UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
245 PEACHTREE CENTER AVENUE N.E., SUITE 1200
ATLANTA, GEORGIA 30303-1200

May 5, 2023

EA-23-040
EN56336

James J. Bittner
Vice President and General Manager
BWXT Nuclear Operations Group, Inc.
P.O. Box 785
Lynchburg, VA 24505-0785

SUBJECT: BWXT NUCLEAR OPERATIONS GROUP, INC. - LYNCHBURG – NRC INSPECTION REPORT 07000027/2023006 AND APPARENT VIOLATIONS

Dear James J. Bittner:

This letter refers to the inspection conducted from March 13 to 16, 2023, at the BWXT Nuclear Operations Group (NOG) Lynchburg, Virginia facility. The purpose of the inspection was to perform a routine nuclear criticality safety inspection along with an evaluation of Event Notification (EN) 56336 (Agency Documents Access and Management System (ADAMS) Accession No. ML23096A225). The enclosed report presents the results of this inspection. The inspectors discussed the preliminary inspection findings with your staff at the conclusion of the on-site portion of the inspection on March 16, 2023.

Based on the results of this inspection, two apparent violations were identified and are being considered for escalated enforcement action in accordance with the NRC Enforcement Policy. The current Enforcement Policy is included on the NRC's Web site at http://www.nrc.gov/about-nrc/regulatory/enforcement/enforce-pol.html. The apparent violations involved the failure to meet performance requirements in Title 10 of the *Code of Federal Regulations* (10 CFR) 70.61(b). Specifically, the failure to ensure the reliability and availability of an air gap safety control and an overflow line safety control associated with an annular organic tank in the recovery facility resulted in making a high consequence event "unlikely" instead of "highly unlikely." These apparent violations are described in detail in the attached enclosure.

Before the NRC makes its enforcement decision, we are providing you an opportunity to (1) respond to the apparent violations addressed in this inspection report within 30 days of the date of this letter, (2) request a Pre-decisional Enforcement Conference (PEC), or (3) request Alternative Dispute Resolution (ADR) mediation. If a PEC is held, it will be open for public observation and the NRC will issue a press release to announce the time and date of the conference. If you decide to participate in a PEC or pursue ADR, please contact Eric C. Michel at 404-997-4555 within 10 days of the date of this letter. A PEC should be held within 30 days and an ADR session within 45 days of the date of this letter.

If you choose to provide a written response, it should be clearly marked as a "Response to Apparent Violations in NRC Inspection Report 07000027/2023006; EA-23-040" and should include for each apparent violation: (1) the reason for the apparent violation or, if contested, the basis for disputing the apparent violation; (2) the corrective steps that have been taken and the

results achieved; (3) the corrective steps that will be taken; and (4) the date when full compliance will be achieved. Your response may reference or include previously docketed correspondence, if the correspondence adequately addresses the required response. Additionally, your response should be sent to the NRC's Document Control Center, with a copy mailed to Anthony D. Masters, Region II, 245 Peachtree Center Avenue N.E., Suite 1200 Atlanta, GA 30303, within 30 days of the date of this letter. If an adequate response is not received within the time specified or an extension of time has not been granted by the NRC, the NRC will proceed with its enforcement decision or schedule a PEC.

If you choose to request a PEC, the conference will afford you the opportunity to provide your perspective on these matters and any other information that you believe the NRC should take into consideration before making an enforcement decision. The decision to hold a PEC does not mean that the NRC has determined that a violation has occurred or that enforcement action will be taken. This conference would be conducted to obtain information to assist the NRC in making an enforcement decision. The topics discussed during the conference may include information to determine whether a violation occurred, information to determine the significance of a violation, information related to the identification of a violation, and information related to any corrective actions taken or planned. In presenting your corrective action, you should be aware that the promptness and comprehensiveness of your actions will be considered in assessing any civil penalty for the apparent violations. The guidance in NRC Information Notice 96-28, "Suggested Guidance Relating to Development and Implementation of Corrective Action," may be helpful in preparing your response (ADAMS Accession No. ML061240509).

