



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION IV  
1600 E. LAMAR BLVD.  
ARLINGTON, TX 76011-4511

July 31, 2017

EA-17-085

Mr. Mark E. Reddemann  
Chief Executive Officer  
Energy Northwest  
P.O. Box 968 (Mail Drop 1023)  
Richland, WA 99352-0968

SUBJECT: COLUMBIA GENERATING STATION - RESPONSE TO DISPUTED NON-CITED VIOLATIONS AND FINDING IN NRC INSPECTION REPORT 05000397/2016009

Dear Mr. Reddemann:

On April 10, 2017, the U.S. Nuclear Regulatory Commission (NRC) issued Inspection Report 05000397/2016009 (Agencywide Document Access and Management System (ADAMS) Accession ML17100A499). In the inspection report, the NRC documented a preliminary White finding and apparent violation, a Green finding, and seven non-cited violations (NCVs). These findings and violations were identified during a special inspection of an improperly packaged and manifested radwaste shipment sent from Columbia Generating Station to US Ecology on November 9, 2016.

On May 9, 2017, Energy Northwest provided a response (ADAMS Accession ML17129A627) that contested the Green finding and three NCVs documented in the April 10, 2017, inspection report. Specifically, Energy Northwest contested: (1) an NCV of Title 10 of the *Code of Federal Regulations* (10 CFR) 20.1904 for the failure to ensure that each container of licensed material in the spent fuel pool bore a label or had documentation providing sufficient information to permit individuals handling the licensed material to minimize exposure; (2) an NCV of 10 CFR 50.71(e) for the failure to periodically provide the NRC a final safety analysis report update with all changes made in the facility or procedures; (3) a Green finding for the failure to follow the requirements of Procedure SWP-CAP-06, "Condition Report Review," when determining the type of cause evaluation required to assess the causes of the higher than expected dose rates on a radwaste container; and (4) an NCV of 10 CFR 61.56(b)(3) for the failure to assure that void spaces within waste packages were reduced to the extent practicable.

In the May 9, 2017, letter, Energy Northwest also requested that the NRC consider combining the preliminary White finding and apparent violation with three other NCVs into one violation. In a letter dated July 6, 2017, Columbia Generating Station - Final Significance Determination of a White Finding, Notice of Violation, Follow up Assessment Letter, and NRC Inspection Report 05000397/2017009 (ADAMS Accession ML17187A364), the NRC documented its conclusion that the violations would not be combined.

In a letter dated May 22, 2017 (ADAMS Accession ML17142A219), the NRC acknowledged receipt of the Energy Northwest letter and informed you that we would review the basis for contesting the NCVs and finding, and provide the results of our evaluation by written response.

The NRC conducted a detailed review of your response and the applicable regulatory requirements, in accordance with Part I, Section 2.2.7 of the NRC Enforcement Manual. Various NRC staff who were not involved with the original inspection effort performed this review. After careful consideration of the bases for your contention, the NRC has concluded that two of the NCVs and the Green finding will be upheld. Specifically, the NCV of 10 CFR 61.56(b)(3) and the finding associated with the failure to follow the requirements of Procedure SWP-CAP-06 will be upheld. The NCV of 10 CFR 20.1904 will also be upheld but we will revise NRC Inspection Report 05000397/2016009 to clearly articulate why the exemptions of 10 CFR 20.1905 were not met. The resolution of the contested NCV associated with 10 CFR 50.71(e) is being held in abeyance pending further review. The details of our conclusions are documented in the enclosure.

If you have any questions about this matter, please contact Heather Gepford, Chief, Plant Support Branch 2, Division of Reactor Safety, at 817-200-1156.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice and Procedure," a copy of this letter and its enclosure will be made available electronically for public inspection in the NRC Public Document Room or from the NRC's ADAMS, accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html>.

