

July 20, 2000

MEMORANDUM TO: Theodore Sherr, Chief  
Safety and Safeguards Support Branch  
Division of Fuel Cycle Safety  
and Safeguards, NMSS

Philip Ting, Chief  
Fuel Cycle Licensing Branch  
Division of Fuel Cycle Safety  
and Safeguards, NMSS

Michael Tokar, Chief  
Special Projects Branch  
Division of Fuel Cycle Safety  
and Safeguards, NMSS

FROM: Dennis C. Morey, Chair /RA/  
91-01 Review Committee  
Operations Branch  
Division of Fuel Cycle Safety  
and Safeguards, NMSS

SUBJECT: MARCH 91-01 EVENT REPORT REVIEW

The FCSS 91-01 Review Committee met on April 20, 2000, and conducted a review of events reported in accordance with NRC Bulletin 91-01 during the month of March 2000. FCOB was represented by Dennis Morey, FLIB by Harry Felsher, SPB by Larry Berg, and IRO by John McKinnon. IRO staff was invited to join the Committee due to the expressed concerns of IRO over the large number of non-safety significant GDP 91-01 event reports from the Gaseous Diffusion Plants. Mr. McKinnon noted that approximately 10 non-safety significant event report in a week would adversely affect IRO and that the GDPs had exceeded this threshold in the past although they have recently declined to a more manageable number. Eight event reports were provided to the Committee by Candice Drummond and the Committee members agreed that these constituted all the March 91-01 reports. The event breakdown is as follows:

<u>Facility</u>	<u>Events Reported This Month</u>	<u>Events Reported Year-to-Date</u>
Global Nuclear Fuels	0	2
CE-Hematite	1	1
Paducah GDP	2	3
Portsmouth GDP	5	13

The Committee made the following determinations regarding the events:

- A. The CE event involved water in-leakage through multiple moderation barriers. This event is considered potentially safety significant due to the licensee dependence on moderator exclusion. No generic issue was noted. The Committee recommends that licensee investigation results be reviewed during a future routine inspection.
- B. The first Paducah event concerned equipment in DOE Material Storage Areas (DMSAs) being incorrectly handled as NCS exempt following the transfer of the DMSA to USEC control because the equipment had been incorrectly assayed. The Committee considers this event potentially safety significant due to the practice of storing HEU contaminated equipment in the DMSAs. No generic issue was noted. Mr. Berg agreed to determine the final correct assay of the equipment in question. The Committee recommends that the DMSA transfer issue be investigated further during a future routine inspection.

Remaining events are discussed in the attachment.

Attachment: As stated

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Attachment: As stated

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**\*See previous concurrence**

OFFICE	SSSB		SPB		SPB			
NAME	DMorey		LBerg		HFelsher			
DATE	7/20/2000		7/20/2000		7/20/2000		/ /2000	

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**ATTACHMENT A**  
**GDP Events**

1. Paducah event concerned equipment being placed in an alkali bath without being surveyed for unconditional release. The equipment in question had been visually inspected and assayed below 5.5%. The Committee noted that the reportability of this event was questionable because it is not clear that a safety significant upset has occurred or is even possible. Mr. Berg agreed to follow-up the final tank sample.
2. Portsmouth event concerned a 55-gallon laundry drum with the lid ajar. The Committee noted that the reportability of this event was questionable due to lack of a clear process upset. There was no discussion or indication that any material in the facility could potentially enter the drum or would be safety significant in the drum. This is an example of an inappropriate NCS control arrangement.
3. Portsmouth event concerned a five-gallon bucket spaced 23 inches in an array instead of the required 24 inches. The Committee noted that the reportability of this event was questionable due to lack of discussion of important parameters such as change in system reactivity. This is an example of an inappropriate NCS control arrangement. This event appears to be a routine infraction.
4. Portsmouth event concerned the connection of a pump with an excessive oil capacity to a cascade cell. The Committee noted that the reportability of this event was questionable due to lack of a process upset such as oil leaking into the cascade. This is an example of the failure of the failure of the NCS program to ensure the actual field requirements are bounded by the NCSE, and controlled by the NCSA.
5. Portsmouth event concerned the same issue with an oil pump reservoir as noted above and the conclusion is the same.
6. Portsmouth event concerned the storage of fissile material samples in an area where fissile material samples are not authorized for storage. The Committee noted that the reportability of this event was questionable because there is no indication that there was any safety issue. The only issue noted is that 27 grams of fissile material was involved which violated a 15 gram boundary definition.