

(ACCELERATED RIDS PROCESSING)

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

MISSION NBR: 9510020260 DOC. DATE: 95/09/25 NOTARIZED: NO DOCKET #
 CIL: 50-397 WPPSS Nuclear Project, Unit 2, Washington Public Powe 05000397
 AUTH. NAME AUTHOR AFFILIATION
 PARRISH, J.V. Washington Public Power Supply System
 RECIP. NAME RECIPIENT AFFILIATION
 Document Control Branch (Document Control Desk)

SUBJECT: Responds to NRC 950824 ltr re violations noted in insp rept
 50-397/95-21. Corrective actions: repaired affected radiation
 barrier.

DISTRIBUTION CODE: IE01D COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 5
 TITLE: General (50 Dkt)-Insp Rept/Notice of Violation Response

NOTES:

	RECIPIENT ID CODE/NAME	COPIES LTTR ENCL	RECIPIENT ID CODE/NAME	COPIES LTTR ENCL
	PD4-2 PD	1 1	CLIFFORD, J	1 1
INTERNAL:	ACRS	2 2	AEOD/DEIB	1 1
	AEOD/SPD/RAB	1 1	AEOD/TTC	1 1
	DEDRO	1 1	FILE CENTER	1 1
	NRR/DISP/PIPB	1 1	NRR/DORS/OEAB	1 1
	NRR/DRCH/HHFB	1 1	NUDOCS-ABSTRACT	1 1
	OE DIR	1 1	OGC/HDS3	1 1
	RGN4 FILE 01	1 1		
EXTERNAL:	LITCO BRYCE, J H	1 1	NOAC	1 1
	NRC PDR	1 1		

NOTE TO ALL "RIDS" RECIPIENTS:

PLEASE HELP US TO REDUCE WASTE! CONTACT THE DOCUMENT CONTROL
 DESK, ROOM OWFN 5D8 (415-2083) TO ELIMINATE YOUR NAME FROM
 DISTRIBUTION LISTS FOR DOCUMENTS YOU DON'T NEED!

TOTAL NUMBER OF COPIES REQUIRED: LTTR 19 ENCL 19





WASHINGTON PUBLIC POWER SUPPLY SYSTEM

P.O. Box 968 • 3000 George Washington Way • Richland, Washington 99352-0968 • (509) 372-5000

September 25, 1995
G02-95-195

Docket No. 50-397

U.S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, D.C. 20555

Gentlemen:

Subject: **WNP-2, OPERATING LICENSE NPF-21
NRC INSPECTION REPORT 95-21, RESPONSE
TO NOTICE OF VIOLATION**

Reference: Letter GI2-95-197, dated August 24, 1995, RA Scarano (NRC) to JV Parrish (SS), "NRC Inspection Report 50-397/95-21 and Notice of Violation"

The Supply System's response to the referenced Notice of Violation, pursuant to the provisions of Section 2.201, Title 10, Code of Federal Regulations, is attached.

Should you have any questions or desire additional information regarding this matter, please call me or D. A. Swank at (509) 377-4563.

Sincerely,

J.V. Parrish (Mail Drop 1023)
Vice President, Nuclear Operations

CJF/ml
Attachment

cc: LJ Callan - NRC RIV
KE Perkins, Jr. - NRC RIV, Walnut Creek Field Office
NS Reynolds - Winston & Strawn
JW Clifford - NRC
DL Williams - BPA/399
NRC Sr. Resident Inspector - 927N

9510020260 950925
PDR ADDCK 05000397
Q PDR

JE01



Appendix A

VIOLATION

During an NRC inspection conducted on July 17-20, 1995, two violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action," 10 CFR Part 2, Appendix C, the violations are listed below:

- A. Technical Specification 6.12.2 requires, in part, that in addition to the requirements of Specification 6.12.1, areas accessible to personnel with radiation levels such that a major portion of the body could receive in 1 hour a dose greater than 1000 mrems shall be provided with locked doors to prevent unauthorized entry. In areas where no enclosure can be reasonably constructed around the individual areas, then that area shall be barricaded, conspicuously posted, and a flashing light shall be activated as a warning device.

Contrary to the above, on May 4, 1995, the Licensee failed to control a high high radiation area on the 512-foot elevation of the drywell with a barricade. A second failure to control a high high radiation area occurred on May 27, 1995.

This is a severity Level IV violation (Supplement IV) (VIO 397/9521-01).

- B. Technical Specification 6.8.1.a requires, in part, that written procedures be established, implemented, and maintained covering activities recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Section 1.a of Regulatory Guide 1.33 includes security activities and Section 7.e.(1) includes procedures for access control to radiation areas.

Plant Procedure Manual (PPM) 11.2.7.3, "High and Very High Radiation Areas Controls", Revision 10, Section 5.2.6.c and PPM 1.7.1, "Access Key Control", Revision 13, Section 6.4.4 state that, in addition to keys issued by Health Physics during normal operations, a set of keys which access high high radiation areas are also located in key repositories in the Central Alarm Station and Secondary Alarm Station in the Main Control Room. The duty shift manager may authorize the issuance of these keys to Operations personnel knowledgeable in the requirements of Technical Specification 6.12.1.

PPM 1.7.1, Section 6.4.4, requires that a set of keys to very high radiation areas be kept in the main control room.

PPM 1.7.1, Section 6.4.2.c, and PPM 11.2.7.3, section 5.2.6.b, state that all restricted area keys will be accounted for at shift turnover and appropriate log entries made.

