10 CFR 71.95 REPORT EVALUATION FORM

Docket No.: 71-9239

Package Model Nos.: MCC-3, MCC-4, and MCC-5

Report Submitted By: Peter J. Vescovi, Westinghouse Electric Company, LLC

Report Date: October 9, 2006

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:

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

2. What is the safety significance? □ High □ Medium ☒ Low

3. Summary of the report: On August 3, 2006, the applicant (Westinghouse) package two fresh fuel assemblies for shipment to a Part 50 licensee. On August 12, 2006, during an receipt inspection of the fuel, the Part 50 licensee found that eight of the nine restraining clamps were closed and secured on the fuel rods and not on the structural grids. The Part 50 licensee did not accept the fuel. A shipment configuration not in accordance with CoC No. 9239, Condition 10.(a). The fuel was returned to the applicant's facility.

The applicant determined the root causes for this event were: (1) shipping container was incorrectly marked prior to placing the container into storage, (2) the incorrectly marked container was later retrieved and used to ship a fuel design consistent with the incorrect marking, (3) the second shift personnel were less experienced and did not recognize the container-fuel design mismatch, and (4) neither the procedure nor the checklist required the verification or independent verification of the pressure pad alignment step.

4. Corrective actions taken by the licensee: The applicant addressed the root causes of this event with several corrective actions. These corrective actions were separated into three categories: remedial actions (actions taken immediately), interim actions, and corrective actions to prevent recurrence of this event.

Remedial Actions: (1) the applicant held a meeting with all packing personnel to review the event in detail and solicit feedback on what could be done to prevent recurrence of this event, (2) a team leader from the first shift was temporarily moved to the second shift for oversight until a realignment of operator experience balance was implemented to ensure

10 CFR 71.95 REPORT EVALUATION FORM

Docket No.: 71-9239

Package Model Nos.: MCC-3, MCC-4, and MCC-5

Report Submitted By: Peter J. Vescovi, Westinghouse Electric Company, LLC

Report Date: October 9, 2006

that experienced personnel are on both shifts, and (3) packing operators and QC verifiers opened all containers on site and verified all steps as well as having QC conduct an independent verification of steps ensuring assemblies were packed correctly.

Interim Actions: (1) packing operators were provided a listing of appropriate contract/ container configuration for MCC packages to be used for configuration verification, and (2) initiated an independent verification of all steps required by the packing area inspection checklist.

Corrective Actions to Prevent Recurrence: (1) disciplinary actions were taken against the operators that failed to perform their assigned task, as required by procedure, (2) improved current systems (including procedures, tooling, and information systems) used to validate and verify container configurations against the contract and fuel assemblies being packed into specific containers, (3) implement QC oversight to provide independent verification of container acceptance prior to release for shipping, and (4) perform an effectiveness review to assess the container control systems ability to accurately validate, verify, and track container configurations through all phases of container movement including container refurbishment and turnaround.

5. Staff comments: Staff considers the applicant's corrective actions to be sufficient to address the root causes of this event.

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.

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

ML062980102

DISTRIBUTION:
SFST 71.95 Report File | IMNS Regional Coordinator | RIOB BC | SFST TA | NMED Project Manager
4 Regions | Part 71 PMs

G:\SFPO\Stuu Brown\Westinghouse MCC71.95 evaluation.wpd

OFC	SFST		SFST		SFST					
NAME	S. Brown		M. DuBose		R. Nelson					
DATE	10/23/06		10/23/06		10/ 23 /06					

C = COVER E = COVER & ENCLOSURE N = NO COPY

OFFICIAL RECORD COPY