Sincerely,

/RA/

Scott A. Morris  
Deputy Regional Administrator

Docket No.: 50-397  
License No.: NPF-21

Enclosure:  
NRC Evaluation of Licensee Response  
to Three Non-Cited Violations and One  
Finding

cc w/encl.  
(electronic distribution)

COLUMBIA GENERATING STATION - RESPONSE TO DISPUTED NON-CITED VIOLATIONS AND FINDING; NRC INSPECTION REPORT 05000397/2016009 DATED JULY 31, 2017

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ADAMS ACCESSION NUMBER: **ML17212A914**

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 By: CCA       Yes     No       Publicly Available       Sensitive      RGN4-001

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**NRC EVALUATION OF LICENSEE RESPONSE TO  
THREE NON-CITED VIOLATIONS AND ONE FINDING**

**Summary of NRC Conclusions**

In a letter to the U.S. Nuclear Regulatory Commission (NRC), dated May 9, 2017, Energy Northwest (licensee) contested three violations and one finding issued in NRC Inspection Report 05000397/2016009. The licensee's letter can be found, in its entirety, in the NRC's Agencywide Document Access and Management System (ADAMS) Accession ML17129A627.

Consistent with the guidance provided in the NRC Enforcement Manual, NRC staff performed an independent review of the documentation associated with these findings. The conclusions from this review are provided below, followed by a summary of the evaluation of each finding.

- (1) A Green non-cited violation (NCV) of 10 CFR 20.1904 for the failure to ensure that each container of licensed material in the spent fuel pool bore a label or had documentation providing sufficient information to permit individuals handling the licensed material to minimize exposure.

The NRC concludes that the NCV documented as NCV 05000397/2016-009-03, "Failure to Label or Provide Written Information for Items Stored in the Spent Fuel Pool," is upheld, but NRC Inspection Report 05000397/2016009 will be revised to clearly articulate why the exemptions of 10 CFR 20.1905 were not met.

- (2) A Severity Level IV NCV of 10 CFR 50.71(e) for the failure to periodically provide the NRC a final safety analysis report update with all changes made in the facility or procedures. Specifically, the licensee changed its radwaste management strategy for the spent fuel pool cooling and cleanup system and material being stored in the spent fuel pool.

The NRC concludes that the NCV documented as NCV 05000397/2016-009-06, "Failure to Update the Final Safety Analysis Report with Changes to Radioactive Waste Processing," requires additional review and resolution is being held in abeyance.

- (3) A Green finding for the failure to follow the requirements of Procedure SWP-CAP-06, "Condition Report Review," when determining the type of cause evaluation required to assess the causes of the higher than expected dose rates on a radwaste container. Specifically, Procedure SWP-CAP-06 required that if an event has high risk and high uncertainty, the level of evaluation required is a root cause evaluation.

The NRC concludes that the finding documented as FIN 05000397/2016-009-07, "Failure to Follow Procedure and Perform a Root Cause Evaluation to Assess the Causes of a Radwaste Shipping Event," is upheld.

- (4) A Green NCV of 10 CFR 61.56(b)(3) for the failure to assure that void spaces within waste packages were reduced to the extent practicable.

The NRC concludes that the NCV documented as NCV 05000397/2016-009-09, "Failure to Minimize Void Spaces in a Radioactive Waste Package," is upheld.

## **Evaluation of NCV 05000397/2016009-03**

The NRC special inspection team chartered to review the November 9, 2016, radwaste shipping incident identified a non-cited violation (NCV) of 10 CFR 20.1904 for the licensee's failure to ensure that each container of licensed material in the spent fuel pool bore a label or had documentation providing sufficient information to permit individuals handling the licensed material to minimize exposure.

### **Summary of the Licensee's Response**

The licensee noted that on December 4, 2007, Federal Register Notice (FRN) 68043 documented an exemption amended to 10 CFR 20.1905 for containers holding licensed materials at nuclear power plants. The exemption states, in part, that licensees are not required to label containers if they are located in an area posted under 10 CFR 20.1902, "Posting Requirements," if the containers are conspicuously marked commensurate with the radiological hazard, and are accessible only to individuals who have sufficient instruction to minimize radiation exposure while handling or working in the vicinity of the containers.

The licensee stated that items tied off the side of the spent fuel pool were not considered to be "in a container" and specified that filters, socks, and their receptacles are not attached to the surface of the spent fuel pool by ropes or chains and cannot be inadvertently pulled to the surface. The licensee noted that the spent fuel pool is located in an area posted in accordance with 10 CFR 20.1902. The licensee also stated that an inventory of materials and mapping information were kept and that only authorized and knowledgeable individuals have access to the material through a radiation work permit.

The licensee concluded that they met the exemption in 10 CFR 20.1905 because the materials stored in the spent fuel pool were within a posted area and were accessible only to individuals who had sufficient instruction to minimize radiation exposures and met the labelling requirements of 10 CFR 20.1904 when materials were removed from the radiologically posted area.

