

10 CFR 71.95 REPORT EVALUATION FORM

Docket No.: 71-9291

Package Model No.: Liqui-Rad (LR) Transport Unit Package

Report Submitted By: Matthew Presson, Westinghouse Electric Company, LLC

Report Date: October 5, 2012

Report ADAMS Accession No.: ML12284A031

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 20, 2012, during receipt inspection of empty packagings shipped from Westinghouse Electric Company LLC (Westinghouse) to Nuclear Fuel Services (NFS), the outer lid was removed from packaging with serial number LR036. NFS operators noticed that 5 of the 12 bolts on the secondary lid did not appear to be normal. Upon further inspection it was determined that the five bolts on the secondary lid were only "finger tightened" and not tightened using a torque wrench.

The operating procedures referenced in the certificate of compliance require all the bolts be torqued to 75 ft-lb [+10, -0], including when transporting empty packages. Since these bolts did not arrive at NFS torqued to the appropriate value the shipment of empty packages was not made in accordance with the conditions in the certificate of compliance.

Contamination surveys were performed on the outer well of the packaging and found that the transferrable contamination was below the limits in the shipper-receiver agreement and well below regulatory limits. The survey showed negligible alpha contamination and the beta-gamma activity was less than 43 dpm/100cm², which is below the limit of 220 dpm/cm² in the Department of Transportation's regulations for maximum level of contamination during transport.

4. Corrective actions taken by the licensee:

Westinghouse entered this event into its corrective action program and implemented a focused oversight process for the unloading and preparation for shipment of these packages. Westinghouse's analysis of the event identified as inadequate set of instructions and expectations for the procedure. In addition, a combination of lost place-keeping and imprecise communications contributed to the event.

Westinghouse established and completed the following corrective actions to prevent recurrence of this event:

- Operating procedure COP-836047 was reviewed to confirm that the instructions were compliant with the safety analysis report, since the procedures in the safety analysis report

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are referenced in the certificate.

- Operations personnel conducted a lessons learned / best practices focused team meeting to identify areas for improvement, and to address the place-keeping and communications issues which had been identified.
- An expanded checklist has been developed for use by the Operations staff, which includes the best practices to ensure critical steps are completed in a safe and compliant manner when shipping LR containers.

5. Staff comments:

Staff reviewed the licensee's report and corrective actions. While the event is not identical, the U.S. Nuclear Regulatory Commission received another report pursuant to Title 10 Code of Federal Regulations 71.95 informing the staff of another instance in which a bolt was not properly secured. In the report submitted in May 2012, (see ADAMS Accession No. ML12151A274) a self-sealing bolt was missing from the leak test port on the outer lid. While two instances in a year do not indicate a trend, especially since the two instances occurred at different facilities. In the May 2012 report, NFS was the shipper unlike this occurrence where Westinghouse was the shipper.

Staff agrees that the safety significance of this incident is low and that the corrective actions are sufficient to minimize future occurrences. Staff will review future reports on this package to look for trends on improperly torqued bolts.

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:

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