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SUBJECT: Responds to NRC 971218 ltr re violations noted in insp rept 50-397/97-17.Corrective actions:technician visually verified area to be clear of personnel & immediately locked gate & performed walkdown to verify locked status of similar areas.

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January 19, 1998
GO2-98-011

Docket No. 50-397

U.S. Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

Gentlemen:

Subject: **WNP-2, OPERATING LICENSE NPF-21**
NRC INSPECTION REPORT 97-19, RESPONSE TO NOTICE OF VIOLATION

Reference: Letter dated December 18, 1997, B Murray (NRC) to JV Parrish (SS), "NRC Inspection Report 50-397/97-19"

The Supply System's response to the Notice Of Violation, pursuant to the provisions of Section 2.201, Title 10, Code of Federal Regulations, is enclosed as Attachment A.

We acknowledge the additional concerns that were identified in the inspection report and the Supply System is taking steps to address the issues.

Should you have any questions or desire additional information regarding this matter, please call Mr. PJ Inserra at (509) 377-4147.

Respectfully,

PR Bemis
Vice President, Nuclear Operations
Mail Drop PE23

Attachment

cc: EW Merschoff - NRC RIV
KE Perkins, Jr. - NRC RIV, WCFO
C Poslusny, Jr. - NRR
NRC Sr. Resident Inspector - 927N
DL Williams - BPA/399
PD Robinson - Winston & Strawn

RESPONSE TO NOTICE OF VIOLATION IN INSPECTION REPORT 50-397/97-19

RESTATEMENT OF VIOLATION A

Technical Specification 5.7.2.a requires, in part, that each entryway to high radiation areas with dose rates greater than 1.0 rem/hour (at 30 centimeters from the radiation source or from any surface penetrated by the radiation) be provided with a locked door, gate, or guard that prevents unauthorized entry.

Contrary to the above, on October 6, 1997, an entryway to the radwaste liner storage room on the 437-foot elevation of the radwaste building, an area with dose rates greater than 1.0 rem/hour (at 30 centimeters from the radiation source or from any surface penetrated by the radiation) was not provided with a locked door, gate, or guard that prevented unauthorized entry.

This is a Severity Level IV violation (Supplement IV) (50-397/9719-01).

RESPONSE TO VIOLATION

The Supply System accepts the violation.

REASONS FOR VIOLATION

The Supply System agrees with the staff's characterization of the reason for this event given in the Report Details section of Inspection Report 50-397/97-19.

The failure to properly secure a chain link gate to a high high radiation area (HHRA) was caused by human error on the part of a health physics technician. One condition that contributed to the event was the failure to perform a timely independent verification of the door's locked status. A second contributing condition was the use of a chain to secure the gate, rather than permanently installed padeyes.

CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED

Upon identification of the event a health physics technician responded, visually verified the area to be clear of personnel and immediately locked the gate. A walk-down was performed to verify the locked status of all other similar areas. No other doors were found to be improperly secured.

An additional walk-down was performed by Health Physics to identify any other HHRA or high radiation areas that were secured by means of chain and padlocks. One additional door (access hatch to the wetwell) was found to be secured in this manner. Supply System staff determined that this hatch did not require a padeye as it is bolted and secured with a heavy chain and padlock.

A work request was issued to install lockable padeyes on the gate to the radwaste liner storage room on the 437' elevation of the radwaste building. Work was completed December 10, 1997.

Lessons learned from the event were discussed and documented in Health Physics Technician Continuing Training. This training was completed December 22, 1997.

The appropriate plant procedure was revised on December 15, 1997 to require performance of independent verification in a timely manner.

Appropriate personnel actions were taken with the health physics technician who failed to properly secure the gate.

CORRECTIVE STEPS TO BE TAKEN TO AVOID FUTURE VIOLATIONS

All corrective actions have been completed.

DATE OF FULL COMPLIANCE

The gate was immediately locked on October 6, 1997 upon identification of the event.

RESTATEMENT OF VIOLATION B

10 CFR 20.1501(a) requires, in part, that each licensee make or cause to be made surveys that may be necessary for the licensee to comply with the regulations in 10 CFR Part 20 and are reasonable to evaluate the quantities of radioactive material and the potential radiological hazards that could be present.

10 CFR 20.1003 defines a survey as an evaluation of radiological conditions and potential hazards incident to the production, use, transfer, release, disposal, or presence of radioactive material or other sources of radiation.

10 CFR 20.1201 requires, in part, each licensee to control the occupational dose to individual adults to 5 rems for the total effective dose equivalent or (to) 50 rems for the sum of the deep-dose equivalent and the committed dose equivalent to any individual organ or tissue other than the lens of the eye.

Contrary to the above, the licensee did not make or cause to be made surveys necessary to comply with 10 CFR 20.1201. Specifically, on April 30, May 30, and July 2, 1997, the licensee failed to perform evaluations of the radiological hazards that could have been present when four individuals were identified to have potentially taken radioactive material internally.

RESPONSE TO NOTICE OF VIOLATION IN INSPECTION REPORT 50-397/97-19

This is a Severity Level IV violation (Supplement IV) (50-397/9719-02).

RESPONSE TO VIOLATION

The Supply System accepts the violation.

REASONS FOR VIOLATION

The Supply System agrees with the staff's characterization of the reason for this event given in the Report Details section of Inspection Report 50-397/97-19.

Briefly restated, the requirement to provide whole-body counts to personnel found with facial contamination was not clearly stated in the appropriate plant procedure.

CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED

Health Physics performed a comprehensive review of 1997 logs and determined that a total of six individuals with facial contamination were not immediately given whole-body counts. These individuals were contacted and whole-body counts were performed. No internal contamination was identified.

The appropriate plant procedure was revised January 8, 1998 to clearly state the requirement that personnel found with facial contamination will receive a whole-body count.

CORRECTIVE STEPS TO BE TAKEN TO AVOID FUTURE VIOLATIONS

A review of the procedure will be incorporated into the Health Physics Quarterly Continuing Training to be completed by February 20, 1998.

DATE OF FULL COMPLIANCE

Full compliance was achieved by December 5, 1997 when affected personnel received whole-body counts.