Attn: Document Control Desk
Director
Office of Nuclear Material Safety and Safeguards
U.S. Nuclear Regulatory Commission
Washington, DC 20555-0001

Louisiana Energy Services, LLC
License Number: SNM-2010
NRC Docket Number: 70-3103

Subject: 60 Day Written Follow-up Report for Event Notification 54324

On October 10, 2019 Louisiana Energy Services, LLC dba URENCO USA (UUSA), submitted Event Notification 54324 to the NRC Operations Center in accordance with 10 CFR 70.74(a). As required by 10 CFR 70 Appendix A(b), UUSA is providing this letter which contains the 60 day written follow-up to the initial report.

Enclosure 1 contains the written content of the notification submitted on October 10, 2019. Enclosure 2 of this letter contains additional information. Together, these enclosures contain the content required by 10 CFR 70.50(c).

If you have any questions, please contact Scott Diggs, Acting Licensing and Performance Assessment Manager at 575-394-6203.

Respectfully,

Stephen Cowne
Chief Nuclear Officer and Compliance Manager

Enclosures: 1. Event Report Notification 54324
2. Written Follow-up Report
ENCLOSURE 1

Event Report Notification 54324
EN 54324

On October 10, 2019 at approximately 6:30 PM, a responsible individual at Louisiana Energy Services LLC, dba URENCO USA was informed that on June 5th, 2018, at approximately 4:00 PM MDT, pressure instrument isolation valve, 1001-471-1A12, was found open when it should have been shut to maintain the pressure boundary of autoclave IL51. The autoclave is used to homogenize UF6 and obtain samples. The autoclave pressure boundary forms IROFS10.

Prior to the event, on May 31 2018, annual maintenance was performed on the autoclave as required by the IROFS10 surveillance requirements. Subsequently, a homogenization and UF6 sampling was performed June 1st through June 5th on a 30B cylinder of UF6. During preparations for a subsequent homogenization cycle, valve 1001-471-1A12 was found open. The valve should have remained closed from the previous homogenization. There was not an initiating event (no release of UF6) and no initiation of an accident sequence. The valve has been shut and the IROFS boundary has been restored. The plant is in a safe configuration.

This event has been identified in UUSA's corrective action program as EV 133619 and a causal investigation is planned.

End of report.
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<th>ISOPOE</th>
<th>ACTIVITY</th>
<th>PHYSICAL FORM</th>
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<td>MONITOR READING</td>
<td>ALARM SETPOINT</td>
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- **PERSONNEL EXPOSURE / CONTAMINATION DATA**
  - ONGOING RELEASE
  - TERMINATED RELEASE: NUMBER OF PERSONNEL EXPOSED: NUMBER OF PERSONNEL CONTAMINATED:
  - OFFSITE RELEASE: MAXIMUM EXTERNAL DOSE: MAXIMUM EXTERNAL LEVEL:
  - ONSITE AREAS EVACUATED: MAXIMUM INTERNAL DOSE: MAXIMUM INTERNAL LEVEL:
  - OFFSITE PROTECTIVE ACTION RECOMMENDED: CRITICAL ORGAN (if known):

- **DEGRADED CRITICALITY SAFETY CONTROLS FOR ACCIDENT SCENARIO(S) (BULLETIN 91-01)**
  - ALL CONTROLS LOST
  - ALL BUT SINGLE CONTROLS LOST
  - DEFICIENT SAFETY ANALYSIS
  - SAFETY SIGNIFICANCE UNKNOWN
  - >45% MINIMUM CRITICAL MASS
  - PRESENT OR READILY AVAILABLE

- NUMBER AND TYPES OF CONTROLS NECESSARY UNDER NORMAL OPERATING CONDITIONS
- NUMBER AND TYPES OF CONTROLS WHICH FUNCTIONED PROPERLY UNDER UPSET CONDITIONS
- NUMBER AND TYPES OF CONTROLS NECESSARY TO RESTORE A SAFE SITUATION

- SAFETY SIGNIFICANCE OF EVENTS

- SAFETY EQUIPMENT STATUS

- STATUS OF CORRECTIVE ACTIONS

**EVENT DESCRIPTION (Continued)**
ENCLOSURE 2

Written Follow-up Report
Written Follow-up Report

I. Applicable information required by 10 CFR 70.50(c)(2)

a. 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 is provided below:

i. UUSA has determined that the causes are the same as the event described in EN54101. As such, the investigation determined that the apparent cause was complacency due to infrequent operation of the 1001-471-1A12 isolation valve. The contributing causes were:
   1. Improper verification of valve positions by use of visual verification –vs- hands on verification.
   2. MA-3-2470-01, Autoclave Leak Check Surveillance IROFS10, leaves the valves out of their normal position
   3. Steps that ensure integrity of IROFS10 and 28 in OP-3-0470-01 are not flagged as critical steps and commitment steps
   4. Valves that are not usually operated makeup the IROFS10 established boundary
   5. Steps that ensure integrity of IROFS are not flagged as critical steps and commitment steps
   6. Not all personnel are aware of the impact their day to day jobs may have on the safety function of IROFS

b. Corrective actions taken or planned to prevent occurrence of similar or identical events in the future and the results of any evaluations or assessments are:

i. UUSA has determined that the corrective actions are the same as the event described in EN54101. The operators will receive coaching on the dangers of complacency when doing routine evolutions. The planned corrective actions that will strengthen the robustness of the IROFS10 boundaries include retraining the operators in the preferred method of performing valve verifications and procedural enhancements to minimize the probability of recurrence.

c. UUSA is subject to Subpart H of 10 CFR 70; therefore, a discussion of whether the condition was identified and evaluated in the Integrated Safety Analysis (ISA) is provided below:

i. The IROFS was identified in the UUSA ISA as a safety control to mitigate the consequences of a release of UF6 within the autoclave. The ISA evaluated accident sequences that could result in consequences to the workers and public. The valve was determined to be needed to mitigate the adverse consequences to workers and public.