**Enclosure 1**

**10 CFR 70.50(c) 30 Day Report**

10 CFR 70.50(c)(1)

(i) Caller's name, position title, and call-back telephone number;

- The individual who facilitated Event Notification (EN) 55480 was Blake Bixenman, Licensing Specialist. The call-back telephone number for Blake Bixenman is 575-394-5102.

(ii) Date, time, and exact location of the event;

- The NRC Event Notification was submitted at 18:06 EST on November 5th, 2021. The discrepancy reported in EN 55564 was identified at approximately 14:00 EST on November 5th, 2021. The location of this event was at Urenco USA in Eunice, New Mexico (Lea County). The affected area within the UUSA facility included the Technical Services Building (TSB), Room 242.

(iii) Description of the event:

- On November 5th, 2021, it was identified that a portable Area Radiation Monitor (ARM), which was performing the 10 CFR 70.24 safety function of the Criticality Accident Alarm System (CAAS), to energize clearly audible alarm signals if accidental criticality occurs, had been removed from the service in error on October 26th, 2021.

  On July 20th 2021, during routine CAAS maintenance, UUSA staff identified an area in which a CAAS alarm was not clearly audible. UUSA arranged the ARM as a compensatory measure which achieves an equivalent 10 CFR 70.24 safety function in the affected area. UUSA reported this event to the NRC under Event Notification 55480 in accordance with 10 CFR 70.50(b)(2) in which equipment is disabled or fails to function as designed when required by regulation.

  Removal of this ARM resulted in an inability for radiation detectors to energize clearly audible alarm signals if accidental criticality occurs in the affected area. UUSA hereby reports this event in accordance with 10 CFR 70.50(b)(2), in which equipment is disabled or fails to function as designed when required by regulation (10 CFR 70.24).

(A) Radiological or chemical hazards involved, including isotopes, quantities, and chemical and physical form of any material released;

- There were no radiological or chemical hazards involved and no material was released. The affected area was limited to an immediate evacuation zone (IEZ). The IEZ is not an area in which such licensed special nuclear material is handled, used, or stored. The IEZ does not

contain criticality accident detection systems, only criticality accident alarm systems which notify personnel, if a criticality event were to occur in an adjacent area. CAAS detection was not affected by this occurrence.

(B) Actual or potential health and safety consequences to the workers, the public, and the environment, including relevant chemical and radiation data for actual personnel exposures to radiation or radioactive materials or hazardous chemicals produced from licensed materials (e.g., level of radiation exposure, concentration of chemicals, and duration of exposure);

- There were no actual or potential health or safety consequences to workers, the public, or the environment. No unexpected exposure to radioactive materials or hazardous chemicals produced from licensed materials occurred. During the time period in which the equipment is postulated to be unavailable, there were no occurrences in which immediate evacuation of the affected area was determined to be necessary.

(C) The sequence of occurrences leading to the event, including degradation or failure of structures, systems, equipment, components, and activities of personnel relied on to prevent potential accidents or mitigate their consequences; and

- RP staff entered the control room to perform calibrations on ARM equipment. This calibration of equipment should have included replacement of removed equipment with like-for-like compensatory measures. The equipment was removed from service without replacement.

(D) Whether the remaining structures, systems, equipment, components, and activities of personnel relied on to prevent potential accidents or mitigate their consequences are available and reliable to perform their function;

- The structures, systems, equipment, components, and activities in the unaffected areas remain available and reliable to perform their function. The occurrence of an ARM being removed in error was limited to the Technical Services Building Room 242.

  Upon discovery, personnel access to the affected area was immediately removed until the ARM could be restored to service. The ARM was correctly placed and verified in service within approximately 30 minutes of discovery. The ARM compensatory measure remains in place and is available and reliable to perform the required safety function to provide an audible alert in the event of a criticality accident.

(iv) External conditions affecting the event;

- No external conditions affected this event.

(v) Additional actions taken by the licensee in response to the event;

- The condition has been entered into UUSA's accredited Corrective Action Program, EV 148643. An Apparent Cause Evaluation (ACE) is being conducted in accordance with UUSA's accredited corrective action program.

(vi) Status of the event (e.g., whether the event is on-going or was terminated);

- The event is not considered to be on-going as the compensatory measure which achieves an equivalent safety function remains in place.

(vii) Current and planned site status, including any declared emergency class;

- No change in site emergency status occurred or will occur in response to this event.

(viii) Notifications, related to the event, that were made or are planned to any local, State, or other Federal agencies;

- No notifications to local, State, or Federal agencies occurred or are planned for this event.

(ix) Status of any press releases, related to the event, that were made or are planned.

- No press releases were made and no press releases are planned.

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(ii) The probable cause of the event, including all factors that contributed to the event and the manufacturer and model number (if applicable) of any equipment that failed or malfunctioned;

- The probable cause of the event is a communication breakdown that defeated work control processes.

(iii) Corrective actions taken or planned to prevent occurrence of similar or identical events in the future and the results of any evaluations or assessments; and

- An Apparent Cause Evaluation (ACE) type investigation has been initiated in accordance with UUSA's corrective action program. Resolution of the ACE is being tracked with EV 148643. This resolution will include the apparent cause of the condition, extent of condition, and applicable corrective action(s) to minimize reoccurrence (CAMR).

(iv) For licensees subject to Subpart H of this part, whether the event was identified and evaluated in the Integrated Safety Analysis.

- The UUSA Integrated Safety Analysis Summary (ISAS), Table 3.7-1, Accident Sequence and Risk Index, lists the potential accident sequences

that were identified that could have consequences that exceed the performance criteria of 10 CFR 70.61 listed in Subpart H. Items Relied on For Safety (IROFS) necessary to prevent or mitigate event sequences that exceed 10 CFR 70.61 criteria have been identified.

CAAS function and equipment are not included in the Table 3.7-1, Accident Sequence and Risk Index. Therefore, the CAAS is not a component of an IROFS and is not necessary to prevent or mitigate event sequences that exceed 10 CFR 70.61.

Section 3.1.5, Criticality Monitoring and Alarms, describes the facility CAAS design, installation, and maintenance commitments.