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January 23, 1997 ,

Mr. Carlton C. Kammerer, Director
Division of Freedom of Information
and Publication Services
Office of Administration
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

FOIA/PA REQUEST

Case No:	97-0023
Date Recd:	1-28-97
Action Off:	Pool
Related Case:	

Re: Freedom of Information Act Request

Dear Mr. Kammerer:

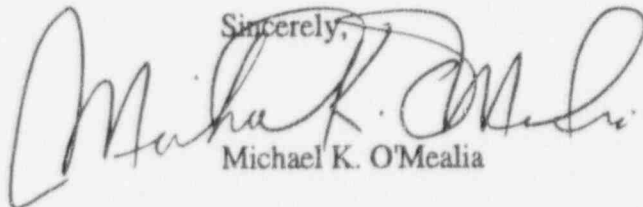
Pursuant to the Freedom of Information Act (5 U.S.C. § 552) and the U.S. Nuclear Regulatory Commission's (NRC) regulations (10 C.F.R. Part 9, Subpart A), I request copies of the following Licensee Event Reports (LER) with all revisions and supplements.

1. LER 50-382-88-010 (Waterford Steam Electric Station No. 3), dated June 16, 1988. This LER is referenced in the attached NRC Notice of Violation dated February 8, 1989.
2. LER 50-445-93-010 (Comanche Peak Steam Electric Station). This LER is referenced on page ten of the attached Inspection Report (NRC Inspection Report 50-445/94-12 and 50-446/94-12).

Neither of these LERs could be located through a database search of the NRC Public Document Room's Bibliographic Retrieval System.

I would appreciate your prompt response within ten (10) working days of the receipt of this request, as provided by 10 C.F.R. Part 9 and the NRC's policies. If you require additional information, please let me know. I can be reached at (202) 634-1439.

Sincerely,



Michael K. O'Mealia

Enc.: as stated

APPENDIX A

NOTICE OF VIOLATION

Louisiana Power & Light Company
Waterford Steam Electric Station No. 3

Docket: 50-382
License: NPF-38

During an NRC inspection conducted during December 19-23, 1988, a violation of NRC requirements was identified. The violation involved radiation overexposures to the skin of the whole body of two workers. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C (1988), the violation is listed below:

Overexposure to the Skin of the Whole Body

10 CFR Part 20.101(a) requires, in part, that "... no licensee shall possess, use, or transfer licensed material in such a manner as to cause any individual in a restricted area to receive in any period of one calendar quarter from radioactive material and other sources of radiation a total occupational dose in excess of . . . (7½ Rems per calendar quarter to the skin of the whole body)."

Contrary to the above, the NRC inspectors determined during a review of Licensee Event Report 88-10, dated June 16, 1988, and subsequent onsite inspection on December 22, 1988, that two individuals had received radiation exposures to the skin of the whole body of 22 and 18 rems on May 16 and 18, 1988, respectively, from radioactive fuel particles.

This is a Severity Level IV violation. (Supplement IV) (382/8830-01)

Pursuant to the provisions of 10 CFR 2.201, Louisiana Power & Light Company is hereby required to submit a written statement or explanation to this office within 30 days of the date of the letter transmitting this Notice. This reply should include for each violation: (1) the reason for the violation if admitted, (2) the corrective steps that have been taken and the results achieved, (3) the corrective steps that will be taken to avoid further violations, and (4) the date when full compliance will be achieved. Where good cause is shown, consideration will be given to extending the response time.

Dated at Arlington, Texas
this 8th day of February 1989

APPENDIX B

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Inspection Report: 50-445/94-112
50-446/94-112

Licenses: NPF-87
NPF-89

Licensee: TU Electric
Skyway Tower
400 North Olive Street, L.B. 81
Dallas, Texas

Facility Name: Comanche Peak Steam Electric Station, Units 1 and 2

Inspection At: Glen Rose, Texas

Inspection Conducted: May 2-6, 1994

Inspector: L. T. Ricketson, P.E., Senior Radiation Specialist
Facilities Inspection Programs Branch

Approved: James H. Reese, Chief
Facilities Inspection Programs Branch

5/25/94
Date

Inspection Summary

Areas Inspected (Units 1 and 2): Routine, announced inspection of activities for both Units 1 and 2 related to the radiation protection program including audits and appraisals, program changes, training and qualifications, external exposure controls, internal exposure controls, controls of radioactive materials and contamination, surveying and monitoring, and the program to maintain occupational exposures as low as reasonably achievable (ALARA).