In lieu of a PEC, you may also request ADR mediation with the NRC in an attempt to resolve this issue. ADR is a general term encompassing various techniques for resolving conflicts using a third-party neutral mediator. The technique that the NRC has decided to employ is mediation. Mediation is a voluntary, informal process in which a trained neutral mediator (the "mediator") works with parties to help them reach resolution. If the parties agree to use ADR, they select a mutually agreeable neutral mediator who has no stake in the outcome and no power to make decisions. Mediation gives parties an opportunity to discuss issues, clear up misunderstandings, be creative, find areas of agreement, and reach a final resolution of the issues. Additional information concerning the NRC's program can be obtained at www.nrc.gov/about-nrc/regulatory/enforcement/adr.html. The Institute on Conflict Resolution (ICR) at Cornell University has agreed to facilitate the NRC's program as a neutral third party. Please contact ICR at 877-733-9415 and Eric C. Michel at 404-997-4555 within 10 days of the date of this letter if you are interested in pursuing resolution of this issue through ADR.

In addition, please be advised that the number and characterization of apparent violations described in the enclosed inspection report may change as a result of further NRC review. You will be advised by separate correspondence of the results of our deliberations on this matter.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice and Procedure," a copy of this letter, its enclosure, and your response, if you choose to provide one, will be made available electronically for public inspection in the NRC Public Document Room or from ADAMS, accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html. To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information so that it can be made available to the Public without redaction.

If you have any questions concerning this matter, please contact Eric C. Michel of my staff at 404-997-4555.

Sincerely,

Signed by Masters, Anthony
on 05/05/23

Anthony D. Masters, Director
Division of Fuel Facility Inspection

Docket No. 07000027
License No. SNM-42

Enclosure:
As stated

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SUBJECT: BWXT NUCLEAR OPERATIONS GROUP, INC. - LYNCHBURG – NRC INSPECTION REPORT 07000027/2023006 AND APPARENT VIOLATIONS

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U.S. NUCLEAR REGULATORY COMMISSION
Inspection Report

Docket Number:	07000027
License Number:	SNM-42
Report Number:	07000027/2023006
Enterprise Identifier:	I-2023-006-0036
Licensee:	BWXT Nuclear Operations Group, Inc.
Facility:	BWXT Nuclear Operations Group, Inc. - Lynchburg
Location:	Lynchburg, VA
Inspection Dates:	March 13 - 16, 2023
Inspectors:	N. Peterka, Fuel Facility Inspector T. Shewmaker, Fuel Facility Inspector T. Sippel, Sr. Fuel Facility Project Inspector
Approved By:	Eric C. Michel, Chief Projects Branch 2 Division of Fuel Facility Inspection

Enclosure

SUMMARY

This was an event follow-up inspection of BWXT Nuclear Operations Group to review the failure of two items relied on for safety (IROFS) associated with an organic waste tank (EN56336). The inspection was conducted in accordance with the NRC inspection procedure IP 88015, “Nuclear Criticality Safety.” The inspection was conducted on March 13 to March 16, 2023.

List of Violations

Air Gap IROFS Failure	
Significance	Report Section
Severity Level APVIO AV 07000027/2023006-01 Open EA-23-040	88015
An Apparent Violation (AV) was identified for failure to meet 10 CFR 70.61(b) due to failure to ensure an air gap control was available and reliable to prevent a high-consequence accident sequence.	

Overflow Drain IROFS Failure	
Significance	Report Section
Severity Level APVIO AV 07000027/2023006-02 Open EA-23-040	88015
An AV was identified for failure to meet 10 CFR 70.61(b) due to failure to ensure an overflow drain control was available and reliable to prevent a high-consequence accident sequence.	