### **NRC Evaluation**

In preparation for the Spent Fuel Pool Cleanup Campaign, approximately 70 Tri-Nuclear® (Tri-Nuke) filters were staged in the spent fuel pool for disposal. These filters were not labeled or marked commensurate with their radiological hazard, nor was there a readily available written record that adequately provided personnel sufficient information such that proper precautions could be taken to minimize personnel exposures. On October 13, 2016, while licensee personnel were transferring the filters from the spent fuel pool to a shipping cask liner, higher than anticipated radiological conditions were experienced, resulting in unnecessary exposure to the radiation workers.

The licensee's position is that the exemption described in FRN 68043 is applicable in this situation. The FRN states, in part, that the third amendment revised 10 CFR 20.1905 by adding an exemption for containers holding licensed material within nuclear power facilities licensed under 10 CFR Part 50, providing certain conditions are met. The licensee contended that it met the exemption provision of 10 CFR 20.1905.

The NRC concluded that the information provided in FRN 68043 is applicable to this situation, but that the licensee did not meet the exemption criteria in 10 CFR 20.1905. Specifically, 10 CFR 20.1905(e) and 10 CFR 20.1905(g) are applicable to the situation described in the inspection report.

10 CFR 20.1905(e) states, in part, that a licensee is not required to label containers that are accessible only to individuals authorized to handle or use them, or to work in the vicinity of the containers, if the contents are identified to these individuals by a readily available written record (examples of containers of this type are containers in locations such as water-filled canals, storage vaults, or hot cells).

10 CFR 20.1905(g) states, in part, that a licensee is not required to label containers holding licensed material at a facility licensed under 10 CFR Part 50 that are within an area posted under the requirements in 10 CFR 20.1902 if the containers are conspicuously marked (such as by providing a system of color coding of containers) commensurate with their radiological hazard.

The licensee did not meet either of these applicable exemptions to labeling requirements. Although the licensee's letter stated that an inventory of licensed materials and mapping information were kept, during the inspection the licensee was unable to provide adequate documentation. Therefore, the NRC concluded that there was no "readily available written record" identifying the contents. Additionally, while the containers holding the filters were located in an area posted under 10 CFR 20.1902, neither the containers, nor the filters (once they were removed from the containers), were "conspicuously marked" commensurate with the radiological hazard. This lack of a readily available written record or conspicuous marking of the containers contributed to the unexpected radiological conditions during the loading of the shipping container.

#### NRC Conclusion

The NRC concludes that the NCV documented in NRC Inspection Report 05000397/2016009 as NCV 05000397/2016-009-03, "Failure to Label or Provide Written Information for Items Stored in the Spent Fuel Pool," is upheld, but will be revised to clearly articulate that the exemptions of 10 CFR 20.1905(e) and 10 CFR 20.1905(g) were not met.

#### **Evaluation of NCV 05000397/2016009-06**

The special inspection team identified a Severity Level IV NCV of 10 CFR 50.71(e) for the failure of the licensee to periodically provide the NRC a Final Safety Analysis Report (FSAR) update with all changes made to the facility or procedures. Specifically, the licensee changed its radwaste management strategy for the spent fuel pool cooling and cleanup system and material being stored in the spent fuel pool. However, the licensee had not changed its process control program or updated the FSAR to reflect the impact on waste streams from processing items stored in the spent fuel pool including activated metals, Tri-Nuke filters, filter socks, and demineralizer filter resins.

## Summary of the Licensee's Response

The licensee noted that the fuel pool filter demineralizer waste stream is not included as an individual waste stream because, as stated in FSAR Section 11.4.2.4, this waste stream is backwashed to the waste sludge phase separator tank together with other waste streams. The licensee does not consider the spent fuel pool filter demineralizer waste stream a major system producing waste, and therefore it is not listed in the FSAR. The licensee contended that since it is not considered a major system producing waste, describing the spent fuel pool filter demineralizer waste stream in the detail described in the NCV is a level of detail beyond that which is required to be in the FSAR.

The licensee stated that the FSAR adequately describes the current radioactive waste practices of backwashing waste streams, such as from fuel pool filter demineralizers, floor drains, and waste collector filter demineralizers. This process is also adequately described in plant procedures. Therefore, the licensee's position is that the FSAR adequately reflects current processes.