Results (Units 1 and 2):

- A good quality assurance audit was performed in this area, ensuring sufficient management overview of the program (Section 2.1).
- The site corrective action program was implemented well in relation to the radiation protection program; however, the radiological awareness report program needed added attention to ensure that it worked as intended (Section 2.1).

- The radiation protection program lessened its dependence on contract technicians, while maintaining sufficient staffing (Section 2.2).
- The training programs offered by the nuclear training organization remained strong and were staffed by experienced instructors (Section 2.3).
- There was a decrease in emphasis on the professional development of radiation protection technicians. However, there was strong management support for the supervisor/technical training program (Section 2.3).
- Most elements of the external exposure control program continued to be viewed as strengths; however, a violation was identified as a result of radiation workers not following the instructions on their general access permit (Section 2.4).
- Actions were taken to correct internal exposure calculation procedure weaknesses identified earlier in the assessment period (Section 2.5).
- From a radiological standpoint, the licensee's facility was very clean (Section 2.6).
- Station person-rem totals were very low (Section 2).
- The ALARA suggestion program received good support from radiation workers (Section 2.7).
- Overall, the radiation protection program continues to be an excellent performer; however, there were areas of the program that could benefit from increased attention to detail.

Summary of Inspection Findings:

- Unresolved Item 445/446/9407-01 was closed (Section 3).
- Licensee Event Report 445/93-10 was closed (Section 4).

Attachment:

- Attachment - Persons Contacted and Exit Meeting

DETAILS

1 PLANT STATUS

During the inspection, Unit 1 was operating at 100 percent power. Unit 2 was involved in a mid-cycle, fuel conservation outage which started April 21, 1994, and was originally scheduled to continue until May 21, 1994.

2 OCCUPATIONAL RADIATION EXPOSURE CONTROL (83750)

The licensee's program was inspected to determine compliance with Technical Specifications and the requirements of 10 CFR Part 20, and agreement with the commitments of Chapter 12 of the Final Safety Analysis Report.

2.1 Audits and Appraisals

The inspector reviewed Audit No. QAA-93-129, performed October 6 through November 30, 1993. Auditors with radiation protection experience were part of the audit team. A technical expert from another nuclear power generating site was also included. The audit findings included a number of observations for program improvement. One deficiency was identified and corrected during the audit. The audit addressed the major program areas.

The inspector also reviewed surveillances performed by the Independent Safety Engineering Group during 1993 and 1994. The surveillance offered good insight into daily operations involving radiation protection personnel. The more significant surveillances resulted in the initiation of Operations Notification Evaluation (ONE) Forms to document problems and track corrective actions.

The inspector reviewed the Plant Incident Reports and ONE reports involving radiation protection for 1993 and 1994. Radiation protection personnel responded to findings within the required time interval. The solutions proposed were technically sound and addressed the problems. Findings were trended and the results were supplied to the radiation protection manager. Licensee personnel stated that they identified a potential problem related to the establishment of set points of effluent radiation monitors per procedure. The situation had the potential of causing set points to be nonconservative. Evaluations performed after the occurrences confirmed that this did not result in actual problems. Corrective actions were implemented and the inspector noted from a review of the 1994 reports that they were apparently successful.

The inspector also reviewed radiological awareness reports. This reporting system documented items of interest below the threshold of the ONE form initiation. The licensee identified that all of the radiological awareness reports had not been evaluated and closed in a timely manner, in accordance with Radiation Protection Procedure RPI-108 and initiated ONE Form 94-627 to document and correct this item. The inspector noted that the radiological awareness report program needed increased attention to ensure that it continued to operate in accordance with management expectations.

A program discussed previously in NRC Inspection Report No. 50-445/93-40; 50-446/93-40, involving tours and observations of the radiological controlled area by radiation protection supervisors, had not been utilized frequently in 1994. Although used consistently in 1993, the program produced only three reports in 1994. The inspections were not required by procedure, but were good enhancements to the program, when utilized.