Additional Tracking Items

Type	Issue Number	Title	Report Section	Status
WER	07000027/2023-001-00	Organic Waste Tank Overfill (EN56336)	88015	Closed

PLANT STATUS

BWXT Nuclear Operations Group is authorized to receive, possess, use, store, and ship special nuclear material pursuant to Title 10 of the *Code of Federal Regulations* (10 CFR) Part 70, *Domestic Licensing of Special Nuclear Material*. The primary activity on the BWXT site is the production of fuel material containing highly enriched uranium for naval reactors. In addition, BWXT has other operations, including the production of uranium fuel for research reactors in the area of the plant known as Research and Test Reactors. However, the annular organic waste tank in Uranium Recovery remained isolated and shutdown since January 19, 2023.

INSPECTION SCOPES

Inspections were conducted using the appropriate portions of the inspection procedures (IPs) in effect at the beginning of the inspection unless otherwise noted. Currently approved IPs with their attached revision histories are located on the public website at http://www.nrc.gov/reading-rm/doc-collections/insp-manual/inspection-procedure/index.html. Inspections were declared complete when the IP requirements most appropriate to the inspection activity were met consistent with Inspection Manual Chapter (IMC) 2600, "Fuel Cycle Facility Operational Safety and Safeguards Inspection Program." The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel to assess licensee performance and compliance with Commission rules and regulations, license conditions, site procedures, and standards.

SAFETY OPERATIONS

88015 - Nuclear Criticality Safety

The inspectors evaluated selected aspects of the licensee's nuclear criticality safety (NCS) program to verify compliance with selected portions of 10 CFR 70, "Domestic Licensing of Special Nuclear Material," including 70.50, 70.61, 70.62, Appendix A; Chapter 5, "Nuclear Criticality Safety," of the facility's license application; and applicable licensee procedures.

Nuclear Criticality Safety

Criticality Incident Response and Corrective Action (IP Section 02.05)

The inspectors reviewed the licensee's response to a recent criticality-related event to verify compliance with 10 CFR 70 and applicable sections of the license application. Specifically, the inspectors followed-up on WER 07000027/2023-001-00, "Organic Waste Tank Overfill (EN56336)," through:

- walkdowns of the organic waste tank, its items relied on for safety (IROFS), associated ventilation and other areas in Uranium Recovery
- interviews with licensee operators, operations engineers and NCS engineers
- review of CA202300083, the licensee's corrective action system entry for the organic tank event
- review of UPRR-30073 B, "Annular Organic Tank Piping and Instrumentation Drawing (P&ID)," Revision (Rev.) 1, dated February 2, 2012
- review of UPRR-30116 B, "Annular Waste Tank P&ID," Rev. 4

- review of OP-0061137, “Operating Procedure for General Purpose Area A/B,” Rev. 50, describes upstream concentration controls
- review of NCS-2011-172, “Nuclear Safety Release for SER 11-024 Phase 1 - Annular Organic Tank,” dated April 11, 2012
- review of NCS-2023-009, “NCS Safety Concern Analysis for Organic Solution Flowing from the Organic Waste Tank into Ventilation Ducting per CA202300083,” dated January 30, 2023
- review of NCS-2023-016, “Revised NCS Safety Concern for Organic Solution Flowing from the Organic Waste Tank into Ventilation Ducting per CA202300083,” dated February 9, 2023
- review of accident sequences and IROFS applicable to the organic waste tank in Safety Analysis Report (SAR) 15.12, “Liquid and Solid Waste Handling Processes in Uranium Recovery,” Rev. 86
- review of the licensee's 60-day report (ML23096A244), dated April 4, 2023

INSPECTION RESULTS

<table>
<tr><td colspan="2">Air Gap IROFS Failure</td></tr>
<tr><td>Severity</td><td>Report Section</td></tr>
<tr><td>Apparent Violation
AV 07000027/2023006-01
Open
EA-23-040</td><td>88015</td></tr>
<tr><td colspan="2">An AV was identified for failure to meet 10 CFR 70.61(b) due to failure to ensure an air gap control was available and reliable to prevent a high-consequence accident sequence.</td></tr>
<tr><td colspan="2">Description: On the evening of January 19, 2023, the licensee identified a spill of uranium bearing organic solution that occurred during a transfer of organic solution via the organic tank’s air diaphragm pump. Solution had been inadvertently transferred into the organic annular storage tank through a partially open valve. This caused the tank to overflow and spill to the floor. The operators noticed lower than expected flows at the receipt point, investigated, and during their investigation they found the spill. At which point, the operators stopped the transfer and began cleanup operations. About 20 liters (L) had spilled to the floor.

