

APPENDIX B

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

NRC Inspection Report: 50-458/91-15

Operating License: NPF-47

Docket: 50-458

Licensee: Gulf States Utilities (GSU)

Facility Name: River Bend Station (RBS)

Inspection At: RBS, St. Francisville, Louisiana

Inspection Conducted: June 3-7, 1991

Inspector: Dr. Dale A. Powers, Senior Reactor Inspector, Test Programs
Section, Division of Reactor Safety

Approved:



William C. Seidle, Chief, Test Programs
Section, Division of Reactor Safety

6/14/91
Date

Inspection Summary

Inspection conducted June 3-7, 1991 (Report 50-458/91-15)

Areas Inspected: Routine, announced inspection of the licensee's partial disassembly and post-irradiation examination of two fuel bundles, which contained failed fuel rods.

Results: The General Electric Co. procedures that were used in the fuel examination activities provided, in general, reasonable guidance with appropriate quality control hold points and safety precautions. The General Electric Co. fuel inspection team exhibited clear understandings of their responsibilities, the safety significance of their work, and their required actions in the event of a fuel handling accident. As a team, they were well experienced in their duties and performed them in a safe manner.

The licensee had arranged necessary equipment in such a manner to permit personnel who were not working with the contaminated equipment to stand near and observe activities without dressing out into anti-contamination clothing. Noteworthy, was that the licensee had placed a television monitor, which was connected to the underwater periscope, outside the contaminated zone for interested parties to view the examination results as they unfolded. Prior to commencing fuel examination activities, the licensee held a briefing with those personnel who would be working in the area. Throughout the fuel handling and examination process, radiation protection personnel were actively engaged in following activities and conducting area and equipment surveys.

The licensee identified an apparent violation involving the movement of an irradiated fuel bundle prior to completing the necessary Technical Specification surveillances that assure fuel building integrity. The required surveillances had been overlooked in the preparations for fuel movement. Also, the surveillances were not specified in the operative fuel handling procedures.

As a result of the fuel examinations, the licensee found that at least one fuel rod in each of the two subject fuel bundles had failed. The failed rods each exhibited cracking and localized swelling at the perforation sites. All other visual characteristics of the fuel rods and fuel bundle components appeared typical of that anticipated. The licensee took prudent action in deciding to discontinue the handling of the two failed fuel rods inasmuch as a safety evaluation had not been performed to assess the mechanical strength residing in the cladding walls of the two failed fuel rods.

The fuel failure mechanism(s) is currently unknown. The licensee has tentatively concluded from the examination process that the failures are most likely attributable to incipient defects not identified during the manufacturing non-destructive examination process, and that further fuel failure in Reload 1 Fuel is not expected.

DETAILS

1. PERSONS CONTACTED

Gulf States Utilities

- *G. S. Young, Supervisor, Reactor Engineering
- *D. N. Lorfing, Supervisor, Nuclear Licensing
- *P. D. Graham, Plant Manager
- *K. E. Suhrke, General Manager, Engineering and Administration
- *W. L. Curran, Site Representative, Cajun Electric
- *E. B. Weinfurter, Senior System Engineer
- *J. C. Maher, Licensing Engineer
- M. L. Wittenburg, Nuclear Fuels Engineer
- R. G. Redmond, Senior Quality Assurance Engineer
- D. D. Castleberry, Senior Quality Assurance Engineer
- *J. E. Booker, Manager, Nuclear Industry Relations
- *W. S. Day, Analyst, Cajun Electric
- *E. M. Cargill, Director, Radiological Programs
- *S. V. Desai, Senior Engineer, Internal Safety Evaluation Group
- *J. P. Schippert, Assistant Plant Manager, Operations, Radwaste, & Chemistry
- *G. A. Bysfield, Assistant Plant Manager, Systems Engineering
- *S. C. Hagge, Senior System Engineer
- *D. R. Derbonne, Assistant Plant Manager, Maintenance
- *W. J. Fountain, Senior Quality Assurance Engineer
- *G. R. Kimmell, Director, Quality Assurance
- *D. E. Thomas, Director, Administration Services
- J. E. Venable, Operations Supervisor

General Electric Co.

- C. M. Berry, Supervisor, Fuel Inspection Team
- *R. K. Stoner, Acting Service Manager

NRC

- *E. Ford, Senior Resident Inspector
- *R. Stewart, Reactor Inspector

During the inspection, the inspector also contacted other licensee personnel.

*Denotes those attending the exit meeting on June 7, 1991.