2.2 Changes

There were no major changes to the organization, personnel, facilities, equipment, programs, or procedures since the previous inspection of this area. It was noted by the inspector in NRC Inspection Report No. 50-445/93-28; 50-446/93-28, that the radiation protection organization placed heavy reliance on contract radiation protection personnel. Since that time, the licensee hired a number of the contract radiation protection technicians as permanent employees, leaving approximately 6 contract technicians to supplement the permanent staff. According to the latest organization chart, the radiation protection organization consisted of 50 permanent members, including administrative personnel. The surveillance and control group was comprised of 19 permanent radiation protection technicians.

2.3 Training and Qualifications of Personnel

The training group presenting general employee training and radiation worker training consisted of 4 experienced instructors. Appropriate facilities and resources were available. There had been no changes within the assessment period. The instructors presented instruction to 9000 to 10,000 people in 1993. The inspector determined that there were appropriate methods of ensuring that applicable Information Notices, ONE Forms and other current event information were reviewed and included in radiation worker training.

The licensee plans to present an advanced radiation worker training course to selected groups of workers. The training will emphasize practical exercises involved in working in contaminated areas.

The radiation protection technician training group consisted of 4 instructors, all with previous radiation protection experience and all were qualified instructors. The group presented two cycles of continuing training per year. The cycle training included discussions of hazards associated with plant systems and current industry events. Other specialized training was presented during the past year to supplement the cycle training. Vendors provided some of the specialized training, such as recent training concerning dosimetry.

The inspector determined that no new senior technicians had joined the radiation protection staff since the last inspection, therefore, no resumes were reviewed during this inspection.

Seventeen members of the radiation protection organization and two from the training organization were registered by the National Registry of Radiation Protection Technologists. The licensee had not provided the preparation/review course to technicians within the last year nor had anyone obtained registration.

There was strong management support for the supervisor/technical training program. Through a review of trip reports and interviews, the inspector confirmed that supervisors were provided opportunities to attend professional seminars, peer evaluations, or vendor-provided training.

2.4 External Exposure Control

The inspector made tours of the radiological controlled area and noted that area postings were well maintained and that locked, high radiation areas were properly controlled. Independent radiation surveys by the inspector failed to identify additional areas needing posting or controlling.

During a tour of the radiological controlled area on May 3, 1994, the inspector questioned a group of workers installing cable in the overhead area, between levels 810 and 832 of the auxiliary building, as to which radiation worker permit they were working in accordance with. They responded that they were working in accordance with General Access Permits 94-02 and 94-03. The inspector reviewed the access permits and noted that both permits required workers to check first with radiation protection personnel before beginning work in overhead areas. Through interviews with radiation workers and radiation protection representatives, the inspector determined that the work crew had not complied with this instruction before starting work.

Technical Specification 6.8.1 requires, in part, that written procedures be established, implemented, and maintained covering the activities recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Regulatory Guide 1.33, Revision 2, February 1978, Appendix A, Section 7.e(1) recommends that procedures for access control to radiation areas, including a radiation work permit system, be covered by written procedures. STA-606, "Work Requests and Work Orders," Revision 20, Section 6.6.4.4 requires that workers comply with radiation work permits. The inspector identified the failure of radiation workers to follow the instructions in the general access permit as a violation of STA-606 and Technical Specification 6.8.1 (445/9412-01; 446/9412-01).

The licensee initiated ONE Form 94-602 to document the event and also identified this as a violation of Station Procedure STA-656, "Radiation Work Control," Step 6.3.5., which required the workers to contact the lead radiation protection technician prior to work in the radiological controlled area.

The inspector asked why workers were working in accordance with two different general access permits. Licensee representatives stated that two work orders (2-94-064804 and 2-94-06556) each initiated parts of the job. However, when ALARA representatives reviewed the work orders they did not note that both were for design modifications and did not assign them to the same general access permit. The work should have been accomplished in accordance with General Access Permit 3, which was written in support of design modifications. The inspector reviewed the special instructions and prohibitions of both general access permits used and noted that there was no significant difference with regard to this event; however, it did indicate a need for increased

attention to detail. Radiation protection representatives stated that this issue would be included with the resolution of ONE Form 94-602.