Regarding the issue that the FSAR does not specifically mention Tri-Nuke or sock filters in the dry active waste or dry solid waste system, the licensee contended that the FSAR Section 11.4.2.7 description of dry active waste consisting of "other similar materials" is inclusive of the Tri-Nuke and sock filters. Tri-Nuke filters are underwater filters and are similar in design to air filtration media, which is specifically listed in FSAR Section 11.4.2.7.

The licensee noted that Nuclear Energy Institute (NEI) 98-03, "Guidelines for Updating Final Safety Analysis Reports," Revision 1, June 1999, discusses simplifying the FSAR to improve focus, clarity, and maintainability. Specifically, by not specifying brands of filters used in the spent fuel pool, the FSAR maintains required detail for a description of the types of items used yet allows for brand changes without a requirement to update the FSAR.

The licensee contended that the NRC Enforcement Policy states that a failure to update the FSAR that does not have a material impact on safety or licensed activities is considered a minor violation of 10 CFR 50.71(e). The licensee concluded that the failure to include the spent fuel pool system filter demineralizers as an individual waste stream or to specify underwater filters as a type of dry active waste did not impact safety or licensed activities. Finally, the licensee concluded that the lack of detail in the FSAR is not a violation nor does it have an impact on how the licensee safely handles and disposes of the radiological material or the radiological safety of the plant workers or the public.

## NRC Conclusion

The NRC determined that the technical information required to evaluate licensee's contentions regarding the NCV documented in NRC Inspection Report 05000397/2016009 as NCV 05000397/2016-009-06, "Failure to Update the Final Safety Analysis Report with Changes to Radioactive Waste Processing," cannot be effectively reviewed from the office. In order to perform an effective review and fully characterize the issue, additional on-site inspection is required. Therefore, an independent review of the finding and associated technical concerns will be conducted during the upcoming NRC baseline inspection using NRC Inspection Procedure 71124.08, "Radioactive Solid Waste Processing and Radioactive Material Handling, Storage, and Transportation." The staff's evaluation and response to this issue will be

documented in NRC Inspection Report 05000397/2017010. As such, the resolution to this issue is being held in abeyance pending this further review.

### **Evaluation of FIN 05000397/2016009-07**

The special inspection team identified a finding associated with the failure to follow the requirements of Procedure SWP-CAP-06, "Condition Report Review," when determining the type of licensee evaluation required to assess the causes of the higher-than-expected dose rates on a radwaste container. Specifically, Procedure SWP-CAP-06 required, in part, that if an event has high risk and high uncertainty, the level of evaluation required is a root-cause evaluation (RCE). However, the licensee failed to adequately assess the uncertainty associated with the causes of the event and performed an apparent-cause evaluation (ACE) rather than an RCE. By performing an ACE instead of an RCE, the licensee remained vulnerable to future radioactive waste processing and transportation errors of significance.

### **Summary of the Licensee's Response**

The licensee asserted that the requirements of Procedure SWP-CAP-06 were followed when it determined that an ACE was the correct level of evaluation.

On November 10, 2016, the licensee's Condition Review Group deemed the uncertainty assessment of the event, documented in Action Request 357593, as "Medium" based on their determination that the causes and corrective actions were both partially known. The unofficial cause was stated to be "improper verification/validation," because it was a known issue that the dose rates would be a challenge for the cask.

The licensee also stated that it disagreed that an RCE would have provided extra insights or changed the cause determined in the ACE because of guidance documented in Procedure CDM-01, "Cause Determination Manual." The licensee posited that if an RCE had been performed instead of an ACE, the station would not have been required to use more than the barrier analysis and change analysis techniques used in the ACE. The licensee further stated that the causes identified in the ACE met the validation of the root-cause test in accordance with Procedure CDM-01, so the root cause of the event was identified.

The licensee also noted that on January 13, 2017, once the dose rates were confirmed to have exceeded the U.S. Department of Transportation limits, a new condition report was written and graded a significant condition adverse to quality; as a result, an RCE was performed.

### **NRC Evaluation**

On November 9, 2016, a radwaste shipment from Columbia Generating Station arrived at the US Ecology low-level radioactive waste disposal facility with dose rates that significantly exceeded those documented on the shipment manifest. Specifically, the manifest documented on-contact liner dose rates of 11.8 rem/hr and the actual dose rates measured at the disposal facility were approximately 90 rem/hr. The disposal facility rejected the waste shipment and informed the Washington State Department of Health. The Washington State Department of Health notified the licensee that its disposal use permit privileges were suspended until they approved a written plan containing corrective actions and performed an onsite inspection. One day following this event, the licensee's Condition Review Group determined this was not a significant condition adverse to quality, as defined by the procedure, and an ACE would be performed.