2. FOLLOWUP ON PREVIOUS INSPECTION FINDINGS (92701)

As discussed in NRC Inspection Report 50-458/91-02, minor discrepancies were identified in the River Bend Station (RBS) Cycle 4 Management Report. In response to the discovery of these discrepancies, the licensee committed in the NRC exit meeting to conduct an audit of the General Electric Co. (GE) work activities involved in preparation of the Cycle 4 Management Report.

During this inspection, the inspector discussed with quality assurance (QA) personnel the results of the Gulf States Utilities (GSU) audit. There were two findings resulting from the audit. These findings involved (1) engineering changes to the Cycle 4 Management Report that were contrary to the GE procedures and (2) failure to include procedurally designated information into the Cycle 4 Management Report. In addition, GSU determined that the GE transmittal letters for cycle management reports should provide more specificity in describing the status of attachments.

It appeared to the inspector that the licensee had fulfilled its commitment, and was working properly to resolve the identified discrepancies. This issue is considered closed.

3. PREPARATION FOR REFUELING (60705)

3.1 Background

The purpose of this inspection was to witness the partial disassembly and post-irradiation examination (PIE) of Fuel Bundles LYH760 and LYH845 and the potential reconstitution of one of the bundles for potential reuse. The Attachment to this inspection report is a tabulation of related documents reviewed by the inspector during the inspection. When a document number is cited below, it will be the number assigned in the Attachment.

During Cycle 3 operation, the licensee observed evidence (i.e., elevated off-gas activity) of fuel cladding failure. Subsequently, the licensee established a fuel integrity committee, which periodically met, planned strategic control rod movements to locate the bundles that contained the failed fuel rods, and reviewed operational data. The analyses of primary coolant system sampling, power maneuvering, and fuel manufacturing records led the licensee to suspect that the fuel failure mechanism was likely attributable to incipient defects in the barrier cladding. Presumably, these manufacturing defects had not been detected by the fuel vendor's QA non-destructive examination (NDE) process. This expectation of a non-generic failure mechanism comports with the historical performance (e.g., Document 1) of the GE barrier-type of fuel, which has served as durable fuel that is no longer under pellet cladding interim operating recommendations limitations as were the earlier design of GE fuels.

During the third refueling outage, the licensee vacuum sipped 66 fuel bundles and determined that 2 bundles contained failed fuel rods. The subject fuel bundles were identified as LYH760 and LYH845. These fuel bundles had been loaded into the RBS core during the first refueling, and as such were designated by the licensee as Reload 1 Fuel. The calculated accrued exposures at the time of indicated cladding breach were 19,350 and 21,000 MWD/MTU, respectively. The results of NRC's inspection of several of the licensee's activities associated with the occurrence of failed fuel were given in Document 2.

3.2 Fuel Surveillance Requirements

In regard to the licensee's fuel surveillance program, the NRC staff accepted the position (Document 3) that a PIE program for RBS could be provided by GE. Later, the NRC staff safety evaluation report (SER) (Document 4) on GESSAR II accepted the position that GE would provide routine PIE for their fuel. Moreover, the NRC SER stated that surveillance beyond the routine surveillance might be required in the event of a fuel problem. Consequently, in response to the RBS fuel failures, GE developed a plan (Document 5) for conducting an inspection, identifying the failed fuel rods and the most probable cause of failure, and performing the reconstitution of one of the bundles. The plan sets forth the understandings of the responsibilities and services to be assumed by GE and GSU. The plan further states that GE will provide a presentation or written report to GSU that summarizes and interprets the data and observations made during the PIE.

3.3 Cycle 5 Fuel Integrity

During this inspection, the licensee's representative stated that there had not been any confirmed indication of fuel failure during Cycle 4 operation. The inspector reviewed the minutes (Document 6) of the May 22, 1991, meeting of the Fuel Integrity Monitoring Committee. The committee had found that the off-gas pretreatment activity, which is used as the primary indicator of failed fuel, had been trending up during Cycle 4 operation. This increasing trend had, however, been in accordance with a somewhat erratic, but generally increasing off-gas system flow rate. The reason for the erratic system flow was currently under investigation by the licensee, and may be a result of air in-leakage. From secondary indicators of fuel failure (i.e., xenon, neptunium, krypton, and strontium activities and activity ratios), there was apparently no indication of fuel failures present in the Cycle 4 core.

