



UNITED STATES
NUCLEAR REGULATORY COMMISSION

REGION IV

611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-8064

November 1, 1996

Stephen M. Quennoz, Acting Vice
President and Chief Nuclear Officer
Portland General Electric Company
Trojan Nuclear Plant
71760 Columbia River Highway
Rainier, Oregon 97048

SUBJECT: NRC INSPECTION REPORT 50-344/96-07 NOTICE OF VIOLATION

Dear Mr. Quennoz:

Thank you for your letter dated October 10, 1996, in response to our letter and Notice of Violation dated September 10, 1996. We have reviewed your reply and find it responsive to the concerns raised in our Notice of Violation. We will review the implementation of your corrective actions during a future inspection at the Trojan Nuclear Plant to determine that full compliance has been achieved and will be maintained.

Sincerely,

Ross A. Scarano, Director
Division of Nuclear Material Safety

Dockets No.: 50-344, 72-17
License No.: NPF-1

cc:
C. Paul Yundt, General Manager
Plant Support and
Technical Function
Portland General Electric Company
Trojan Nuclear Plant
71760 Columbia River Highway
Rainier, Oregon 97048

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PDR ADOCK 05000344
G PDR

Mr. Michael J. Sykes
Board of County Commissioners
Columbia County
St. Heiens, Oregon 97501

Mr. David Stewart-Smith
Oregon Department of Energy
625 Marion Street NE
Salem, Oregon 97310

Mr. Lloyd K. Marbet
19142 S.E. Bakers Ferry Road
Boring, Oregon 97009

Mr. Jerry Wilson
Do It Yourself Committee
570 N.E. 53rd
Hillsboro, Oregon 97124

Mr. Eugene Roselie
Northwest Environment Advocates
133 S.W. 2nd Avenue
Portland, Oregon 97204

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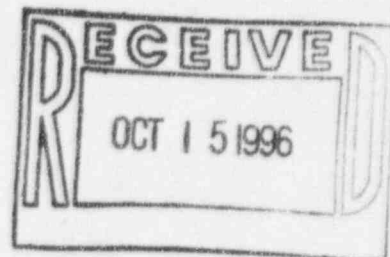
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Portland General Electric Company

Stephen M. Quennoz
Trojan Site Executive



October 10, 1996

VPN-057-96

Trojan Nuclear Plant
Docket 50-344
License NPF-1

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

Dear Sirs:

Reply to a Notice of Violation

The purpose of this letter is to transmit Portland General Electric Company's (PGE's) response to Notice of Violation 50-344/9607-01 which was transmitted to PGE with Nuclear Regulatory Commission Inspection Report 50-344/96-07, dated September 10, 1996. The response is provided in the Attachment to this letter.

Sincerely,

Stephen M. Quennoz
Trojan Site Executive

Attachment

c: M. T. Masnik, NRC NRR
L. J. Callan, Regional Administrator, NRC Region IV
Dr. D. B. Spitzberg, NRC Region IV
R. A. Scarano, NRC Region IV
A. D. Gaines, NRC Region IV
J. V. Everett, NRC Region IV
D. Stewart-Smith, ODOE

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REPLY TO NOTICE OF VIOLATION
NOV 50-344/96-07-01

Violation

During an NRC inspection conducted on August 19-22, 1996, one 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:

Facility Operating License NPF-1, Paragraph 2.C(2), states, in part that the Technical Specifications contained in Appendix A to the license are incorporated into the license. Section 5.10.2 of the Technical Specifications states, in part, that the doors into locked high radiation areas shall remain locked except during periods of access by personnel under an approved radiation work permit (RWP) that shall specify the dose rate levels in the immediate work areas and the maximum allowable stay times for the individuals in those areas. In lieu of the stay time specification of the RWP, direct or remote continuous surveillance may be made by personnel qualified in radiation protection procedures to provide positive control over the activities being performed within the area.

RWP 960016, "Large Bore Pipe Cutting," required continuous radiation protection coverage during entry into high radiation areas.

Contrary to the above, on July 25, 1996, a contract employee working under the provisions of RWP 960016 entered a locked and posted high radiation area without continuous radiation protection coverage or assigned stay times.

This is a Severity Level IV violation (Supplement IV).

Response to Violation

Portland General Electric (PGE) acknowledges the violation.

1. Reason for Violation

Following discussions with job coordinators, radiation protection supervisors, the contractor site manager, job steward and available contract craftsmen and radiation technicians it was concluded that this violation was an isolated case of poor judgement on the part of the individual involved and was not indicative of a problem with the working relationship between the radiation protection personnel and the crafts or other

programmatic deficiencies (e.g., such as training weaknesses) or deliberate misconduct pursuant to 10 CFR 50.5.

The contract craftsman had been sent to the lower floor elevation by his supervisor to perform the duties of a fire watch while cutting operations were underway. Grating on the floor of the upper elevations allowed hot slag to fall to the lower elevations. The individual indicated that he scaled the locked fence because of a concern that falling slag could cause a chance of a fire. Due to the limited quantity and type of combustible material in the Containment, its noncombustible interior walls and structural components and the deactivation of the major equipment inside containment (e.g., removal of steam generators, reactor coolant pump oil and hydrogen recirculation unit charcoal) the likelihood of a fire has been reduced and there is no longer any significant nuclear safety consequences associated with a fire in Containment.

2. Corrective Steps That Have Been Taken and the Results Achieved

Work was stopped in the area, and a Corrective Action Request (CAR 96-0014) was initiated to investigate the cause of the incident and to identify any needed corrective actions. Access to the radiologically controlled area was immediately revoked for the individual in question. Meetings were convened with job coordinators, radiation protection supervisors, the contractor site manager, job steward and available contract craftsmen and radiation technicians to determine if there was a problem with the working relationship between the crafts and the radiation protection organization that may have contributed to the incident. Statements were collected from the individuals that were associated with the incident to obtain a clearer understanding of the facts related to the event and the knowledge level of those involved. It was determined that the other contract workers were aware of the requirements for high radiation area entry.

The individual received a total dose for the day of the event of 17.4 mRem. From a dose perspective, the incident was not safety significant. The contract worker was subsequently laid-off on August 1, 1996.

Training was conducted on July 30, 1996, to reinforce the contract craft workers' knowledge of the entry requirements for High Radiation Areas. In addition, a review of the responsibilities of individuals that act as fire watches, safety watches and hot work performers in Containment was conducted with the craft workers because the individual involved was assigned fire watch duties during the incident.

Additional information on radiation barriers and their entry requirements was added to the Category II General Employee Training/General Employee Retraining (GET/GERT) training on September 27, 1996.

3. Corrective Steps That Will Be Taken to Avoid Further Violations

The changes to the Category II GET/GERT training ensure that personnel will have the entry requirements for radiation barriers reinforced.

4. Date When Full Compliance Will Be Achieved

Full compliance was achieved the same day as the incident, July 25, 1996, when the individual found in the locked high radiation area was directed to leave the high radiation area and his access to the radiologically controlled area was revoked.