Station Procedure SWP-CAP-06, "Condition Report Review," Attachment 8.2, "CAQ Risk Evaluation Level Guidance," requires, in part, that the level of cause evaluation required depends on the two factors: uncertainty and risk. If both the uncertainty and risk are characterized as "High," an RCE is required. The uncertainty is determined by using the results of two questions and applying them to the uncertainty table contained in the procedure. The two questions are: "Are the causes known?" and "Are the corrective actions known?" Procedure SWP-CAP-06, Attachment 8.2, "CAQ Risk and Evaluation Level Guidance," states, "Determine how much is known about the cause of the event or condition. 'Partial' can be used when direct causes are known and verified. If underlying causes are not known, consider 'no'. If underlying causes are simple, known and verified, consider 'yes'." The uncertainty table in the procedure states that if the cause is not known, the uncertainty is 'High'."

As stated in the licensee's letter dated May 9, 2017, the licensee's unofficial cause was "improper verification/validation" because it was a known issue that the dose rates would be a challenge for the cask. While the NRC agrees that there was improper verification/validation of the cask before it was shipped, this fact alone leading to a "Partial" response in Procedure SWP-CAP-06 does not address the fact that the underlying causes were unknown. The procedure states, "If underlying causes are not known, consider 'no'. If underlying causes are simple, known, and verified, consider 'yes'." In this case, the underlying causes were not known, verified, or simple.

The NRC notes that, prior to the shipment to US Ecology, the licensee staff were aware that the dose rates would be a challenge for the cask. After the liner was loaded with spent fuel pool cleanup filters that had unexpectedly high dose rates, the licensee spent approximately 2 weeks developing a formal plan to reduce dose rates down to a level acceptable for shipment. Following the recovery plan approved by the ALARA committee, the licensee removed material from the shipping container to lower dose rates so that it could be shipped. With that level of planning and oversight, dose rates on the final shipment had presumably been resolved and should not have been a challenge.

Based on the level of coordination and work that went into preparing the cask for shipment, and the fact that dose rates were significant enough to warrant US Ecology returning the package, there was clearly a more complex underlying cause than simply failing to verify or validate the dose rates. Additionally, the licensee decided not to verify or validate the dose rates of the liner or the characterization of its contents prior to shipment. Lastly, the shipment was made even after some licensee staff voiced concerns about the shipment not meeting transportation requirements. Therefore, when performing the Uncertainty Assessment, the answer to the question "Are the causes known?" should have been "No" because the underlying causes were not known, simple, or verified.

The licensee stated additional insights would not have been provided had they conducted an RCE because this event was classified as a non-significant condition adverse to quality, and therefore, additional analysis techniques were not required for conducting an RCE or an ACE by procedural guidance. The NRC agreed that many of the aspects of an RCE and an ACE were the same. However, not all of the requirements were identical. One example is the requirement to perform an effectiveness review to validate the effectiveness of corrective actions to minimize the likelihood of recurrence. Effectiveness reviews are not required for an ACE but are highly recommended for RCEs. By performing an ACE instead of an RCE, the licensee was under no obligation to evaluate the effectiveness of its corrective actions and remained vulnerable to future radioactive waste processing and transportation errors of significance.

It is also worth noting that at the Regulatory Conference held on May 2, 2017, at the Region IV office, the licensee stated that the root cause was “station procedures to implement clean-up activities and the associated radioactive waste surveys, processing, and shipping activities were not sufficient to ensure compliance with all requirements.” The root cause identified in the RCE was different than that determined by the ACE, and additional insights into the event were in fact gained from the subsequent RCE.

Finally, in view of the fact that this event resulted in suspension of the licensee’s permit to ship radioactive waste to the disposal facility and violations from the Washington State Department of Health, and there had been other recent shipping events at Columbia Generating Station, the NRC concluded that an RCE would have been more consistent with the intent of the licensee’s corrective action program.

