Westinghouse Electric Corporation
Commercial Nuclear Fuel Division

NRC-93-038
Drawer R
Columbia South Carolina 29250
(803) 776 2610

December 9, 1993

U. S. Nuclear Regulatory Commission
Region II
Attn: E. J. McAlpine, Chief
Radiation Safety Projects Section
101 Marietta Street, N.W.
Atlanta, Georgia 30323

Dear Mr. McAlpine:

Per our telephone conversation of December 6, 1993, we are supplementing our response to NRC inspection 93-06. Additional information regarding the causes for the violations are included.

If you have any questions, please call me at (803) 776-2610 extension 3426.

C. F. Sanders

C. F. Sanders, Manager
Nuclear Materials Management and Product Records

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2. A Root Cause Analysis of the incident determined that the general reason for the observation was a failure to follow the provisions of Section 3.2.5.5 of License SNM-1107 which states, "training shall be provided by the Radiation Protection component or line management to maintain a constant awareness by the employee of the necessity for radiation protection and nuclear criticality safety requirements and applicable portions of 10 CFR 19 and 20".

Specifically, it was determined that a Pellet Area Operator, new to the area, was being trained at the time on all aspects of area operation. The operator had not been adequately trained in how to inspect the enclosure; or, what to look for during such inspection; and, was not properly trained on the Nuclear Criticality safety significance of the need for an effective inspection. As a result, while working alone, the operator checked the bulk enclosure for powder accumulation (in interpretation of relevant procedures), noticed "brown discoloration" in the enclosure; but, did not realize there was a powder containment problem, and did not notify the cognizant supervisor.

2. A Root Cause Analysis of the incident determined that the general reason for the observation was a failure to follow the provision of Chapter 2, Section 2.6, of License SNM-1107 which states, "Special nuclear material processing shall be conducted in accordance with approved written procedures or instructions" -- due to uncertainty in procedural requirements.

Specifically, it was determined that Fitzmill enclosure inspections were inadequate because of vague, inconsistent guidance in applicable procedures and control forms. As a result, the three different conversion shifts, and even operators within a given shift, were conducting the enclosure inspections in various ways and at different frequencies.