R2/E15

Events at Westinghouse

Date of Event	Event #	NMED #	R2/ Description
2/19/05	41424	050102	Bulletin 91-01: It was observed that the required samples for generation of the composite sample were not being taken consistently
2/17/05	41418	05101	Bulletin 91-01: A different sponge media was used that was more dense. The licensee determined that the configuration control process for the sponge jet blast system was bypassed.
2/04/2005	41372	050070	Bulletin 91-01: The licensee reported the loss of double contingency criticality control for non-favorable geometry bulk container - the sensor was knocked awry and did not register a polypack as being "consumed." The PLC did not lock up process as designed.
8/24/04	40985	040606	Bulletin 91-01: The licensee reported an event involving the failure of double contingency protection. A team leader opened the wrong set of valves the incorrect valve line-up caused a batch from the solvent extraction system to be pumped to the uranyl nitrate bulk storage tank without having the necessary sample results for grams U-235/liter, percent free acid, and pH. SL-IV vio given in IR 04-04
7/21/04	40888	040531	Bulletin 91-01: Unanalyzed condition. The licensee reported that during a highly unusual upset condition on Conversion Line 3, ADU powder backed up in the elevator and hot oil dryer and into N2 accumulator tank, URI 2004-202-07, still open
7/7/2004	40855	040501	Bulletin 91-01: The licensee reported finding a canvas-lined cart in the UF6 bay. The cart had slits cut in bottom. Having cart in bay was unanalyzed condition. NCV 2004-202-06 issued
6/4/04	40793	040408	The licensee reported the discovery of material accumulation in a 55-gallon drum (capture moisture condensate from high pressure drying of UF6 cylinders). One example in SL IV VIO 2004-202-04

Ex. 4

K-5

Date of Event	Event #	NMED #	Description
3/4/04	40567	040169	Bulletin 91-01: The licensee reported operating their incinerator off-gas system outside the approved criticality safety basis - significant material build up in incinerator and greater than 21.8wt % concentration SL II VIO with 8 examples
1/12/04	40440	040026	[redacted]
10/16/03	40255	030833	Bulletin 91-01The licensee reported the loss of double contingency protection for the ADU Bulk Blending System.A software malfunction left less than adequate double contingency protection for the system. The software prevents high moisture polypaks from being dumped into a bulk container. Immediately after all 122 packs were dumped into the bulk container to complete the blend of material, Operations noticed that the packs had not been denoted as "consumed" by the data base and notified the computer system administrator and Nuclear Criticality Safety. The computer system administrator stopped all dumping operations.
10/14/03	40246	030826	The licensee reported that dry combustible trash was placed into a single 55-gallon drum without proper mass control.
10/2/03 Not Reportable	40265	030848	The licensee reported the loss and recovery of a fuel rod (#18768319) that contained 85 grams of U-235.
9/12/03	40152	030733	The licensee reported that lead-filled rods in a small number of replica fuel assemblies were scanned using an improper instrument.
7/17/2003	40004	030585	The licensee reported that an operator transferred a batch of uranyl nitrate solution from a favorable geometry vessel to the non-favorable geometry bulk storage vessel prior to receiving the required sample results for U-235 concentration, percent free acid, and pH.

Ex. 4

Date of Event	Event #	NMED #	Description
3/31/2003	39751	030303	The licensee reported an event involving the loss of double contingency protection. Six UF6 cylinders were placed on hold because the licensee questioned if the cylinders were properly tested following repair.
1/23/03	39998	030573	The licensee reported that a process engineer generated a temporary procedure to compact air filter paper and did not place the NCS function on review or approval.
9/23/02	39214	020896	The licensee reported finding scrubber ventilation ductwork containing gross contamination stacked without proper spacing in the Conversion Decontamination Room.
9/5/02	39170	0208843	The licensee reported that during a planned shutdown and inspection they detected material and liquid in the ventilation ductwork.
6/24/02	39016	020622	The licensee reported finding damp material in ventilation ductwork, filters, and the filter housing.
6/5/02	38965	020567	The licensee reported that 13 packs of U3O8 were taken into the Erbia Modcon area without the proper moisture controls.
3/13/02	38767	020285	The licensee reported that when an empty bulk container was returned to the bulk blending room, an operator noticed a film of oil on the outside of the container and its feeder valve, and on a horizontal structural plate of the container.
2/14/02	38728	020224	The licensee reported that their process information form (PIF) for flushing and pumping out the lines of the C4 dissolvers did not contain all of the required criticality controls.
1/27/02	38656	020139	The licensee reported the loss of double contingency protection. It had been determined that the granulator screen needed to be replaced and operations were stopped.
1/6/02	38612	020020	The licensee reported that a water leak occurred in the Burnable Absorber Expansion System Moderation Control Area.
10/16/01		020323	The licensee reported an event involving a significant reduction in the effectiveness of a Type-B container during shipment.

Date of Event	Event #	NMED #	Description
8/16/01		010987	The licensee reported that they received notification from Framatome ANP of Richland, Washington, that the certificate of compliance for the ANF-250 powder/pellet container was being withdrawn. This was the result of the discovery of typographical errors in the license drawings for that container.
7/20/01	38177	010718	The licensee reported an event involving one special nuclear material (SNM) container that was unexpectedly returned to BWX Technologies, Incorporated
5/21/01	38020	010483	The licensee reported an event involving the failure of criticality safety controls on their Ammonium Diuranate (ADU) process lines.
12/7/00		010229	The licensee reported the shipment of three containers with contact radiation levels in excess of the regulatory limit of 2 mSv/hr (200 mrem/hr).
10/18/00	37441	000814	The licensee reported that periodic testing of the condensate level detection system in the 3A vaporizer steam chest determined that the system could not perform its intended function due to blockage in the system by loose debris.
7/26/00	37189	000551	The licensee reported that during a routine procedure review associated with a plant-wide procedure upgrade process, a Nuclear Criticality Safety (NCS) engineer noted that a procedure was not written in compliance with the documented criticality safety evaluation.
7/9/00		000679	The licensee reported a violation of Shipping Container Certificate of Compliance USA/9203/AF.
2/7/00	36727	000144	The licensee reported that contamination was discovered on a small portion (approximately 100 square feet) of a 20 foot by 50 foot outside concrete pad, located adjacent to the Columbia Plant Manufacturing Building (between the building and the Uranyl Nitrate Tank Storage Pad).
8/5/99 Not Reportable		990160	The licensee reported that while making a routine, twice-per-shift check, the operator noticed that dry uranium dioxide (UO2) powder was not coming out of the granulator while the granulator and roll compactor were running.

Date of Event	Event #	NMED #	Description
1/12/99	35249	990038	The licensee reported that an operator noticed a small fire in a polypack located in a ventilated hood (704) which services an oven used to dry press cake.