3.4 Quality Assurance and Work Controls

The licensee had specified the fuel handling and examination activities in a maintenance work order (MWO) (Document 7). The MWO stated that the work was to be performed under GSU's fuel handling procedures and GE procedures (submitted in Document 8). The GE procedures were controlled under the GSU vendor technical information (VTI) system. Documents 9 and 10 were the GSU fuel handling procedures referenced by the MWO for use of the fuel preparation machine and the fuel handling platform. The MWO indicated that the secondary containment Technical Specification (TS) would be in effect when fuel was being moved or in the fuel preparation machine. The inspector reviewed with the licensee the QA controls placed on the GE fuel inspection services. Programmatically, GSU had endorsed, via the Updated Safety Analysis Report (Document 11) and the respective QA directives and instructions, the GE QA controls for fuel examination and reconstitution activities.

The GE procedures that were available for the inspection team activities are given in Documents 12 through 17. Document 12 describes the unpacking, inspection, and repacking of GE equipment shipped to RBS. Document 13

describes the removal and reinstallation of a channel on an irradiated fuel bundle. Document 14 describes the method and sequence of tasks for the visual examination of irradiated fuel bundle components. Document 15 describes the method for the removal and reinstallation of an irradiated fuel bundle upper tie plate and individual fuel rods. Document 16 describes the method to be used for the accountability of a fuel rod removed from a fuel bundle. Document 17 describes the NDE (i.e., eddy current and ultrasonic techniques) used to assess the integrity of irradiated fuel cladding. The inspector reviewed the documents and, in general, found them to provide reasonable guidance with appropriate quality control (QC) hold points and safety precautions.

The GE fuel inspection team consisted of four individuals and a supervisor. Throughout the course of the inspection, the inspector interfaced with and interviewed the contractor personnel. The contractor personnel exhibited clear understandings of their responsibilities, the safety significance of their work, and their required actions in the event of a fuel handling accident. As a team, the contractor personnel were well experienced in their duties and performed them in a safe manner.

The licensee's fuel inspection activities were conducted in the fuel handling floor room of the fuel building. The fuel preparation machine and underwater lighting had been mounted on one wall of the spent fuel pool. The licensee had arranged necessary equipment in such a manner to permit personnel who were not working with the contaminated equipment to stand near and observe activities without dressing out into anti-contamination clothing. Noteworthy, was that the licensee had placed a television monitor, which was connected to the underwater periscope, outside the contaminated zone for interested parties to view the examination results as they unfolded.

The examination activities were under the coordination of a senior system engineer from reactor engineering. Occasionally present during the movement of irradiated fuel was the shift supervisor. The inspector noted that OC-Operations also closely observed the fuel handling and examination activities. Prior to moving the two subject fuel bundles from the spent fuel pool, the licensee held a briefing with those personnel who would be working in the area. During the meeting, radiation protection personnel briefed the crew members on necessary precautions, such as maintaining the TS required 8 feet 2 inch water level above the top of the active fuel and their response to local radiation monitor alarms, which were set to alarm at 20 mR/h. Throughout the fuel handling and examination process, radiation protection personnel were actively engaged in following activities and conducting area and equipment surveys. In regard to communications, the licensee maintained frequent contact with the control room staff in order to brief operations on significant activities that were about to occur.

Prior to moving fuel, the licensee also stationed a security officer just inside the room in order to ensure that all personnel working on the fuel handling floor had read the applicable fuel handling abnormal operating procedure (AOP) (Document 18). Entering personnel were also required, for housekeeping purposes, to list on a form all items carried onto the floor.

3.5 Fuel Movement and PIE Results

The first fuel movement commenced at 2:24 p.m. on June 4 while the reactor was in Mode 1. During this movement, Fuel Bundle LYH845 was transferred from its spent fuel pool storage location into the fuel preparation machine. Because of a lack of 480 volt power for underwater lighting, all examination activities were subsequently deferred until the next day. Later, at 3:30 p.m. on June 4, the assistant shift supervisor was reviewing activities and noticed that TS 4.6.5.2 surveillance requirements had been overlooked.

TS 4.6.5.2 states that secondary containment integrity-fuel building shall be demonstrated within 24 hours prior to and at least once per 7 days during the handling of irradiated fuel in the fuel building, by verifying that: (1) pressure is less than 0.25 inches of water vacuum, (2) equipment hatch covers are installed, (3) at least one door in each access is closed except for routine entry and exit, and (4) all penetrations required to be closed during fuel handling accident conditions (except ventilation system charcoal filtration system penetrations) are closed. The basis to the TS states that the fuel building and other associated structures provide secondary containment during normal operation and that secondary containment is designed to minimize any ground level release of radioactive material, which may result from a fuel handling accident. TS 4.6.5.2 provides assurance that secondary containment integrity-fuel building is maintained pursuant to TS 3.6.5.2. Surveillance Test Procedure STP-000-0103 (Document 19) is the governing procedure that implements the surveillance requirements of TS 4.6.5.2.

