



VERMONT YANKEE NUCLEAR POWER CORPORATION

SEVENTY SEVEN GROVE STREET
RUTLAND, VERMONT 05701

2.C.2.11
FVY 82-45
REPLY TO:
ENGINEERING OFFICE
1671 WORCESTER ROAD
FRAMINGHAM, MASSACHUSETTS 01701
TELEPHONE 617-872-8100

April 22, 1982

U.S. Nuclear Regulatory Commission
Office of Inspection & Enforcement
Region I
631 Park Avenue
King of Prussia, PA 19406

Attention: Richard W. Starostecki, Director
Division of Project and Resident Programs

References: a) License No. DPR-28 (Docket No. 50-271)
b) USNRC Letter to VYNPC, dated March 23, 1982,
and Inspection Report 50-271/82-01

Dear Sir:

Subject: Response to I&E Inspection No. 50-271/82-01

This letter is written in response to Reference (b) which indicates that certain of our activities were not conducted in full compliance with Nuclear Regulatory Commission requirements. The alleged violations were identified during the inspection performed by your Messers W.J. Raymond and S.J. Collins during the period January 5 - February 1, 1982.

Information is submitted as follows in answer to the alleged violations in Appendix A to your letter:

Violation (82-01-01) 10 CFR 20, Standards for Protection Against Radiation, section 20.202 (b)(2), states in part, "Radiation Area means any area, accessible to personnel, in which there exists radiation, ..., at such levels that a major portion of the body could receive in any one hour, a dose in excess of 5 millirem, ..." 10 CFR 20, section 203 (b), states in part, "Each radiation area shall be conspicuously posted with a sign or signs bearing the radiation caution symbol and the words: CAUTION RADIATION AREA."

Contrary to the above, on January 5, 1982, at 3:00 P.M., a compacting wood shipping box located within the site protected area adjacent to the intake structure indicated a radiation level reading in excess of 5 millirem per hour and was not barricaded or posted as a radiation area.

Response: Immediately after notification of the situation the box was properly posted and moved to a controlled storage location. Further corrective action was undertaken as follows:

1. Auxiliary operators have been reinstructed in the importance of labeling boxes before putting waste in them.
2. Plant procedure OP 2511 was revised on 2/22/82 to ensure that maintenance department personnel do not move radioactive material without H.P. supervision.
3. Administrative controls were established to require that H.P. personnel tour outside of buildings on a daily basis to ensure that proper H.P. practices are maintained. Plant procedure DP 0640 will be revised by May 15, 1982 to formalize this policy.
4. Indoor space will be made available for temporary storage of radioactive material by September 1982. This storage area will be properly designated, posted and barricaded, therefore greatly reducing the probability of recurrence of this type of event.

Violation:
(82-01-02)

Technical Specification 6.5.A requires that, "Detailed written procedures involving nuclear safety, including applicable check-off lists and instructions, covering areas listed below shall be prepared and approved. All procedures shall be adhered to... 6. Surveillance and testing requirements." Procedure AP 4000, Surveillance Testing Control, Revision 6, was developed pursuant to Technical Specification 6.5.A.6, and states in part, A.6 "The Department Supervisor will review all test results and initiate any special testing required as a result of a failure of a system or component."

Procedure RP 4396, Strong Motion Accelerograph Functional Test, Revision 5, Functional Test Acceptance Criteria, states, "The developed film must indicate excitation of X-Y and Z accelerometers."

Contrary to the above, between the dates of December 16, 1980 and January 18, 1982 the strong-motion accelerograph installed in the facility was not available to record ground motion in the X-Y and Z directions as evidenced by function test data developed film, and no corrective action or special testing requirements were initiated.

Response: Upon notification by the resident inspector of a potential problem with the results of film obtained from the strong motion accelerograph, the accelerograph was removed from its pedestal and taken to the instrument and control shop for checkout and possible repair.

It was determined that all three accelerometers were functioning properly and two of the three were transmitting information to the recording film by light beam. The light beam path for the third was blocked by a wire harness which had become improperly positioned. The accelerograph was restored to operation on January 20, 1982. No other repairs or adjustments were necessary.

The applicable surveillance procedure will be revised prior to the next scheduled test to include cautions relative to blocking the accelerograph light beams and other items which may have the potential of degrading the device. Technicians were instructed on the problem and the new cautions. Supervisory personnel who are responsible for reviewing the accelerograph output data were reinstructed in proper trace evaluation.

Violation
(82-01-04)

Technical Specification 6.5.A requires that detailed written procedures involving nuclear safety be prepared, approved and followed. OP 3021, Natural Disaster, Revision 9, was developed pursuant to the above and prescribes the immediate operator actions to be taken in the event an earthquake has been experienced. The required operator actions include in part: verification of control rod operability; verification of building air samples; visual inspection of specified plant structures for damage; and verification of upstream and downstream dam integrity.

Contrary to the above, on the evening of January 18, 1982, a seismic event occurred at the Vermont Yankee site as detected by ground motion and offsite instruments, and the required actions of OP 3021 were not initiated.

Response: While acknowledging that the requirements of OP 3021 were not explicitly carried out during this event, we want to emphasize that the response actions taken were appropriate in that the operator 1) did dispatch another operator to inspect for damage; 2) did make the proper logbook entries; and 3) did initiate the required offsite notification of state authorities. Routine operational activities subsequently verified control rod positions, normal equipment performance, and reactor system integrity. Taken together, those measures provided adequate confidence that safe plant operation had not been compromised.

In order to avoid any further violations of this nature, procedure OP 3125, Emergency Plan Classification and Action Level Scheme, has been revised to include reference to OP 3021 for similar events. Additionally, a copy of the notice of violation was placed in the night order book for review by operating shift personnel. No other actions are considered necessary.

To characterize this event as a Severity IV violation "that measurably degrade the safety of operations, incident response or environment" is not consistent with the guidance provided by the interim enforcement policy and is simply not justified. In this regard, we suggest that the violation be reduced to a less severe level which more correctly reflects an event of minor safety or environmental significance.

We trust that the responses provided are satisfactory. Should additional information be required, please contact us.

Very truly yours,

VERMONT YANKEE NUCLEAR POWER CORPORATION

Earl W. Jackson
Earl W. Jackson
Manager of Operations

EWJ/dm

STATE OF VERMONT)
)ss
WINDHAM COUNTY)

Then personally appeared before me, Earl W. Jackson, who, being duly sworn, did state that he is Manager of Operations of Vermont Yankee Nuclear Power Corporation, that he is duly authorized to execute and file the foregoing request in the name and on the behalf of Vermont Yankee Nuclear Power Corporation, and that the statements therein are true to the best of his knowledge and belief.

Diane M. McCue
Diane M. McCue Notary Public
My Commission Expires February 10, 1983