On the morning of January 20, 2023, during a routine check, operators noticed organic solution in a dropout column coming off a low point in the ventilation ductwork. The dropout column is located between the organic tank’s connection to the ventilation system and main recovery scrubber. The organic solution in the dropout column was found to have roughly the same uranium concentration as the contents of the organic tank that had overflowed. About 3.5 L of organic solution was removed from the dropout column. At this time during the licensee’s investigation of the spill and organic in the ventilation system, the licensee identified that when the organic tank overflowed, some of the overflow had occurred through the air gap between the organic tank and the ventilation system. The licensee determined that some of the overflowing organic solution had been sucked into the ventilation system.

The organic tank has two criticality safety IROFS applied to it to prevent organic solution from getting into the ventilation system. The first is an overflow drain that spills to the floor. The second is an air gap between the top of the organic tank and the ventilation system that is located above the overflow drain. Because there had been flow out of the air gap, the licensee declared the overflow drain IROFS to be degraded. Because some of that flow had</td></tr>
</table>

made it into the ventilation system, the licensee declared the air gap IROFS to be degraded. The licensee's ensuing investigation focused on the adequacy of the licensee's initial verification of those IROFS. The initial IROFS verification was documented in NCS-2011-172, "Nuclear Safety Release for SER 11-024 Phase 1 - Annular Organic Tank," dated April 11, 2012, and was performed when the tank was being repurposed as an organic storage tank.

During that investigation, the licensee identified that a rupture disc that had once been part of the overflow drain had not been verified as being removed during the verification of the IROFS in NCS-2011-172. After disassembling the overflow drain, the rupture disc was found to still be present. Therefore, the licensee determined that the overflow drain IROFS was failed.

Accident Sequence 12-14 of SAR Appendix 15.12 identified the air gap and overflow drain IROFS, as well as an upstream concentration control IROFS, as in place controls to prevent an accidental criticality due to organic solution overflowing into the ventilation system. The licensee performed a preliminary analysis of the accident sequence in NCS-2023-016, "Revised NCS Safety Concern for Organic Solution Flowing from the Organic Waste Tank into Ventilation Ducting," and determined the following:

The failure of the air gap IROFS was considered part of the initiating event for Accident Sequence 12-14, and scored at -2 (e.g., a roughly 10^{-2} per year likelihood of organic flowing into the ventilation system). Due to the air gap being degraded, the licensee re-assessed its credit at -1. No credit was given to the overflow drain due to it being failed. The upstream concentration control IROFS are administrative (e.g., rely on operators to take samples and verify safe concentration before transfers) so they are scored at 2 for this upset case. The resulting score for the upset case is therefore -3 (-1 – 2 = -3). This is considered unlikely based on the licensee's NRC-approved integrated safety analysis (ISA) methodology (See Table 3.2.4-4: Risk Assessment Table in the License Application). As such, the licensee reported this condition to the NRC as EN56336. The NRC has not made a final determination on the overall likelihood of the event.

In SAR 15.12, the licensee identified the inspections performed in NCS-2011-172 as the management measure applied to both IROFS to ensure that they were available and reliable. However, for the air gap IROFS, NCS-2011-172 did not identify or perform any design analysis to ensure that the IROFS would be able to perform its intended safety function.

Corrective Actions: The licensee's immediate corrective actions included shutting down the pump that was transferring organic solution, cleaning up the spill, isolating the organic tank by locking valves closed and investigating the causes of the event. Long-term corrective actions are still being developed by the licensee.

Corrective Action References: The licensee entered this issue into its corrective action program as CA202300083.

