unloading. The operator had started the truck unloading before checking to ensure that the right truck was being unloaded. Once the operator reviewed his sheet, he then realized that he was unloading sodium hydroxide instead of sulfuric acid into the sulfuric acid tank. The inspector determined that the unloading operations of the sodium hydroxide into the sulfuric acid tank did not involve licensed source material. The licensee entered the issue into the corrective action program as Incident Report IR-13-2026.

b. Conclusion

No violations of NRC requirements were identified.

4. Structural Damages (Cracks) to The A- and B-Fluorinator Supports

a. Inspection Scope and Observations

The inspector performed a follow-up inspection of the licensee's discovery of structural damages (cracks) to the A- and B-Fluorinator supports. On September 21, 2013, during normal operations of the B-Fluorinator, the licensee noticed what appeared to be a crack in one of the structural braces that support the B-Fluorinator. An investigation of the A-Fluorinator determined a crack in the same structural braces that support the A-Fluorinator. Structural tests were performed by an outside contractor, and it was determined that the cracks were due to the movement and vibration of the fluorinators during operations. Also, the investigation determined that the foot structures that attached the fluorinators to the braces were welded instead of bolted down. The cracks were discovered in the welded areas where the foot structures attached to the braces. The licensee did not identify cracks or defects on the structural supports for the C-Fluorinator.

The inspector walked down the fluorinators and determined that the licensee had installed stiffeners and re-enforced the structural braces, which were bolted down to the supports for the fluorinators. The licensee has updated the diagram for the fluorinators to reflect the upgrade to the structure supports. The licensee entered the issue into the corrective action program as Incident Report IR-13-1859.

b. Conclusion

No violations of NRC requirements were identified.

5. Follow-up on Previously Identified Issues

a. (Closed) Incident Report Number (IR) 971754.

This Incident Report involved an inspection of rail cars during a receipt inspection of a Gondola Container on April 1, 2011. An inspection of rail cars containing radioactive waste identified liquid dripping from a drain cover on one rail car (a Gondola Container at Energy Solutions, Clive, Utah). The inspector reviewed the corrective actions that were reported by the licensee by letter, Subject: "Reply to Notice of Violation, NRC inspection Report No. 40-3392/2011-003 and Notice of Violation dated August 25, 2011." The inspector determined that the remaining corrective actions were incorporated into appropriate procedure revisions to prevent recurrence. Based on the verification of the licensee's corrective actions, this item is closed.

6. Exit Meeting

The inspection scope and results were presented to members of the licensee's staff at various meetings throughout the inspection period and were summarized on November 7, 2013, with Larry Smith, Plant Manager, and other members of the licensee's staff. No dissenting comments were received from the licensee. Proprietary information was discussed, but not included in the report.

SUPPLEMENTAL INFORMATION

1. KEY PERSONS CONTACTED

D. Bilski, Security Manager
D. Craig, Operations Plant Superintendent
J. Cybulski, Site Services Manager
L. Litinski, Regulatory Affairs
M. Mena, Quality Assurance Supervisor
T. Noll, ISA Project Manager
S. Patterson, Regulatory Affairs Manager/Radiation Program Manager
J. Price, Technology Manager
J. Pritchett, Plant Operations Superintendent
R. Robertson, Regulatory Affairs Specialist
J. Smith, Maintenance Manager
J. P. Smith, Employee Representative, USW Local
L. Smith, Plant Manager
M. Wolf, Nuclear Compliance Director

Other licensee employees contacted included operations, management staff, engineers, HP-technicians, security, and office personnel.

2. INSPECTION PROCEDURES USED

IP 88005	Management Organization and Controls
IP 88025	Maintenance and Surveillance of Safety Controls

3. ITEMS OPENED, CLOSED, AND DISCUSSED

<u>Item</u>	<u>Status</u>	<u>Description</u>
IR 971754	Closed	During a receipt inspection of a Gondola Container of radioactive waste material, it was discovered that the drain cover was leaking liquid.
VIO 70-1257-2013-005-001	Open	Failure to govern the use of and adherence to written procedures which resulted in a safety system failing leading to a release of source material through the stack of the secondary Ash Dust Collector.

4. LIST OF DOCUMENTS REVIEWED

Procedures:
MTW-SOP-TFO-0215, Revision (Rev.) 2, Sulfuric Acid Truck to Process Operations
MTW-SOP-TFO-0214, Rev. 5, Sodium Hydroxide Unloading Operations
MTW-SOP-TFO-0210, Rev. 14, HF Unloading Operations
MTW-SOP-F2N-0702, Rev. 0, F2N Fluorination Maintenance Support

Attachment

MTW-ADM-PRO-0100, Rev. 5, Development and Implementation of Policies and Administrative Procedures
 MTW-ADM-PRO-0103, Rev. 15, Development and Implementation of Plant Technical Procedures
 MTW-ADM-PRO-0109, Rev. 5, Document Control
 MP-241, Rev. 2, Hooking up Low Boiler Condenser for Wash
 MTW-ADM-MT-0001, UF6 Distillation #1 Cylinder Fill Spot
 MTW-ADM-OPS-0121, Management of PFAPS

Work Orders:

100926197, A-Top Hydrogen Fluorinator re-gasket of wind box
 100926762, R-417, Weld hole in a D/O to Old Screw, (Crack in piping A-Fluorinator Draw off line)
 100926454, R-401, GE Dissociator will not heat up, (Replaced and weld new heating coil)
 100926055, U-488, B-Side Nash discharge header change out scrubber 8" Nash welding
 100918695, E-462 #2 Low Boiler Condenser set up for annual PM wash out

Preventative Maintenance:

70604118, CR-400 Bridge, UF6 Cylinder Crane weekly inspection electrical checks
 70605249, CR-400 Bridge, UF6 Cylinder Crane weekly inspection electrical checks
 70601703, Plant Disaster siren annual checks
 70484603, Test fuel gas safety shut off valves, E-608 green salt B-train Redu Htr
 7048606, Check the temperature for the furnace over-ride controller
 70490762, F-700, A-3 Fluorination primary filter change out

Incident Reports:

IR-2013-2090
 IR-2013-2060
 IR-2013-2072
 IR-2013-1994
 IR-2013-1978
 IR-2013-1956
 IR-2013-1932
 IR-2013-1860
 IR-2013-1859