On the afternoon of May 3, 1994, the inspector interviewed workers encountered in the Unit 2 containment building and determined that a radiation worker assisted a work crew installing the equipment hatch doors. The individual's job was simply delivering bolts. The worker was working in accordance with General Access Permit 7, Task 8. This specific general access permit was written for scaffolding erection. Work on the equipment hatch should have been performed in accordance with General Access Permit 7, Task 4. The worker stated that he had been working previously in accordance to the former task and did not realize the other workers used a different task. The inspector reviewed the special instructions and prohibitions for both tasks and noted they were essentially the same. The inspector did not identify this as a violation, but discussed it with licensee representatives as another example of workers lacking familiarity with all provisions of the general access permits. In response to the two preceding items, radiation protection representatives stated that the large number of tasks facilitated dose tracking objectives, but acknowledged that workers were sometimes confused as a result. The licensee further stated that they would evaluate the radiation work permit system and determine if they would continue to employ the current number of tasks used.

After reviewing radiation work permits and access control procedures, the inspector noted that there was no means of ensuring that workers had read the latest revision of general access permits and radiation work permits. Each worker personally logged onto the access computer before entry into the radiological controlled area. Part of the process required that the workers acknowledge by pressing a certain function key that he/she had read and understood the latest revision of the general access permit or radiation work permit. There was no way for the inspector to verify this since there were no written records. Licensee representatives acknowledged that this was true, but added that revisions of general access permits, under which most work was performed, were relatively rare. The inspector did not identify specific situations which would demonstrate that this was a weakness.

During a tour of the Unit 2 containment building on May 4, 1994, the inspector identified that Steam Generator Compartment Room 2-02 (2-154J) was not locked. The room was posted as a high radiation area. A radiation protection representative touring with the inspector acknowledged that the door was unlocked and then ensured that the door was locked before leaving. The inspector reviewed survey records of the room and verified that the radiation levels inside the room did not exceed 1000 millirems per hour and therefore did not have to be locked in accordance with Technical Specification 6.12.2. The inspector reviewed Station Procedure STA-660, "Control of High Radiation Areas," Revision 4, and Radiation Protection Procedure RPI-602, "Radiological Surveillance and Posting," Revision 14. The inspector concluded that, even though radiation protection personnel were unaware of the unlocked door and it was the licensee's practice to keep such areas locked, no violation of regulations or procedures occurred. The significance of the event was that radiation protection personnel had not identified it during routine tours. The inspector confirmed that high radiation areas, less than 1000 millirems

per hour, were controlled administratively through the use of radiation work permits.

The inspector also noted, during a tour of the radiological controlled area, that the latest survey information posted outside of the Unit 1 volume control tank room was dated October 13, 1993. Licensee representatives confirmed that this was the latest information and said that locked high radiation areas such as this were not surveyed routinely, but were surveyed before entry. The inspector noted that this was good ALARA practice and reviewed records of entry into Locked High Radiation Areas (Form STA 660-1). The inspector verified that no entries into the room were made since the date of survey.

2.5 Internal Exposure

Radiation protection personnel revised Radiation Protection Procedure RPI-507, "Internal Dose Calculation," (now Revision 1) to correct deficiencies noted during a previous inspection. As noted during NRC Inspection 50-445/93-40; 50-446/93-40, the procedure made no distinction between Annual Limits on Intake for ingestion and those for inhalation. One of the revisions to the procedure was a statement alerting the procedure user to the fact that "analysis of an ingestion pathway calculation should be performed on a case by case basis." Another revision states clearly that the procedure is to be used for cases of inhalation of radioactive material.

2.6 Control of Radioactive Materials and Contamination, Surveys, and Monitoring

Housekeeping in the radiological controlled area was excellent. The licensee maintained a very low percentage of contaminated area. Additionally, the containment building was decontaminated so that entry in street clothes was allowed in much of the area.