Analysis: Accident Sequence 12-14, when uncontrolled, leads to a criticality event which is a high consequence event. For the controlled accident sequence the IROFS are applied to limit the likelihood of occurrence to highly unlikely. This event did not lead to a criticality, and so had no actual safety consequences. However, the potential consequence of this event was that the high consequence accident sequence was no longer maintained as highly unlikely.

Enforcement:

Violation: 10 CFR 70.61(b) requires, in part, that "The risk of each credible high-consequence event must be limited. Engineered controls, administrative controls, or both, shall be applied to the extent needed to reduce the likelihood of occurrence of the event so that, upon implementation of such controls, the event is highly unlikely…"

10 CFR 70.62(d) requires, in part, that each "licensee shall establish management measures to ensure compliance with the performance requirements of 70.61…The management measures shall ensure that engineered and administrative controls…that are identified as IROFS…are designed, implemented, and maintained, as necessary, to ensure they are available and reliable to perform their function when needed, to comply with the performance requirements of 70.61."

Contrary to the above, from April 11, 2012, to January 19, 2023, an IROFS was not designed, implemented, and maintained as available and reliable to reduce the likelihood of occurrence of a high-consequence event so that, upon implementation of such controls, the event is highly unlikely. Specifically, the air gap between the Annular Organic Tank vent and the ventilation system was inadequately designed, such that it failed to prevent the overflow of liquid from the Annular Organic Tank into the ventilation system which could lead to a criticality event in the ventilation system.

WER 07000027/2023-001-00, "Organic Waste Tank Overfill (EN56336)" is being closed to AV 07000027/2023006-01, "Air Gap IROFS Failure" and AV 07000027/2023006-02, "Overflow Drain IROFS Failure."

Enforcement Action: This violation is being treated as an apparent violation pending a final significance (enforcement) determination.

Overflow Drain IROFS Failure	
Severity	Report Section
Apparent Violation AV 07000027/2023006-02 Open EA-23-040	88015
An AV was identified for failure to meet 10 CFR 70.61(b) due to failure to ensure an overflow drain control was available and reliable to prevent a high-consequence accident sequence.	
Description: On the evening of January 19, 2023, the licensee identified a spill of uranium bearing organic solution that occurred during a transfer of organic solution via the organic tank's air diaphragm pump. Solution had been inadvertently transferred into the annular organic storage tank through a partially open valve. This caused the tank to overflow and spill to the floor. The operators noticed lower than expected flows at the receipt point, investigated, and during their investigation they found the spill. At which point, the operators stopped the transfer and began cleanup operations. About 20 liters (L) had spilled to the floor. On the morning of January 20, 2023, during a routine check, operators noticed organic solution in a dropout column coming off a low point in the ventilation ductwork. The dropout column is located between the organic tank's connection to the ventilation system and the main recovery scrubber. The organic solution in the dropout column was found to have roughly the same uranium concentration as the contents of the organic tank that had	

overflowed. About 3.5 L of organic solution was removed from the dropout column. At this time during the licensee's investigation of the spill and organic in the ventilation system, the licensee identified that when the organic tank overflowed, some of the overflow had occurred through the air gap between the organic tank and the ventilation system. The licensee determined that some of the overflowing organic solution had been sucked into the ventilation system.

The organic tank has two criticality safety IROFS applied to it to prevent organic solution from getting into the ventilation system. The first is an overflow drain that spills to the floor. The second is an air gap between the top of the organic tank and the ventilation system that is located above the overflow drain. Because there had been flow out of the air gap, the licensee declared the overflow drain IROFS to be degraded. Because some of that flow had made it into the ventilation system, the licensee declared the air gap IROFS to be degraded. The licensee's ensuing investigation focused on the adequacy of the licensee's initial verification of those IROFS. The initial IROFS verification was documented in NCS-2011-172, "Nuclear Safety Release for SER 11-024 Phase 1 - Annular Organic Tank," dated April 11, 2012, and was performed when the tank was being repurposed as an organic storage tank.

During that investigation, the licensee identified that a rupture disc that had once been part of the overflow drain had not been verified as being removed during the verification of the IROFS in NCS-2011-172. After disassembling the overflow drain, the rupture disc was found to still be present. Therefore, the licensee determined that the overflow drain IROFS was failed.

