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Ms. Alison O'Connor
Project Officer, Nuclear Processing Facilities Division
Canadian Nuclear Safety Commission
P.O. Box 1046, Station B
Ottawa, Ontario
Canada
K1P 5S9

Subject: Full Report – PTNSR Dangerous Occurrence Event of October 7, 2025

Dear Ms. O'Connor,

This letter is intended to tabulate and fulfill the reporting requirements of the *Packaging and Transport of Nuclear Substances Regulations (2015)* (PTNSR), Section 38, with respect to a recent dangerous occurrence (as defined by PTNSR Section 35 (g)) that involved SRB Technologies (Canada) Inc. as a consignor offering a certified Type B(U) package for transport.

The preliminary report requirements were fulfilled on October 7, 2025.

Information required in the full report

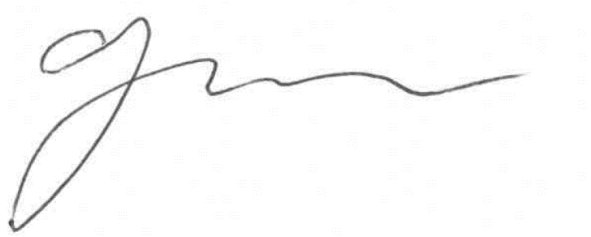
The date, time and location of the dangerous occurrence	Date: October 7, 2025 Time: approximately 0830h Location: SRB Technologies (Canada) Inc., 320 Boundary Road, Suite 140, Pembroke, Ontario, Canada
The names of the persons involved	Jamie MacDonald (SRBT) Joshua Bull (SRBT) Darci Gaudette (SRBT) Sunjay Mistry (CNL) Natalie Philippi (CNL)

The details of the packaging and packages	The shipment in question consisted of two (2) Type B(U) certified packages as follows: Package 1: 3605-397 Package 2: 3605-409 These packages are certified as Type B(U) under CNSC Certificate CDN/E204/(Rev.8). SRBT is a registered user of these packages (ref: email from C. Ouellette (CNSC) to J. MacDonald (SRBT), *Confirmation of Registered User Registration for Certificate No. CDN/E204/ (Rev. 8) for Croft Associates Ltd. 3605D,* dated January 27, 2023. The packages each contained 51 TBq of tritium in solid metal tritide form (approximately 1.3% of the maximum authorized loading of 4 PBq). The shipment was picked up by CNL transport and delivered to CNL that day without incident. Around 1100h, an employee noticed that one of the two upper cork spacers / inserts remained in the facility, leading to the conclusion that one of the two packages had been shipped without this component inside. It was determined that this constituted a failure to comply with the provision of a package certificate, in that the preparation for shipment of the package was not in accordance with Foreign Certificate No. GB/3605D/B(U) (Issue 8), Clause 2.1. The CNSC Duty Officer was notified of this event, and the information comprising a preliminary report was sent to the SRBT Project Officer on October 7 at 1348h (ref: email from J. MacDonald (SRBT) to A. O'Connor (CNSC), *SRBT Preliminary Report - PTNSR 35 (g) - Failure to Comply with the Provisions of a Package Certificate,* dated October 7, 2025). The consignee was also notified of this event shortly after it was realized. The cork spacer / insert has since been shipped to CNL, to be re-inserted with the package from which it is missing.
The probable cause	The event was most probably caused by an error in human performance, as a step was missed in the process of preparing one of the two packages for transport. This is the first such event of this type in organizational memory.

The effects on the environment, the health and safety of persons, and national or international security that have resulted or may result	None. All other steps in properly preparing this package for transport were completed, and the shipment was completed without incident.
The doses of radiation that any person has received or is likely to have received	No doses of radiation were received or are likely to have been received by any person as a result of this event.
The actions taken to remedy the failure to comply or the dangerous occurrence and to prevent its recurrence	An investigation into this event was conducted, and the results and root causes of the event were documented in accordance with SRBT's corrective actions process MSP-012, via a Non-Conformance Report (NCR-1027). Actions taken to remedy the dangerous occurrence and to prevent its recurrence: • A training needs analysis (TNA) was completed in accordance with the SRBT Training Program, in order to identify the gaps in training that may have contributed to this error. • Procedural revisions are to be completed before December 31, 2025, based on identified gaps. • Supplementary training will be developed and completed before December 31, 2025 for all qualified employees. • A controlled checklist will be developed, to be used by qualified employees as a supplementary administrative tool to prevent recurrence of this type of event in the future.

Please don't hesitate to contact me should you have any questions or require clarification.

Best Regards,



Jamie MacDonald
Manager – Health Physics and Regulatory Affairs
SRB Technologies (Canada) Inc.

cc: J. Bull, SRBT
R. Fitzpatrick, SRBT
D. Gaudette, SRBT
K. Levesque, SRBT
S. Levesque, SRBT