UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
SAM NUNN ATLANTA FEDERAL CENTER
61 FORSYTH STREET, SW, SUITE 23T85
ATLANTA, GEORGIA 30303-8931

February 6, 2009

Mr. David Kudsin
President
Nuclear Fuel Services, Inc.
P. O. Box 337, MS 123
Erwin, TN 37650

SUBJECT: CORRECTED PAGES FOR NRC INSPECTION REPORT NO. 70-143/2008-004 AND NOTICE OF VIOLATION (ML090340111)

Dear Mr. Kudsin:

This letter refers to the inspection conducted at your Erwin, TN on October 5, 2008 to December 31, 2008. A procedure number was incorrectly typed in the Notice of Violation (NOV) "A" and in Section 2 on page 2 of the original inspection report details (ML090340111). Please replace the corresponding pages of the Notice of Violation and the Inspection Report attached. We apologize for any inconvenience that may have resulted from this error. No further response or acknowledgment is required.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter and its enclosure 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.

Should you have any questions concerning this letter, please contact us.

Sincerely,

/RA/

D. Charles Payne, Chief
Fuel Facility Inspection Branch 1
Division of Fuel Facility Inspection

Docket No. 70-143
License No. SNM-124

Enclosure: Corrected Notice of Violation and Inspection Report Pages

cc w/encl: (See page 2)

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NOTICE OF VIOLATION

Nuclear Fuel Services, Inc.
Erwin, Tennessee

Docket No. 70-143
License No. SNM-124

During NRC inspections conducted from October 5, 2008 through December 31, 2008, violations of NRC requirements were identified. In accordance with the NRC Enforcement Policy, the violations are listed below:

A. Safety Condition S-1 of Special Nuclear Materials (SNM) License No. SNM-124, authorizes the use of licensed materials in accordance with the statements, representations, and conditions in the License Application and Supplements.

Section 2.7 of the License Application, "Procedures," states in part that SNM operations and safety function activities shall be conducted in accordance with approved written procedures.

Standard Operating Procedure (SOP) 401, Section 37, "Tank XX-WF-03/WF-04," Revision 6, Section 6.3 requires the opening of valve WF50, "Tank XX-WF-04 suction" when transferring the contents of tank WF-04 to the waste treatment facility

SOP 409, Section 8, "U-Metal Oxidation and U-Oxide Dissolution," Revision 26 Attachment XV, step 21, requires the closure of valve 3C48 following a transfer of material from the 3-day column to the mix and measure column. Additionally, Attachment V requires the operator to verify closed valve 3C48 prior to transferring the contents of the 3-day column to the 7-day column.

Procedure NFS-GH-65, "Problem Identification," Revision 4 requires all employees who have knowledge of an event to report it in the Problem Identification, Resolution and Correction System (PIRCS) as soon as reasonably possible. An event is defined, among other things, to include equipment difficulties.

Contrary to the above, the following three examples were identified:

- On October 17, 2008, when transferring the contents of tank WF-04 to the waste treatment facility, valve WF-51, "Tank XX-WF03 suction" was mistakenly opened and a portion of tank WF-03 was transferred to the waste treatment facility.

- On December 4, 2008, operations failed to close valve 3C48 following a transfer of material from the 3-day column to the mix and measure column. Additionally, on December 5, operations failed to verify close valve 3C48 prior to transferring the contents of the 3-day column to the 7-day column. Both actions resulted in the overflow of the mix and measure column.

- Operating Procedure (SOP) 401, Section 37, "TankXX-WF-03/WF-04," Revision 6, Section 6.3 directed the operator to open valve WF-50. However, the operator mistakenly opened WF-51 and tank WF-03 was transferred instead. The operator subsequently noted the error and secured the transfer. Approximately 3 to 5 inches of the tank contents were transferred. The licensee entered the issue into the Problem Identification, Resolution, and Correction System (PIRCS) as PIRCS item 15829. The Criticality Safety Engineer was notified of the issue and the tanks contents were sampled. Sample results indicated the contents were within acceptable limits. This issue was reported to the Headquarters Operations Officer (HOO) on October 17 as Event Notification (EN) 44579 due to the licensee failing to meet the performance criteria of 70.61 (See Section 6).

- On December 4, 2008, BPF operations transferred special nuclear material (SNM) from the 3-day column to the mix and measure column. Following completion of this transfer, valve 3C48 was left in the " locked open" position which was contrary to SOP 409, Section 8, "U-Metal Oxidation and U-Oxide Dissolution," Revision 26, Attachment XV, step 21, which required the valve to be locked closed. On December 5, 2008, BPF operations began a transfer of SNM from the 3-day column to the 7-day column. Step 15 of Attachment V to SOP 409 Section 8 requires valve 3C48 to be verified closed. Similarly, this step was missed and SNM was transferred from the 3-day column to not only the 7-day column as desired but also to the mix and measure column. At the time, the mix and measure column was approximately full and the column subsequently overflowed to the knockout column. At this point, operations realized an error had occurred and the transfer was secured. Additionally, during the overflow, an elbow in the wet off gas (WOG) line leaked material and some material wetted the mix and measure columns as well as the adjacent wall. Operations was unable to complete decontamination of the area within 24 hours and reported the event to the NRC HOO as EN 44700 in accordance with 10 CFR 70.50(b)(1) (See Section 6). The area was subsequently decontaminated, the WOG line repaired, and the issue was entered into the corrective action system as PIRCS item 16452.

On December 22, BPF operations began to fill the caustic tank 6H10 in accordance with procedure SOP 409, Section 24, "333 BPF Process Ventilation System," Revision 4. This procedure set up the tank for an auto-fill operation. Subsequent to the system alignment, operators noted caustic spilling into the chimney area of building 333 and secured the caustic transfer. Initial diagnosis indicated that the level probe had failed and the tank overfilled. The inspectors noted however, that it was somewhat common knowledge among numerous operators that the level probe was faulty. Other crews had recently performed the same procedure but manually filled the tank since the level probe operation was questionable. Procedure NFS-GH-65, "Problem Identification," Revision 4, requires all employees who have knowledge of an event to report it in the PIRCS as soon as reasonably possible. This procedure defines an event to include equipment difficulties. This equipment difficulty was not entered into the corrective action system and thus the information was never relayed to the operating crew on the evening shift of December 22.