



Westinghouse Electric Company LLC
Columbia Fuel Site
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USA

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November 17, 2017

SUBJECT: WESTINGHOUSE REPORTED EVENT # EN53026 30 DAY FOLLOW-UP REPORT

The following information is being provided by Westinghouse Electric Company LLC (Westinghouse) in accordance with 10CFR70.50(c)(2). A copy of the initial notification report, Event Report #EN53026, pertaining to the Columbia Fuel Fabrication Facility (CFFF) can be found in Enclosure 1 and provides the applicable information required by 10CFR70.50(c)(1). The information required in accordance with 10CFR70.50(c)(2) is provided in Enclosure 2.

If you have any questions regarding this information, please contact me at (803) 647-3338.

Sincerely,

A handwritten signature in dark ink that reads 'Nancy Blair Parr'.

Nancy Blair Parr, Manager
Licensing
Westinghouse Columbia Fuel Fabrication Facility
Docket 70-1151 License SNM -1107

Enclosure 1: Original Event Report #EN53026
Enclosure 2: 10CFR70.50(c)(2) Required Information

cc:

U. S. Nuclear Regulatory Commission
11555 Rockville Pike
Rockville, Maryland 20852-2738
Attn: Ms. Marilyn Diaz
Mail Stop: T-4B60

U. S. Nuclear Regulatory Commission, Region II
245 Peachtree Center Avenue NE, Suite 1200
Atlanta, GA 30303-1257
Attn: Mr. Tom Vukovsky

ENCLOSURE 1

Original Event Report #EN53026 dated 19 October 2017.

Caller Identification and Facility Information

Nancy Parr, Licensing Manager. Westinghouse Electric Company LLC, Commercial Fuel Fabrication Facility, Columbia SC.

Low enriched (≤ 5.0 wt.% U-235) fuel fabricator for commercial light water reactors. License: SNM-1107.

Call-Back Number (803) 647-3338.

24 Hour Event Notification based on 10CFR70.50(b)(1) for an unplanned contamination event that requires access to the contaminated area to be restricted for more than 24-hours, by imposing additional radiological controls or by prohibiting entry into the area.

Description of the Event

On October 18, 2017 at approximately 10:05 a.m., while operators were unloading a LR-230 container of liquid uranyl nitrate the liquid offload hose became disconnected from the container fitting. The event resulted in a uranyl nitrate exposure to one operator and a release in the offloading area. The estimated quantity of spilled solution was 6-8 gallons.

Immediate Corrective Actions

The operator used the emergency shower and was cleared by Health Physics and Medical personnel. Operations and Health Physics personnel cleaned up the spill of low-enriched uranyl nitrate. While decontamination efforts are essentially complete, efforts continue to assure there is no smearable contamination.

This event has been entered into the facility Corrective Action Prevention And Learning system (CAPAL).

ENCLOSURE 2

10CFR70.50 (c)(2) Information:

(i) Complete applicable information required by § 70.50(c)(1);

On October 18, 2017, at approximately 10:05 a.m., during the unloading of a LR-230 container of liquid uranyl nitrate (UN), an operator connected the air hose before connecting the liquid hose. This sequence was contrary to the procedure. When the operator was connecting the liquid hose, the operator bumped the handle on the air line, forcing air into the container. This resulted in the release of approximately six to eight gallons of UN onto the trailer, operator and surrounding area. The operator used the emergency shower and was cleared by Health Physics and Medical personnel. There were no adverse radiological or chemical safety consequences to the operator. Operations and Health Physics personnel cleaned up the spill. There were no adverse consequences to the environment. In addition, there were no actual or potential consequences to members of the public.

The initial event report notification is provided as Enclosure 1.

(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 Apparent Cause Analysis (ACA) for this event has not been finalized. The probable causes are shown in the following table along with the basis for each:

Probable Cause 1	Human error.
Basis for Probable Cause 1	Procedural steps were not followed during the connection of the offloading hoses to the LR-230 container.
Probable Cause 2	Location of the air supply valve was in the path of the operator during the connection process.
Basis for Probable Cause 2	The air supply valve was inadvertently bumped and opened during the connection process.

There was no equipment that failed or malfunctioned.

(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;

Corrective Actions:

- The following corrective actions were taken:
 1. The UN offload procedure and accompanying controlled form were refined to require use of a checklist/placekeeping tool to aid in assuring all steps are followed in order.
 2. Instructions for pressurizing the LR-230 container were modified to include the use of a valve located away from the container connections, which removes the operator from the potential release area and eliminates the possibility of inadvertently opening the air supply to the container.
 3. The handle on the existing ball valve on the air line was changed to an oval configuration, in order to reduce the possibility of the valve being unintentionally opened.
 4. Personal protective equipment (PPE) was revised to require use of a long sleeve apron or acid suit, face shield, hard hat with chin protector and chemical resistant gloves when connecting and disconnecting hoses to the LR-230 containers.
- Additional planned corrective actions may be determined by the completed apparent cause analysis (ACA) and will be tracked to completion in CAPAL 100498147.

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

The CFFF is subject to Subpart H, and the accident sequence is identified and evaluated in the Integrated Safety Analysis (ISA).