### NRC Staff Conclusion

The NRC concludes that the finding documented in NRC Inspection Report 05000397/2016009 as FIN 05000397/2016-009-07, “Failure to Follow Procedure and Perform a Root Cause Evaluation to Assess the Causes of a Radwaste Shipping Event,” is upheld.

### **Evaluation of NCV 05000397/2016009-09**

The team reviewed a self-revealed NCV of 10 CFR 61.56(a)(3) for the licensee’s failure to assure that void spaces within a waste package were reduced to the extent practicable. Specifically, a shipment of dry active waste sent to US Ecology in May 2016 arrived at the disposal facility with voids in excess of 15 percent of the total waste volume, contrary to License Condition No. 23 of US Ecology’s Radioactive Material License WN-I019-2.

### Summary of the Licensee’s Response

The licensee stated that void spaces were reduced to the extent practicable. The licensee also noted US Ecology’s license condition regarding voiding is License Condition 24, not 23 as written in the NCV.

The licensee stated that the ACE determined that material settled while the package was waiting for shipment. Personnel involved provided statements that the container was 100 percent full and “difficult to close,” which indicated that the void spaces were limited to the extent practicable. The licensee also pointed out that the 15 percent void license condition is subjective. US Ecology did not take exact measurements, and pictures show the container as being mostly full. Finally, the licensee noted that this was an isolated incident.

The licensee concluded by stating that its position was that there was not a violation because US Ecology did not perform a physical confirmation to quantify the volume of the void space and the shipment was ultimately accepted for burial. The licensee also stated that if the NRC upholds the violation, it should be of minor significance.

### NRC Evaluation

The licensee was correct in noting that US Ecology’s license condition regarding voiding is License Condition No. 24, not License Condition No. 23, as written in the NCV. However, the NRC notes that the violation was not written against US Ecology’s license or for causing US

Ecology to be out of compliance with its license conditions. The reference to US Ecology's license in the violation was intended to give context to the phrase "to the extent practicable" in 10 CFR 61.56(a)(3) and describe the self-revealing nature of the violation.

The container in question was loaded between May 25 and 26, 2016, by reactor maintenance, vendor, and health physics technicians using Procedure PPM 11.2.23.4, "Packaging Radioactive Material and Waste." At the completion of the loading, a health physics technician verified that the box was 100 percent full, to the extent that it was difficult to close. The container was shipped July 13, 2016. The fact that the waste settled to the extent shown in the photographs is evidence that void spaces had not been reduced to the extent practicable, a requirement intended to ensure structural stability of the waste for burial.

The licensee determined that the apparent cause of the void spaces in the shipment was that Procedure PPM 11.2.23.4 did not provide for verification that the box was full prior to being shipped. The licensee concluded that if the container had been opened and its contents verified, the potential issue of the bags containing radioactive material having settled would have been corrected prior to shipping. As corrective action, the licensee revised Procedure PPM 11.2.23.4 to require a radwaste transportation specialist or radioactive material controls supervisor to perform an evaluation of non-compactible boxes to be direct shipped to the disposal facility and to repackage, compact, or add waste, as appropriate.

The NRC noted that the licensee's evaluation stated that US Ecology performed a "random inspection" of Container 10056, implying that containers are not checked 100 percent of the time. If, as concluded by the ACE, the shipping procedure had a weakness regarding proper verification techniques prior to shipping and US Ecology does not check every container received, the NRC cannot conclude that this was an isolated occurrence of excessive void spaces in a radwaste container.

The NRC determined that void spaces within the waste package were not reduced to the extent practicable. Regardless of the actual volume of contents that had settled to produce voids, the fact that the contents had visibly settled indicates the contents had not been packaged in a way to prevent the development of voids. Consistent with the licensee's ACE, the NRC concluded that the container had been waiting for shipment long enough for the materials inside to settle, but licensee staff did not open the container to verify the contents had not settled prior to shipment.

The performance deficiency was more than minor because it adversely affected the NRC's Reactor Oversight Process Public Radiation Safety Cornerstone objective to ensure adequate protection of public health and safety from the exposure to radioactive materials released to the public domain. Specifically, the failure to ensure that void spaces were removed in the radwaste container subjected the disposal facility to the possibility of improper disposal of the waste.

#### NRC Conclusion

The NRC concludes that the NCV documented in NRC Inspection Report 05000397/2016009 as NCV 05000397/2016-009-09, "Failure to Minimize Void Spaces in a Radioactive Waste Package," is upheld.