10 CFR 71.95 REPORT EVALUATION FORM

Docket No.:	71-9291
Package Model No.:	Liqui-Rad (LR) Transport Unit Package
Report Submitted By:	M.P. Elliott, Nuclear Fuel Services, Inc. (NFS)
Report Date:	May 22, 2012

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 April 17, 2012, Westinghouse personnel unloading the Model No. Liqui-Rad (LR) Transport Unit Package at the Westinghouse Columbia Fuel Fabrication Facility in South Carolina noticed that the self-sealing bolt was missing from the leak test port on the outer lid. The bolt is shown on Drawing No. LR-SAR, sheet 3 of 4, which is referenced in the certificate. Additionally, the operating procedures referenced in the certificate of compliance require that the port plugs are installed and torque to 60 +10 -0 in-lbs. Westinghouse personnel found the bolt loose in the outer well of the package. The secondary lid seals were successfully leak tested prior to shipment.

The NFS Blended Low-Enrichment Uranium Prep Facility Manager had the operators who load the package open all loaded units and verify the self-sealing bolts were in place and torqued correctly. The manager also issued instructions to operators to start documenting in the comments section of the LF-230 Trailer Fill, Runsheet 45, that the bolts are in place and torque. A second operator is to verify that the bolts are installed and torqued and record having completed the verification check in the Comments portion of the runsheet.

4. Corrective actions taken by the licensee:

NFS assembled a team to investigate the infraction. The team determined that the cause of this incident could be attributable to either human error (not screwing bolt into port or incorrect torque on bolt) or equipment malfunction (worn threads on either the bolt or the leak test port). The team also recommended that Westinghouse (owner of the packages) evaluate that condition of the test ports in the secondary containers and that NFS replace their adjustable torque wrench with a torque wrench supplied by the manufacturer that is already set to the torque limit in the operating instructions.

NFS replaced the bolt and the problem has not reoccurred on subsequent shipments to date.

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5. Staff comments:

Staff reviewed the licensees report and corrective actions. Staff agree that the safety significance of this incident is low and that the corrective actions are sufficient to minimize future occurrences.

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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