

# CATEGORY 1

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 AUTH.NAME , AUTHOR AFFILIATION  
 BEMIS,P.R. Washington Public Power Supply System  
 RECIP.NAME RECIPIENT AFFILIATION  
 Document Control Branch (Document Control Desk)

SUBJECT: Responds to NRC 960719 ltr re violations noted in insp rept  
 50-397/96-10.C/A:initiated immediate evacuation of drywell,  
 re-established function of flashing light & counseled  
 personnel in Radiation Protection Department.

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August 19, 1996  
GO2-96-163

Docket No. 50-397

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

Gentlemen:

Subject: **WNP-2, OPERATING LICENSE NPF-21  
NRC INSPECTION REPORT 96-10  
REPLY TO NOTICE OF VIOLATION**

Reference: Letter dated July 19, 1996, TP Gwynn (NRC) to JV Parrish (SS), "NRC Inspection Report 50-397/96-10 and Notice of Violation"

The Supply System's reply 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 Ms. L.C. Fernandez at (509) 377-4147.

Respectfully,



P.R. Bemis  
Vice President, Nuclear Operations

Attachments

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

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## VIOLATION

During an NRC inspection conducted on June 24-28, 1996, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600, the violation is listed below:

Technical Specification 6.12.2 requires, in addition to the requirements of Technical 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 millirems shall be provided with locked doors to prevent unauthorized entry. For individual areas that are located within large areas where no enclosure exists for the purposes of locking and no enclosures can be reasonably constructed around the individual area, 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 23, 1995, and April 10, 1996, areas within the drywell and accessible to personnel with radiation levels such that a major portion of the body could receive in 1 hour a dose greater than 1000 millirems were not identified with a flashing light activated as a warning device to prevent unauthorized entry.

This is a Severity Level IV violation (Supplement IV)(397/9610-01).

## REPLY TO THE VIOLATION

The Supply System accepts this violation.

## REASON FOR THE VIOLATION

At approximately 1000 hours on May 23, 1995, a section of flashing lights used to define part of the boundary of high-high radiation (HHR) areas in the Primary Containment drywell was discovered to be de-energized. Although workers in the drywell area at that time were aware of the location of the HHR area and were equipped with electronic dosimeters that would alarm if preset limits or dose rates were reached, the Health-Physics technician caused the drywell area to be immediately evacuated as a conservative measure to assure that radiation exposures could not be inadvertently incurred by potentially affected workers. The de-energized state of the flashing lights was determined to have resulted from loss-of-power surveillance testing of the Standby Diesel Generator, that was connected to the electrical distribution bus providing power to the flashing lights in the drywell. At 0130 hours on April 10, 1996, a section of flashing lights defining part of the boundary of a HHR area in the drywell was discovered to be de-energized. The Health-Physics technician making this discovery immediately routed power to the de-energized lights from another AC source, restoring the function of the flashing lights. In this case, there was no potential for inadvertent

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exposure of workers because no personnel were working in the drywell area at the time. Battery powered flashing lights were also stationed by the Health-Physics technician near the re-powered flashing lights as a contingency in the event of recurrence. The cause of the second event was indeterminate, since the electrical connections with the lights were intact and no testing or other activities had occurred that would have resulted in loss of power to the AC powered lights.

The corrective action for the first event was to revise the surveillance procedures for testing of the Standby Diesel Generators to require notification of Health-Physics personnel prior to initiation of loss-of-power testing. This permits appropriate action to be taken to prevent inadvertent radiation exposure of workers which could occur if the flashing lights became de-energized during the tests. Additionally, a plan was developed to require battery powered lights to be made routinely available in the drywell area as a contingency for unplanned de-energization of the AC sources used by the flashing lights. However, these corrective actions were not effective in preventing recurrence of the problem in 1996 because no loss-of-power surveillance testing of the Standby Diesel Generator had been scheduled that would have required notification of Health-Physics personnel, and the battery powered flashing lights had not been installed in the drywell at the time of the second event. Review of the events determined that the identified corrective actions were focused exclusively on the drywell area, and did not consider the possibility of occurrence of similar events in other plant areas. Consequently, the reason for the violation is ineffective and untimely corrective action, without consideration of the potential for recurrence in areas other than the drywell.

## **CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED**

In both events, immediate action was taken by Health-Physics personnel to assure that workers were not subjected to unplanned radiation exposures in the drywell, by causing an immediate evacuation of the drywell in the first event, and promptly re-establishing the function of the flashing light in the second event. It should be noted that the evacuation in the first event was effected as a conservative measure, even though the workers present in the drywell area were aware of the location of the HHR area because of the signs and other barriers present, and were equipped with electronic dosimeters that would have alarmed if preset dose rates or limits had been reached. Surveillance procedures governing loss-of-power testing of the Standby Electric Power systems were revised to require prior notification of Health-Physics personnel of the possibility of interruption of AC power to flashing lights used to define portions of the boundary of HHR areas. Battery powered flashing lights were made available during the Spring 1996 outage to supplement AC powered lights defining boundaries of HHR areas in the drywell. The individual that developed the corrective action for the first event was counseled to assure that his future corrective action recommendations would address problems on a broader scope rather than limiting corrective action to a specific situation.

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**CORRECTIVE STEPS TO BE TAKEN TO PREVENT FUTURE VIOLATIONS**

Flashing lights used to define boundaries of HHR areas anywhere in the plant will utilize battery powered lights in conjunction with AC powered lights, or will be replaced with units having uninterruptible power provisions. Either alternative will assure continuing automatic function in event of interruption of the normal AC power source. Supervisory personnel in the Radiation Protection Department will be counseled to emphasize the importance of timely implementation of corrective actions.

**DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED**

The Supply System has been in full compliance since 0130 hours on April 10, 1996 when a Health-Physics technician re-established the functioning of de-energized flashing lights used to define boundaries of HHR areas in the Primary Containment drywell.