LICENSEE EVENT REPORT EVALUATION FORM

EVENT CLASS: LAS - LOST, ABANDONED, STOLEN MATERIAL

LICENSEE / REPORTING PARTY INFORMATION:

Licensee/Reporting party name:	ENI US Operating Company / Tom Liverance, RSO		
License number :	50-29422-01		
Docket number :	030-38377		
Licensee's City of record :	Anchorage		
Licensees State of record :	Alaska		
NRC regulated?	Yes	If so, what Region?	R-IV
Working under reciprocity?	No		

EVENT INFORMATION:

In what City and State did the event occur?	Oliktok Point, Kuparuk, Alaska
Event date :	June 04, 2011
Discovery date :	June 04, 2011
Report date :	June 05, 2011
Agreement State reportable?	N/A
NRC reportable?	Yes
Reporting regulation :	10 CFR 30.50(b)(2)(i)
NMED Item Number :	110274

ADDITIONAL PARTIES INVOLVED:

Name :	None
License number :	N/A
City :	N/A
State :	N/A

LICENSEE EVENT REPORT EVALUATION FORM

EVENT CLASS: LAS - LOST, ABANDONED, STOLEN MATERIAL

CONSULTANT INFORMATION (if any):

Consultant name :	N/A
Company :	N/A
Who hired consultant?	N/A

DEVICE INFORMATION:

Manufacturer :	Tracerco Limited
Model number :	600DP Fixed Gauge
Serial number :	1898

RADIATION SOURCE INFORMATION:

Isotope :	Cesium-137	
Activity :	925 MBq	
Manufacturer :	Eckert & Ziegler Product Laboratories	
Model number :	Cs7.P03	
Serial number :	RM510	

LICENSEE EVENT REPORT EVALUATION FORM

EVENT CLASS: LAS - LOST, ABANDONED, STOLEN MATERIAL

NARRATIVE EVENT DESCRIPTION:

During a routine semi-annual shutter test, the extension rod (attached to the arming rod with the cesium source) the site RSO found that it could not be withdrawn sufficiently to move the source behind the shutter mechanism and determined that the gauge could not be "locked out". Withdrawing the extension rod from the dip tube into the shutter mechanism required twisting the cabling during withdrawal. Binding of the arming and/or extension rods could be felt as the RSO attempted to move the source behind the shutter mechanism. Mechanical restrictions were felt as he successfully returned the source to its "in service" position following the failed shutter test. The fixed gauge was in service so there was no immediate operational or safety requirement to lock the gauge out. Tracerco was immediately notified (06/04/11) and informed INC that a technician would be dispatched to investigate the anomaly. ENI had an identical gauge at the same location and source model that was successfully shutter tested at the same time without incident.

CORRECTIVE ACTIONS:

On June 23, 2011, Tracerco was on site to investigate a report of deficiencies in the 600DP shielded container isolation abilities. After investigating the shutter mechanism, no deficiencies were reported. It was concluded that the source rod required understanding into its function. Moving the rod past the shoulder within the shutter mechanism required a light twisting of the cable in clockwise rotation, which allowed the mechanism to move easily. After five (5) cycles of the shuttering device and having the site RSO cycle the shutter a minimum of two (2) times, it was agreed that the mechanism was functioning properly. No adjustments or repairs were required. It was determined that the 600DP gauge was fit for service with no manufacturing defects to report. The Tracerco service representative stated that the shutter mechanism was designed with tight clearances to decrease shine through the arming rod's path into the housing. Authorized users of the fixed gauges have been made aware of the tight clearances and the requirements of locking out the 600DP gauges at this location.

RECOMMENDED FOLLOWUP:

Was a reactive inspection conducted?	No	If so, inspection report number :	Routine Safety Inspection was conducted on 07/26/11 ML11237A092 & ML11237A095
Is LER recommended for closure?	Yes		
Is this NMED Item Number recommended to reflect "complete"?	Yes		

LER Evaluator:	Branch Chief or Designee Review:
Name: Rick Muñoz Date: 10/26/2011	Name: Date: 10/26/2011