The licensee's immediate corrective actions in response to its finding were to: (1) notify the coordinating engineer in the fuel building to cease fuel handling activities, (2) danger tag the air supply valve to the fuel preparation machine, (3) perform the surveillance requirements of Procedure STP-000-0103, and (4) interview licensee personnel in order to ascertain the status of the applicable surveillance items immediately prior to the onset of fuel movement. Upon completing Procedure STP-000-0103 at 5:28 p.m. on June 4, the licensee found that all specified plant conditions and components met its acceptance criteria. The licensee's interviews determined that, collectively, personnel were able to attest to the acceptability of all specified plant conditions and components within 24 hours prior to fuel handling except one component. This component was a normal ventilation intake plenum access hatch. The licensee concluded that it was unlikely that this particular equipment hatch had been disturbed during the time of fuel handling because: (1) the hatch was in a location requiring scaffolding or similar means to access, (2) there were no outstanding MWOs effecting the hatch, and (3) the fuel building vacuum was greater than the TS requirement (TS 3.6.5.1).

The licensee's secondary corrective actions included issuing a condition report (Document 20) and placing the necessary statements to conduct STP-000-0103 in the fuel handling and movement procedures via temporary change notices (TCNs) (Documents 21, 22, and 23).

The licensee determined that STP-000-0103 had not been performed within the previous 24 hours prior to moving the irradiated fuel bundle because: (1) the event-based TS requirement had been overlooked in the fuel movement preparation, and (2) the fuel handling and fuel movement procedures (i.e., Documents 9 and 10) did not caution the user to conduct the surveillance. The licensee's representative stated that this particular instance was the first occasion when irradiated fuel had been handled while the plant was not in a refueling outage. The licensee's representative also indicated that the radiological hazards associated with damaging the subject fuel bundle were low. This was because the bundle had been discharged from the core several months ago, and that its fission gas inventory would have significantly decayed. The inspector inquired and learned from the licensee that a radiological assessment of accident dose levels in the fuel handling floor room had not been conducted to determine the safety significance of such a fuel handling accident with the subject fuel bundle. The licensee's representative stated that GSU considered that a nonreportable, procedural violation had occurred, but did not believe that a TS violation occurred. This belief resulted from the observation that the TS 3.6.5.1 limiting condition for operation was being met during the time of irradiated fuel movement.

The surveillance requirements of TS 4.6.5.1, for Modes 1, 2, and 3 operation, address the same surveillance requirements as TS 4.6.5.2. The surveillance frequencies specified in TS 4.6.5.1 are different from those in TS 4.6.5.2 in that hatches, doors, and penetrations are to be monitored on a less frequent basis of every 31 days. Another difference between the TS surveillance requirements is that the fuel building pressure acceptance criterion in TS 4.6.5.1 is less restrictive than that of TS 4.6.5.2. The licensee's representative stated, however, that fuel building integrity could be extrapolated from the fact that fuel building pressure was being maintained at a vacuum greater than either TS requirement and that such pressure was monitored within 24 hours of irradiated fuel movement. The licensee's deduction of fuel building integrity may be correct; however, the failure to execute Procedure STP-000-0103 surveillance requirements within 24 hours prior to the handling of irradiated fuel is an apparent violation of TS 4.6.5.2 (50-458/9115-01).

The fuel examination process resumed on June 6. In examining the two fuel bundles, the licensee did not use the channel go/no-go gauge; however, from observation of the bundles through binoculars and the periscope, the channels did not exhibit any obvious bow, twist, or other distortion. The channels appeared to have normal discoloration. There were no components observed missing from either of the two bundles. All spacer grids appeared to be properly aligned and located at the proper elevations. There also was no evidence of excessive rod bowing, general rod swelling, or excessive rod elongation. Fuel rods were seen to be covered with a red crud between the lower elevation of the transition from natural-to-enriched uranium and the upper elevation of the plenum.

