INTERNAL CORRESPONDENCE

PBM 96-0320

To: C. A. Castell B. D. O'Connell S. A. Pfaff S. J. Zepplin

From: G. J. Maxfield

Date: May 29, 1996

Subject: INCIDENT INVESTIGATION II 96-01
BRIEF COMBUSTIBLE GAS BURN DURING DRY STORAGE CONTAINER SHIELD LID WELDING

Copy To: R. E. Link W. B. Fromm T. C. Guay G. J. Maxfield
J. G. Schweitzer R. D. Seizert T7.4.3

At approximately 0245 hours on Monday, May 28, 1996, during initiation of welding the shield lid inside the third dry fuel storage container, an unidentified combustible gas briefly ignited. The ignition slightly cocked the shield lid. Continuous air measurements in the cask decontamination area showed no measurable radioactivity. There were no personnel injuries as a result of this event. An initial activity plan focused on notification of the NRC resident inspector; determination of immediate reporting requirements; identification and monitoring of the source of the gas; removal of the shims and replacement of the shield lid; and preparations for returning the loaded container to the spent fuel pool.

I would like you to participate on an incident investigation team to review this event. The scope of the investigation should include:

- Determination of the root cause(s) of this event using TapRoot root cause techniques.
- Identification of the source of the gas.
- A review of welding procedures, processes, and work practices, including purging during welding as is the normal practice for primary side welding activities, positioning of the person performing the welding and sampling for combustible gases.
- An evaluation of operating experience at other utilities using the VSC-24 multi-assembly sealed basket and with CarboZinc coating.
- A review of precursors to this event. The precursors may include, but not be limited to previous evaluations of the protective coating and experiences during the loading of the previous two containers.

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Mr. Castell is appointed chairman of this incident investigation team. It is anticipated that the scope of this investigation will not need to be more broad then detailed above; however, should the team believe that the scope needs to be changed, this should be discussed with me. I anticipate that this investigation can be completed by Friday, June 7, 1996,

The investigation should follow the instructions provided in procedure NP 5.3.3, "Post-Incident Critique and Investigation." Thus, your team will prepare a report of your investigation for me, and will present your report to the Manager's Supervisory Staff. The report should be prepared by Friday, June 14, 1996.

G. J. Maxfield
Plant Manager

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POINT BEACH VSC-24 STORAGE CASK EVENT - MAY 28, 1996

DISCUSSION

- Event Followup
  - AIT Findings & Conclusions
  - Vendor Inspection Findings
  - Summary of Public Concerns

- Initial Regulatory Actions
  - Issued IN 96-34 on May 31, 1996.
  - CALs Issued June 3, 1996 to Affected Licensees (Pt. Beach, Palisades, ANO).

- Future Regulatory Actions
  - Generic Communications:
    - Cask Vendors
    - Utilities operating or planning ISFSIs
  - Modify SRP for Storage Casks