NRC-94-026

Westinghouse Electric Corporation
Commercial Nuclear Fuel Division

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June 03, 1994

U.S. NUCLEAR REGULATORY COMMISSION
ATTN: Document Control Desk
Washington, DC 20555

SUBJECT: REPLY TO A NOTICE OF VIOLATION
REFERENCE: NRC Inspection Report No. 70-1151/94-02
Docket No. 70-1151 -- License No. SNM-1107

Gentlemen:

Pursuant to the provisions delineated in Section 2.201 of the NRC's Rules of Practice, Part 2, Title 10, Code of Federal Regulations, Westinghouse herein provides formal response to your letter of May 4, 1994, regarding your Region II Inspector C. H. Bassett's inspection of the Columbia Fuel Fabrication Facility, conducted during the period of April 4-7, 1994.

Appendix A provides our response to the apparent violations of NRC requirements specified in the Notice of Violation. Appendix B of this document addresses the particular concern expressed in the NRC Notice of Violation that the violations show a lack of procedural compliance by the group that is responsible for ensuring that procedures are followed.

I hereby affirm that the statements made in this response are true and correct to the best of my knowledge and belief. Should you have any questions, or require additional information, please telephone me at (803) 776-2610.

Sincerely,

WESTINGHOUSE ELECTRIC CORPORATION

J. A. Fici

James A. Fici, Plant Manager
Columbia Fuel Fabrication Facility

Attachment: Appendices A and B

090045

cc: U.S. Nuclear Regulatory Commission
Regional Administrator
101 Marietta Street, N. W.
Atlanta, Ga. 30323

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APPENDIX A

WESTINGHOUSE RESPONSE TO NOTICE OF VIOLATION 94-02

VIOLATION A - Example 1:

The following information is provided in response to the Inspector's observation that on January 26, 1994, an operator relieved the pressure in the 401C pigtail through the UF_6 line which was not in accordance with Procedure COP-810101. This action had not received the appropriate safety review by licensee management.

1. The observation is correct as stated in the Notice of Violation.

2. The reason for the observation was the failure of Procedure COP-810101 to provide operator instructions for relieving line pressure in the event of eduction nozzle plugging. The operator first attempted to relieve the pressure though the eduction line as specified in the procedure. When this ac n failed, he was instructed by his supervisor to relieve the pressure through the UF_6 line. Although this action was not covered by procedure, it had been reviewed and approved by Regulatory Affairs in the past.

3. Immediate actions taken to correct the observed condition, and results achieved, included:

   * Westinghouse identified the inadequacy of Procedure COP-810101 during the root cause investigation of the UF_6 gas leak (Data Pack EP&S 94-01). Revision of the procedure was made a condition of restart. Revision 29, which provided additional steps to prevent blockages in the UF_6 eduction lines by maintaining a constant N_2 purge, was approved and issued on February 4, 1994.
   * Conversion line operators were required to read and acknowledge the procedure change prior to operating the line.

4. Actions taken, or planned to prevent recurrence of events of the type observed include:

   * Procedure COP-810101 was further revised on February 17, 1994 to require periodic checks of the steam tracing.
   * Procedure COP-810101 was revised on May 17, 1994 to increase the N_2 flow requirement to further reduce the possibility of blockages in the UF_6 eduction lines.

5. Full compliance was achieved with the issuance of Revision 29 of Procedure COP-810101 on February 4, 1994.

VIOLATION A - Example 2:

The following information is provided in response to the Inspector's observation that on April 7, 1994, change authorization packages 93162, 93272, 93282, and 93300 which were initiated between August 5 and December 15, 1993, did not contain the Regulatory Affairs Change Verification/Release Form as required by Procedure RA-104.

1. The observation is correct as stated in the Notice of Violation.

2. The reason for the observation was a failure to use the approved Form RAF-104-2. A new form had been designed to consolidate the information from several forms into a single form. This new form was functionally equivalent to the approved Form RAF-104-2 but had not been submitted as a controlled form for formal review and approval.

3. Immediate actions taken to correct the observed condition, and results achieved, included:

   * The use of Form RAF-104-2 was immediately resumed. Regulatory Affairs personnel will continue to use this form until revisions to Procedure RA-104 and the corresponding forms can be completed, reviewed, approved, and issued.
   * Regulatory management met with their employees to remind them that "unofficial changes" to controlled documents (procedures, forms, or sketches) could not be used under any circumstances.

4. Actions taken, or planned to prevent recurrence of events of the type observed include:

   * The Regulatory Affairs Manager issued a memo on May 9, 1994 to his staff requiring a zero-based review of all Regulatory Affairs Procedures. Procedure owners are to have procedure review commitments to their managers by June 17, 1994.

5. Full compliance was achieved on April 8, 1994 when the use of Form RAF-104-2 was resumed.

VIOLATION A - Example 3:

The following information is provided in response to the Inspector's observation that from March 4, 1993 to April 7, 1994, Nuclear Criticality Safety (NCS) engineers were not assigned audits to perform during the PMS Objectives Development Process as required by Procedure RA-106.

1. The observation is correct as stated in the Notice of Violation.

2. The reason for the observation was as follows:

   The Nuclear Criticality Safety program was reviewed in detail in 1993. As a result the following programs were reevaluated or reengineered:
   * Moveable Non-Favorable Geometry Containers
   * Configuration Change Control
   * Floor Storage of SNM
   * Criticality Signs/Postings
   * Regulatory Inspections
   * Criticality Baseline Evaluations

   It was believed that these reviews were much more rigorous than the regulatory audits required in Procedure RA-106. Consequently, a management decision was made to forego the audits in 1993. The responsible manager however, failed to modify Procedure RA-106 when this decision was made.

