10 CFR 71.95 REPORT EVALUATION FORM

Docket No.: 71-9196

Package Model No.: UX-30

Report Submitted By: C. M. Vaughan, Manager, Global Nuclear Fuel - Americas, LLC

Report Date: 08/24/2005

Review the incoming report to determine if additional Commission or staff action is warranted. The review should consider whether the report identifies a generic defect or problem with the package design and the safety significance of the issue. Note that a high safety significance represents a potential for significant radiation exposure, medium safety significance represents a potential for some moderate radiation exposure, and low safety significance represents little or no potential for radiation exposure.

1. The report identifies:

9 Significant reduction in the effectiveness of a package during use;
9 Defect with a safety significance;
: Shipment in which conditions of the approval were not observed.

2. What is the safety significance? 9 High 9 Medium : Low

3. Summary of the report:

Shipments in the UX-30 overpack were not in conformance with condition no. 9(c) of the Certificate of Compliance. Condition 9(c) of the certificate requires the package to be prepared for shipment and operated in accordance with the Operating Procedures of Chapter 7 of the application. Chapter 7, section 7.1.5 states that prior to shipment a standard 30-B cylinder should have the valve cover removed. However, one of three cylinders had a valve cover on the valve. This event is similar to the one GNF reported on June 21, 2005. GNF stated that the cause of this event was different than the cause for the first event.

4. Corrective actions taken by the licensee:

Global Nuclear Fuel - Americas (GNF-A), LLC, will take the following corrective actions:

1. Issue a stop shipment for all UF6 cylinders to be forwarded.
2. Issue a Temporary Operating Procedure, until modification of the permanent procedure, to have cylinder dock operators perform an independent verification to insure valve covers have been removed from the cylinder valves once they have been placed in UX-30 overpacks.
3. Conduct an internal review.
4. Communicate to the cylinder dock operators the expectation of following procedures.

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5. Staff comments:

This occurrence was similar to a previous event reported to the NRC on June 21, 2005. The basic cause of the event was different.

6. Staff conclusion:

: The report does NOT identify generic design or license/certificate issues that warrant additional Commission or staff action. This report is considered closed.

9 There is a need to take additional action. Provide a summary of the bases and recommended actions:

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