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LES-19-178-NRC



ATTN: Document Control Desk
Director, Division of Spent Fuel Management
Office of Nuclear Material Safety and Safeguards
U.S. Nuclear Regulatory Commission
11555 Rockville Pike
Rockville, MD 20852

Louisiana Energy Services, LLC
NRC Docket No. 70-3103

Subject: 10 CFR 71.95 60 Day Report, Missing Cylinder Cap Gasket

On November 6, 2019, Louisiana Energy Services, dba URENCO USA (UUSA), was notified that the cap gasket was missing from a 30B cylinder shipped to the Westinghouse fuel fabrication facility in April 2019. UUSA has determined that this event is reportable per 10 CFR 71.95(b). In accordance with 10 CFR 71.95(c), UUSA is providing a written report within sixty days of the discovery of this event (Enclosure 1).

If you have questions concerning this submittal, please contact Wyatt Padgett, Licensing and Performance Assessment Manager at 575.394.5257.

Respectfully,

A handwritten signature in black ink, appearing to read "Stephen R. Cowne".

Stephen R. Cowne
Chief Nuclear Officer and Compliance Manager

Enclosure: 1.) 10 CFR 71.95 Report Regarding a Missing Cylinder Cap Gasket

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Enclosure 1

10 CFR 71.95 Report

As required by 10 CFR 71.95(c), UUSA provides response to the following items:

(1) A brief abstract describing the major occurrences during the event, including all component or system failures that contributed to the event and significant corrective action taken or planned to prevent recurrence.

On April 5, 2019, UUSA shipped a full 30B cylinder (Urenco identification number UREU103819) within a UX-30 shipping package to the Westinghouse Fuel Fabrication Facility at Columbia South Carolina. On October 19, 2019, Westinghouse plant operators started to put the cylinder online to process. Upon removing the cylinder valve cap, the operators discovered that the cap gasket was missing. The operators reported the situation to supervision and a determination was made that it was safe to process the cylinder. The cylinder was emptied and a new gasket was installed prior to replacing the cap. Westinghouse reported the missing gasket to UUSA on 11/6/2019. UUSA entered the event in the Corrective Action Program as EV134994 and performed a causal investigation. The investigation determined that a human performance error occurred in that, following filling of the cylinder, a gasket was not verified in the cap prior to installing.

(2) A clear, specific, narrative description of the event that occurred so that knowledgeable readers conversant with the requirements of part 71, but not familiar with the design of the packaging, can understand the complete event. The narrative description must include the following specific information as appropriate for the particular event.

(i) Status of components or systems that were inoperable at the start of the event and that contributed to the event;

There were no components or systems that were inoperable and contributed to the event.

(ii) Dates and approximate times of occurrences;

Date Westinghouse discovered the missing gasket: 10/19/2019

Date UUSA was informed of the missing gasket: 11/6/2019

(iii) The cause of each component or system failure or personnel error, if known;

This event occurred due to lack of self-checking when installing the cylinder valve cap.

(iv) The failure mode, mechanism, and effect of each failed component, if known;

There were no failed components that contributed to this event.

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(v) A list of systems or secondary functions that were also affected for failures of components with multiple functions;

There were no failed components that contributed to this event.

(vi) The method of discovery of each component or system failure or procedural error;

Westinghouse notified UUSA of the missing cap gasket. UUSA performed a causal investigation and identified that due to a lack of self-checking, did not follow the procedure and ensure a gasket was installed in the cylinder cap.

(vii) For each human performance-related root cause, a discussion of the cause(s) and circumstances;

UUSA will brief Shift Operations on the gasket requirement.

(viii) The manufacturer and model number (or other identification) of each component that failed during the event; and

There were no components that failed during the event.

(ix) For events occurring during use of a packaging, the quantities and chemical and physical form(s) of the package contents.

The cylinder, when shipped to Westinghouse on 4/5/2019, contained 2238 kg of UF6 in solid form.

(3) An assessment of the safety consequences and implications of the event. This assessment must include the availability of other systems or components that could have performed the same function as the components and systems that failed during the event.

The purpose of the cap gasket is to prevent any loss or dispersal of possible contamination from the valve's internal space and also to protect the valve from intrusion of dirt and/or water from the outside. The cap gasket is not part of the pressure retaining containment of the valve. A missing cap gasket could result in increased risk of minor contamination of the internals of the UX-30 package or intrusion of dirt and/or water to the cylinder valve. It is likely that the installed cap, without the gasket, would have performed this same function, therefore the safety consequences of this event are low.

(4) A description of any corrective actions planned as a result of the event, including the means employed to repair any defects, and actions taken to reduce the probability of similar events occurring in the future.

UUSA will brief Shift Operations on the gasket requirement.

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(5) Reference to any previous similar events involving the same packaging that are known to the licensee or certificate holder.

A search of previous events did not identify any examples of UUSA shipping a cylinder without a cap gasket. The following two examples were identified where UUSA received a cylinder without a cap gasket.

- On June 26, 2017, UUSA reported that a 30B cylinder was received without a cylinder cap gasket.
- On June 4, 2016, UUSA reported that a 30B cylinder was received without a cylinder cap gasket.

(6) The name and telephone number of a person within the licensee's organization who is knowledgeable about the event and can provide additional information.

Additional information can be obtained by contacting Wyatt Padgett, Licensing and Performance Assessment Manager at 575.394.5257.

(7) The extent of exposure of individuals to radiation or to radioactive materials without identification of individuals by name.

This event did not result in additional exposure to individuals.