There were 41 skin contamination events in the licensee's facility in 1993. Twenty-four of the events involved discrete particles. Thirty-two percent of the contamination events resulted in exposures in excess of 100 millirems (as measured in an area of 1.0 cm²). The highest exposure as a result of a hot particle was 72.1 rems. The event is discussed in Section 4. Licensee representatives have recognized a trend of decreasing general contamination events, but increasing particle contaminations over the last year.

While touring the Unit 2 containment building on May 5, 1994, the inspector noticed two workers wearing rubber shoe covers. When asked about the shoe covers, workers stated that the shoe covers were to protect their shoes from water. The inspector had not noticed significant amounts of water in areas toured. When informed, the radiation protection technicians at the radiological controlled area access point stated that the workers should not be wearing shoe covers unless they were preparing to enter a contaminated area. The inspector noted that attention was needed to ensure consistent implementation of the use of protective clothing.

2.7 Maintaining Occupational Exposure ALARA

There were no major changes to the ALARA organization. The ALARA supervisor was also responsible for the supervision of the respiratory protection and the decontamination programs. The ALARA supervisor was recently assigned the responsibility for the industrial respiratory protection program, but stated that additional personnel would be provided to prevent the extra duties from adversely affecting the remainder of the program.

Radiation work permits were routinely generated by the ALARA group. Members of the group were part of the work control organization and, therefore, had advance knowledge of upcoming work items. The inspector noted during NRC Inspection 50-445/93-40; 50-446/93-40 that ALARA work packages prepared for the refueling outage were complete and incorporated dose reduction techniques.

Specific, dose reduction initiatives completed by the ALARA group in 1993 included:

- The design and purchase of a filter shield carousel for use in handling spent filters,
- The approval of the use of more efficient filtration media in reactor coolant system, and
- The implementation of a design modification that reduced the number of bolts needed to secure the fuel transfer canal flange.

The ALARA Suggestion Program was very successful in 1993 with regard to soliciting suggestions. There were 84 suggestion submitted. Of these, 34 were dispositioned. There were also 16 suggestions from previous years that were closed. The inspector noted that the oldest unclosed suggestion was from 1990. When questioned about this item, ALARA representatives stated that the suggestion, once considered viable, was now moot because of other plant modifications. ALARA representatives were not timely in closing the item.

A summary of the licensee's exposure results is listed below.

YEAR	1990	1991	1992	1993
PERSON-REM	5.1	134	174	109*
PWR AVERAGE	291	223	219	**

*Unit 2 began commercial operation; total for both units

**Average not yet available

The exposure goal for 1993 was 170 person-rems. The goal for 1994 is 160 person-rems.

2.8 Conclusions

A good quality assurance audit was performed in this area, ensuring sufficient management overview of the program.

The site corrective action program (ONE Form) was implemented well in relation to the radiation protection program; however, the radiological awareness report program needed added attention to ensure that it worked as intended. The program of documenting radiation protection supervisors' observations, likewise, needed attention.

The radiation protection program lessened its dependence on contract technicians, while maintaining sufficient staffing.

The training programs offered by the nuclear training organization remained strong and were staffed by experienced instructors. There was a decrease in emphasis on the professional development of radiation protection technicians. However, there was strong management support for the supervisor/technical training program.

Most elements of the external exposure control program continued to be viewed as strengths; however, a violation was identified as a result of radiation workers not following the instructions on their general access permit.

Actions were taken to correct internal exposure calculation procedure weaknesses identified earlier in the assessment period.

From a radiological standpoint, the licensee's facility was very clean.

Person-rem totals were very low. The ALARA suggestion program received good support from radiation workers. The ALARA program sponsored a number of initiatives which should result in reduced personnel exposures.

Overall the radiation protection program continues to be an excellent performer; however, there were areas of the program that could benefit from increased attention to detail.

3 FOLLOWUP (92904)

(Closed) Unresolved Item 445/446/9407-01: Meteorological Data Recovery

Because of computer software problems, the licensee had not reviewed and computed the percentage of meteorological data recovery achieved. The licensee committed to following the guidance provided in Regulatory Guide 1.23, which stated that 90 percent recovery should be achieved.

The licensee corrected the software problems and determined that meteorological data recovery was in excess of 94 percent in 1992 and in excess of 95 percent in 1993.