Bundle LYH845, which was the first bundle placed in the fuel preparation machine, was observed to release bubbles as it was being lowered during the channel removal process. The bubbles apparently came from Rod E1: a peripheral, non-gadolinia bearing, non-tie rod. An axial examination of Rod E1

revealed that it was cracked at three elevations. One area of the cracks was located just above the lower elevation of transition from natural-to enriched uranium. In the vicinity of this crack site, there was a small degree of localized rod swelling. The cladding was perforated at this crack location, and the failure opening appeared to resemble a splinter. There appeared to be evidence of a small amount of steam cleaning above the elevation of the perforation. The other two cracks, which were at higher elevations did not necessarily appear to be through-wall cracks and did not have any visible swelling or steam cleaning associated with them. In order to further assess the damage to rod E1, the upper tie plate was removed, and Rod E1 was rotated by 180 degrees. Upon rotating Rod E1, it was observed that another crack collocated at the elevation corresponding to the crack at the highest elevation (i.e., about 138 inches) on the other side of the rod became evident. In view of the extent of the cracking and the previously observed apparent leaning of the upper portion of the rod when the upper tie plate was removed, the licensee decided to discontinue handling the damaged rod. Subsequently the upper tie plate and channel were replaced, and the bundle was placed back into a spent fuel storage rack.

The examination of Bundle LYH760 revealed that Rod D1 had a long axial split. Rod D1 is a peripheral, non-gadolinia, non-tie rod. The split was located between two mid-level spacer grids, and was approximately 10 inches in length. The crack opening was at maximum about one-sixteenth to one-eighth of an inch. A large area of steam cleaning was noticeable above the crack location, and there appeared to be some yellow staining in the steam-cleaned area that was presumably due to fuel pellet washout. No other obvious cracking was evident on Rod D1. Because of the extent of the damage to Rod D1, the licensee decided not to remove the upper tie plate or further examine the bundle. Subsequently, the fuel bundle was rechanneled and returned to its storage location in the spent fuel pool.

The inspector believed that the licensee took prudent action in deciding to discontinue the examination of the two failed fuel rods. Further handling was questionable, inasmuch as a safety evaluation had not been performed to assess the mechanical strength residing in the cladding walls and their ability to withstand the loading and bending forces during the extraction process.

From the examinations, the licensee determined that at least one rod in each fuel bundle had failed. Neither fuel rod was from the same cladding lot. Cracks, localized rod swelling, and obvious perforations on each failed rod were found not to coincide with end-plug welds or spacer grid locations. There was no evidence of fretting or foreign debris in the bundles. The failed rods exhibited no noticeable evidence of pellet-cladding mechanical interference or excessive oxidation. The damage appeared not to be atypical to that seen in other reactor cores.

The fuel failure mechanism(s) is currently unknown, although the video tapes and photographs taken may afford GE the ability to rule out some failure mechanisms and reasonably speculate on others. The licensee has tentatively concluded from the examination process that the failures are most likely attributable to incipient defects not identified during the manufacturing NDE

process. The licensee has been informed by GE that other cladding manufacturing defects have resulted in cladding failures in other reactor cores, and that these failures have primarily occurred in the second cycle of exposure (as were the failures that occurred in the RBS core). Therefore, the licensee expects that the remaining Reload 1 Fuel residing in the RBS core will not experience failure.

3.6 Fire Barrier Door

On the morning of June 6, the inspector noted that a fire door was tied open to apparently allow a power cable to pass through into the fuel handling floor room. The inspector questioned the licensee's representative on the fire watch controls placed on the door, which was labeled FB 113-05. In discussion with the control room staff, the licensee's representative learned that the door was not a fire barrier door, and had been improperly posted with a sign stating "Fire Door/Keep Closed/Insure Door Latches." The licensee also determined that the subject door, although mis-posted, had been placed on the control room Fire Watch Location Log on June 5 prior to being tied open. Later on June 6, the barrier posting was removed from the subject door.

One violation and no deviations were identified in the review of this program area.

4. EXIT MEETING

On June 7, 1991, the inspector met with members of the licensee's organization denoted in paragraph 1, and summarized the scope and findings of this inspection.

The licensee identified as GE proprietary the inspection plan and the procedures used by GE contractor personnel in the performance of the fuel inspection and reconstitution activities. During the inspection, the inspector participated in two telephone calls with GE personnel from San Jose. The purpose of those telephone conferences was to establish what specific information in the subject documents were considered to be proprietary by GE. This was necessary inasmuch as there were no non-proprietary versions of the subject documents. None of the information from the subject documents that is described in this inspection report contains proprietary information. Observations of the incurred fuel damage made by the inspector during the inspection are not considered proprietary.