Accident Sequence 12-14 of SAR Appendix 15.12 identified the air gap and overflow drain IROFS, as well as upstream concentration control IROFS, as in place controls to prevent an accidental criticality due to organic solution overflowing into the ventilation system. The licensee performed a preliminary analysis of the accident sequence in NCS-2023-016, "Revised NCS Safety Concern for Organic Solution Flowing from the Organic Waste Tank into Ventilation Ducting," and determined the following:

The failure of the air gap IROFS was considered part of the initiating event for Accident Sequence 12-14, and scored at -2 (e.g., a roughly 10^{-2} per year likelihood of organic flowing into the ventilation system). Due to the air gap being degraded, the licensee re-assessed its credit at -1. No credit was given to the overflow drain due to it being failed. The upstream concentration control IROFS are administrative (e.g., rely on operators to take samples and verify safe concentration before transfers) so they are scored at 2 for this upset case. The resulting score for the upset case is therefore -3 (-1 – 2 = -3). This is considered unlikely based on the licensee's NRC-approved ISA methodology (See Table 3.2.4-4: Risk Assessment Table in the License Application). As such, the licensee reported this condition to the NRC as EN56336. The NRC has not made a final determination on the overall likelihood of the event.

In SAR 15.12, the licensee identified the inspections performed in NCS-2011-172 as the management measure applied to both IROFS to ensure that they were available and reliable. However, for the drain IROFS, NCS-2011-172 did not identify that the rupture disc was present and require it to be verified as removed, or tested to show that the drain would actually function in the as built configuration.

Corrective Actions: The licensee's immediate corrective actions included shutting down the pump that was transferring organic solution, cleaning up the spill, isolating the organic tank by

locking valves closed and investigating the causes of the event. The investigation included disassembly of the drain to determine if the rupture disc was still present. Long-term corrective actions are still being developed by the licensee.

Corrective Action References: The licensee entered this issue into its corrective action program as CA202300083.

Analysis: Accident Sequence 12-14, when uncontrolled, leads to a criticality event which is a high consequence event. For the controlled accident sequence the IROFS are applied to limit the likelihood of occurrence to highly unlikely. This event did not lead to a criticality, and so had no actual safety consequences. However, the potential consequence of this event was that the high consequence accident sequence was no longer maintained as highly unlikely.

Enforcement:

Violation: 10 CFR 70.61(b) requires, in part, that "The risk of each credible high-consequence event must be limited. Engineered controls, administrative controls, or both, shall be applied to the extent needed to reduce the likelihood of occurrence of the event so that, upon implementation of such controls, the event is highly unlikely…"

10 CFR 70.62(d) requires, in part, that "each licensee shall establish management measures to ensure compliance with the performance requirements of 70.61…The management measures shall ensure that engineered and administrative controls…that are identified as IROFS…are designed, implemented, and maintained, as necessary, to ensure they are available and reliable to perform their function when needed, to comply with the performance requirements of 70.61."

Contrary to the above, from April 11, 2012, to January 19, 2023, an IROFS was not designed, implemented, and maintained as available and reliable to reduce the likelihood of occurrence of a high-consequence event so that, upon implementation of such controls, the event is highly unlikely. Specifically, an intact rupture disk was located in the overflow line for the Annular Organic Tank, which blocked flow through the overflow line preventing the IROFS from performing its safety function of preventing a criticality event in the ventilation system.

WER 07000027/2023-001-00, "Organic Waste Tank Overfill (EN56336)" is being closed to AV 07000027/2023006-01, "Air Gap IROFS Failure" and AV 07000027/2023006-02, "Overflow Drain IROFS Failure."

Enforcement Action: This violation is being treated as an apparent violation pending a final significance (enforcement) determination.

EXIT MEETINGS AND DEBRIEFS

The inspectors verified no proprietary information was retained or documented in this report.

- On March 16, 2023, the inspectors presented the Nuclear Criticality Safety inspection results to James Bittner and other members of the licensee staff.