3. Immediate actions taken to correct the observed condition, and results achieved, included:

   * In a meeting on May 19, 1994 all NCS engineers were instructed to revise their 1994 PMS objectives to include program audit responsibilities as assigned by the NMM&PR Manager. Revisions are to be completed on or before June 30, 1994.
   * Revision of Procedure RA-106 to permit alternatives to the PMS method of accountability will be completed during the next scheduled review of the procedure (on or before March 4, 1995).

4. Actions taken, or planned to prevent recurrence of events of the type observed include:

   * The Regulatory Affairs Manager issued a memo on May 9, 1994 to his staff requiring a zero-based review of all Regulatory Affairs Procedures. Procedure owners are to have procedure review commitments to their managers by June 17, 1994.

5. Full compliance will be achieved on or before June 30, 1994 with revision of NCS engineer PMS objectives.

VIOLATION A - Examples 4 & 5:

The following information is provided in response to the Inspector's observation that from January 1, 1992 to April 7, 1994, routine audits of records and activities of the operability of the criticality accident alarm system were not conducted, and that the results of routine siren audibility audits were not documented on Form RAF-304-4 as required by Procedure RA-304.

1. The observation is correct as stated in the Notice of Violation.

2. The reason for the observation was a failure to follow Procedure RA-304 in that siren audibility documentation was not completed on Form RAF-304-4. Although the tests were conducted, the results were not properly documented as required by the procedure.

3. Immediate actions taken to correct the observed condition, and results achieved, included:

   * Procedure RA-304 was revised to eliminate the periodic Regulatory Affairs audits of the alarm system. Responsibility for ensuring the proper functionality of the alarm system was transferred to Operations. Instructions in Procedure RA-304 now state that, in the event of an alarm malfunction or high noise levels that reduce the audibility of the alarm, Maintenance is to be notified by Operations and a redbook item is to be generated. Regulatory Affairs will follow-up on required corrective actions through the redbook process. Form RAF-304-4 has also been deleted as it is no longer necessary.

4. Actions taken, or planned to prevent recurrence of events of the type observed include:

   * The Regulatory Affairs Manager issued a memo on May 9, 1994 to his staff requiring a zero-based review of all Regulatory Affairs Procedures. Procedure owners are to have procedure review commitments to their managers by June 17, 1994.

5. Full compliance was achieved on May 19, 1994 with revision of Procedure RA-304.

VIOLATION A - Example 6:

The following information is provided in response to the Inspector's observation that criticality monitor calibrations exceeded the 26-week limit stated in procedure MCP-202037.

1. The observation is correct as stated in the Notice of Violation.

2. The reason for the observation was as follows:

   Contrary to license requirements, Procedure MCP-202037 permitted delays in calibration of the GA-6M criticality monitors which exceeded the 26-week frequency requirement. This condition resulted from an oversight on the part of the Maintenance Engineer responsible for this procedure.

3. Immediate actions taken to correct the observed condition, and results achieved, included:

   * Procedure MCP-202037 was revised and issued on April 20, 1994. This revision clarified that the maximum allowable time between calibrations (26 weeks) is 225 days as defined in NRC License SNM-1107.
   * A workplace meeting was held with all instrument technicians during which time it was again emphasized that the calibration requirements for safety significant alarms and interlocks must be strictly adhered to.

4. Actions taken, or planned to prevent recurrence of events of the type observed include:

   * All related MCP procedures were reviewed by maintenance engineers to ensure that the procedures were written to maintain strict compliance with regulatory requirements.

5. Full compliance was achieved on April 20, 1994 with revision and approval of Procedure MCP-202037.

APPENDIX B

RESPONSE TO CONCERN

In this Appendix, Westinghouse addresses the NRC concern that apparent violations discovered during the routine unannounced inspection of Mr. C. H. Bassett showed a lack of procedural compliance by the group (Regulatory Affairs) that is responsible for ensuring that procedures are followed.

Of the six examples cited in the notice of violation, four are the responsibility of the Regulatory Affairs Department (Items 2, 3, 4, & 5). In one instance (item #5), the procedure was actually followed by the regulatory engineer assigned with responsibility for performing routine siren audibility audits, but the supporting documentation was either lost or inadvertently destroyed. In the remaining three cases, procedural noncompliances did occur. In Items 2 & 3 the intended requirements of the applicable procedures were met but the documentation did not meet the precise procedure requirements.

Each case of Regulatory Affairs noncompliance can be attributed to the failure of the responsible individual to carefully follow the procedure precisely as written. Although the overall intent of the procedure was followed, specific documentation requirements or assignments were not completed.

In order to correct these violations and to reduce the possibilities for future similar violations, the manager of the Regulatory Affairs Department has issued a letter to his staff directing that:

1. Ownership of each Regulatory Affairs procedure be reaffirmed or reassigned if appropriate.
2. Each Regulatory Affairs procedure be reviewed and revised, if necessary.
   a. Emphasize "performance-based" as opposed to "prescriptive" procedures.
   b. Assign the level of detail that is optimally appropriate for the task being described.
   c. Ensure that each procedure reflects current regulatory requirements and actual plant practices.
   d. Specify responsibilities by job functions and not organizational titles.
   e. Combine procedures where appropriate.
3. An action plan with firm commitment dates be prepared by June 17, 1994.

Upon completion of these reviews and revisions, the Regulatory Affairs Department will ensure compliance with these procedures by holding all individuals within the department strictly accountable for procedural compliance.