Contrary to the above, very high radiation area keys were not maintained in the main

control room. Also, keys to high high radiation areas were maintained in the radioactive waste control room, an unauthorized location. Keys in the radioactive waste control room had not been inventoried since January 1990, and, thus, were not accounted for on a shiftly basis.

This is a severity Level IV violation (Supplement IV) (VIO 397/9521-02).

RESPONSE TO VIOLATION A

The Supply System accepts this violation.

REASON FOR THE VIOLATION

During the 1995 refueling and maintenance outage, two incidents involving cut radiation barrier ropes occurred.

At 1900 hours on May 4, 1995, a Health-Physics technician in the WNP-2 containment drywell observed that a rope constituting an essential part of a High High (HH) radiation barrier was intact. At 2015 hours on May 4, 1995, the same rope was observed by another Health-Physics technician to be not in place, in violation of Technical Specification 6.12.1. The rope was observed to be cut, and was taken to the Nondestructive Examination Laboratory. Examination indicated that a tool with blunt cutting edges such as a lineman's pliers had apparently been used to cut the rope. No other explanation has been identified to date. Therefore the violation is surmised to be the result of an intentional act.

A similar incident occurred on May 27, 1995. However, in the second incident, only one of several barrier ropes interlaced across an opening in the floor were cut, the HH radiation area warning sign was still in place, and a rotating warning light was in operation nearby. Consequently, the second incident did not result in a violation of Technical Specification 6.12.1.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

In both incidents, the affected radiation barrier was promptly repaired.

Security investigations were initiated on both occasions to help identify the person or persons responsible. As part of that activity, radiation dose and dose rate data obtained from electronic dosimeters were reviewed for individuals who had entered the containment drywell on the dates of the incidents. These investigations failed to identify the person or persons responsible for cutting the ropes.

Past problem reports were examined to determine if such events had occurred prior to 1995. No previous instances of cut ropes were identified.

CORRECTIVE STEPS TO BE TAKEN TO AVOID FURTHER VIOLATIONS

General employee training will include an increased emphasis on the importance of maintaining the integrity of radiological barriers and the proper response when a radiation barrier is observed to be breached.

DATE OF FULL COMPLIANCE

WNP-2 has been in full compliance since May 4, 1995, when the radiation barrier was repaired.

RESPONSE TO VIOLATION B

The Supply System accepts this violation.

REASON FOR THE VIOLATION

The cause of the violation is inadequate change management.

Revisions effective January 1, 1994 to 10 CFR 20, "Standards for Protection Against Radiation", included a requirement to provide supplementary access control for areas having radiation dose rates of 500 rem/hour or more. These areas are designated as Very High (VH) radiation areas. Plant procedure PPM 1.7.1 was revised on January 1, 1994 to require that a set of keys to the VH radiation areas be kept in the Main Control Room. This change was made proactively to be consistent with the pre-existing practice of maintaining keys in the Main Control Room for High and High High (HH) radiation areas per Technical Specification 6.12.2. However, this procedure change was not adequately coordinated with the Radiation Protection department, and was not explicitly required by either the Technical Specifications or 10 CFR 20. Since there were no regulatory requirements to have keys to VH radiation areas in the Control Room, the Radiation Protection department did not initiate corresponding revisions to plant procedure PPM 11.2.7.3 or request keys for the Main Control Room VH radiation area key repository. This resulted in an inconsistency that would not have occurred if the change had been correctly managed.

It was determined that a key repository with a complete set of keys for HH radiation areas had been established in the Radwaste Control Room in 1987 to allow the Shift Support Supervisor, acting as the Emergency Response Team Leader, to access such areas during plant emergencies. The physical change was not adequately coordinated with the Radiation Protection department,

and was therefore not reflected in revisions to plant procedures resulting in poor key control and failure to account for the keys at each shift turnover. This would have been avoided if the inclusion of a HH radiation area key repository in the Radwaste Control Room had been correctly managed.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

Keys to HH radiation areas were promptly removed from the Radwaste Control Room. An inventory count of the keys to HH and VH radiation areas determined two HH area keys to be missing. As a result, door locks to all HH radiation areas were re-keyed, and new keys were provided to Health Physics Access Control and Main Control Room locations, consistent with PPM 11.2.7.3. The key repositories in the Main Control Room were physically inspected to verify that keys to VH radiation areas were not present. PPM 1.7.1 was revised to delete the requirement to have VH radiation area keys in the Main Control Room. These actions restored compliance with procedural requirements.

Shop meetings were conducted to inform all Health-Physics personnel of the non-conformance and of the actions being taken to resolve the deficiencies.

In October of 1994, the Plant Operating Committee formed the Procedure Review Subcommittee pursuant to plant procedure PPM 1.1.5. The charter of the subcommittee is to assure that all procedures and procedure changes submitted for approval by the Plant Operating Committee conform to procedural and process requirements, and that necessary change management actions have been identified and planned for implementation. This strengthens the procedure control process, and directly addresses the cause of the violation. Had this subcommittee been in operation in 1993 when PPM 1.7.1 was revised as discussed above, the procedural inconsistency might have been avoided.

CORRECTIVE STEPS TO BE TAKEN TO AVOID FURTHER VIOLATIONS

Plant procedure PPM 11.2.7.3 will be revised to be consistent with PPM 1.7.1 in regard to control and inventorying of keys to HH and VH radiation areas. The issue of control of keys to HH and VH radiation areas will be included as a subject in the Industry Events training program.

DATE OF FULL COMPLIANCE

The Supply System has been in full compliance since the unauthorized keys were removed from the Radwaste Control Room and PPM 1.7.1 was revised to delete the requirement to have keys to VH radiation areas in the Main Control Room.