ATTACHMENT

Documents Reviewed

1. "Fuel Performance Annual Report for 1988," NUREG/CR-3950, PNL-5210, Vol. 6
2. NRC Notice of Violation (NRC Inspection Report 50-458/90-29), dated December 27, 1990
3. NRC Letter from L. S. Rubenstein to R. L. Gridley (GE), dated June 27, 1984
4. NRC SER on GESSAR II BWR/6 Nuclear Island Design, Docket 50-447, NUREG-0979, April 1983
5. GE Test Plan and Procedures, "River Bend Cycle 4 Failed Fuel Inspection," May 1991 (GE proprietary)
6. Memorandum from G. S. Young (GSU), "Fuel Integrity Monitoring Meeting for May 1991," dated May 29, 1991
7. GSU Maintenance Work Order No. R167799, dated May 24, 1991
8. GE letter GFP-688 OSP 91-053, dated February 27, 1991
9. GSU Procedure FHP-0007, "Use of Fuel Preparation Machines," Revision 3, October 4, 1989
10. GSU Procedure FHP-0002, "Fuel Handling Platform Operation," Revision 3A, February 8, 1991
11. River Bend Station Updated Safety Analysis Report Chapter 17.2.7, "Control of Purchased Material, Equipment, and Services"
12. GE Procedure GP #22, Revision 1, "Generic Procedure for Reactor Site Receiving, Inspection, & Packaging of Individual Fuel Bundle Components," July 14, 1981 (GE proprietary)
13. GE Procedure 246-GP-37, Revision 2, "Removal and Reinstallation of a Channel on an Irradiated Fuel Bundle," April 12, 1984 (GE proprietary)
14. GE Procedure 246-GP-03, Revision 2, "Irradiated Fuel and Component Visual Examination," January 1990 (GE proprietary)
15. GE Procedure 246-GP-01, Revision 8, "Fuel Bundle Upper Tie Plate Removal/Replacement and Individual Rod Handling," January 10, 1990 (GE proprietary)
16. GE Procedure 246-GP-43, Revision 0, "Fuel Rod Accountability," February 6, 1985 (GE proprietary)
17. GE Procedure 246-GP-23, Revision 6, "Eddy Current and Ultrasonic Testing of Irradiated Fuel Rods," May 1985 (GE proprietary)

18. GSU Procedure AOP-0027, Revision 7, "Fuel Handling Mishaps," February 15, 1991
19. GSU Procedure STP-000-0103, "Irradiated Fuel Handling in Fuel Building," Revision 2, February 13, 1990
20. GSU Condition Report No. 91-0254, dated June 4, 1991
21. GSU TCN 91-0411, "Use of Fuel Preparation Machines," June 5, 1991
22. GSU TCN 91-0412, "Fuel Handling Platform Operation," June 5, 1991
23. GSU TCN 91-0413, "Special Nuclear Material (SNM) Movement Control and Accounting," June 5, 1991

NRC FORM 786 A 1-81 U.S. MC 0635 INSPECTOR'S REPORT (Continuation) Office of Inspection and Enforcement	DOCKET NO. (8 digits) OR LICENSE NO. (BY PRODUCT) (13 digits)		REPORT		MODULE NUMBER	VIOLATION SEVERITY OR DEVIATION		EYE RELATED	SUPL.
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VIOLATION OR DEVIATION (Enter up to 2400 characters for each item. If the text exceeds this number, it will be necessary to paraphrase. Limit lines to 50 characters each.)

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3 River Bend Station Technical Specification 3.6.5.2 states that

4 secondary containment integrity-fuel building shall be

5 maintained.

6 River Bend Station Technical Specification 4.6.5.2 requires that

7 secondary containment integrity-fuel building shall be

8 demonstrated within 24 hours prior to the handling of irradiated

9 fuel in the fuel building.

10 Gulf States Utilities' Surveillance Test Procedure 000-0103,

11 "Irradiated Fuel Handling in Fuel Building," is the governing

12 procedure that implements the Technical Specification 4.6.5.2

13 surveillance requirements.

14 Contrary to the above, on June 4, 1991, the licensee discovered

15 that it had handled irradiated fuel bundle LYH845 without first

16 demonstrating secondary containment integrity-fuel building by

17 performing Procedure STP-000-0103 within the prior 24 hours.

18 This is a Severity Level IV violation. (Supplement I) (50-

19 458/9115-01)

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