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ILLINOIS POWER

Docket No. 50-461

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

Subject: Response to Notices of Violation
Contained in Inspection Report 50-461/96009

Dear Sir or Madam:

This letter provides the Illinois Power Company (IP) response to the eight violations discussed in the Notice of Violation (NOV) contained in Inspection Report 50-461/96009. IP admits that these eight violations occurred. The following attachments provide immediate corrective actions and steps taken to prevent recurrence for each of the violations.

The following attachments to this letter provide the responses to the violations:

- Violation of procedures when the inadequacies of Clinton Power Station (CPS) procedure 3509.01C001, "Division I Nuclear System Protection System Bus Outage Checklist," caused a Reactor Water Cleanup pump to fail.

- Violation of Technical Specifications when suppression pool temperature was not recorded during Reactor Core Isolation Cooling system testing.

- Violation of condition... enses, when licensee designated individuals to be responsible for directing the licensed activities of licensed operators had not performed the required 40 hours of shift function under the direction of a senior operator or the required quarterly shifts.

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- Violation of procedures when unintended isolation of security lighting resulted from safety tagging.

- Violation of procedures when personnel did not follow the required steps of CPS 3882.01, "Diesel Generator Overspeed Trip Test."

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- Violation of procedures when Use History Analysis on measuring and test equipment were not performed in a timely manner.

- Violation of Technical Specifications when an individual failed to wear protective clothing while crossing a contaminated zone boundary.

- Violation of Technical Specifications when Emergency Operating Procedure-8, "Secondary Containment Control," was identified to have errors in Table U.

IP is confident that these responses address the concerns identified in these violations.

Sincerely yours,

Wilfred Connell
Vice President

BGS/krk

Attachments

cc: NRC Clinton Licensing Project Manager
NRC Resident Office, V-690
Regional Administrator, Region III, USNRC
Illinois Department of Nuclear Safety

Response to Notice of Violation 50-461/96009-01

The Notice of Violation states:

"10 CFR 50, Appendix B, Criterion V, requires, in part, that activities affecting quality shall be prescribed by documented instructions, procedures, or drawings of a type appropriate to the circumstances.

Contrary to the above, on October 30, 1996, Clinton Power Station (CPS) Procedure 3509.01C001, "Division I Nuclear System Protective System (NSPS) Bus Outage Checklist," a procedure affecting quality, was inadequate in that valve 1G33-F004 was returned to service prior to restoration of reactor water cleanup pump protection logic, resulting in failure of the pump."

Background and Reason for Violation

On October 30, 1996, a maintenance outage was planned for the Division 1 NSPS bus. This bus provides power to the Reactor Water Cleanup(RWCU) System. To perform the bus outage and maintain the Reactor Water Cleanup system in operation for shutdown cooling, the breaker for the outboard containment isolation/pump suction valve, 1G33-F004, must be opened and jumpers installed in the pump trip circuitry. The crew held a pre-activity brief and discussed the possibility that various system actuation's could occur during bus re-energizations as described in system operating procedure CPS 3509.01, "Instrument Power System, "Appendix C," Division I NSPS Bus Outage Effects." However, the individual items restored in accordance with the checklist were not reviewed to determine how each would be affected by the restoration of power with isolation signal not reset. As a result, the reactor operator involved in this activity did not monitor the affected equipment for unwanted actuations or isolations nor did they receive guidance concerning which items should be monitored.

During restoration from the bus outage in accordance with CPS 3509.01, the RWCU Pumps Outboard Suction Valve (1G33-F004) stroked shut after its breaker was turned on. Because jumpers had been installed on the RWCU pumps 'Low Flow Trip' to allow pump operation during the bus outage and those jumpers were not required to be removed until later in the checklist sequence, the A and C RWCU pumps did not trip and continued running for approximately one minute until the operator noticed an unexpected change in Fuel Pool Cooling (FC) surge tank level. The operator then saw the closed indication for 1G33-F004 and stopped the pumps.

Analysis determined that a more in-depth review of the status of each item in the restoration section of the checklist would have increased the likelihood that valve 1G33-F004 would have been monitored for motion upon re-energization of its breaker. A change in the position of valve 1G33-F004 would have been identified as it occurred rather than one minute later. The cause of this violation is attributed to an inadequate procedure. The CPS 3509.01C001 checklist does not provide guidance regarding items

that could be affected by any isolation signal that does not reset at bus reenergization. Had some reminder been provided, the crew would have been more likely to identify that the open valve could be affected by any isolation signal that did not reset.

Corrective Steps that Have Been Taken and the Results Achieved

The system alignment with the FC surge tank providing make-up prevented loss of suction pressure which prevented loss of system performance when the valve went shut. An engineering representative performed vibration monitoring of RWCU pumps A and C when they were restarted. There was no equipment failure or abnormal vibration readings of either pump.

Corrective Steps to Avoid Further Violations

Since similar occurrences could be experienced during recovery from the other divisional bus outages, the appropriate checklists for CPS 3509.01 have been revised to add a "CAUTION" at the beginning of Section B identifying that one or more isolation trips may not have reset when the bus re-energized and that, when re-energizing valve breakers, a valve that had been left open should be monitored to assure that it remains in the desired position.

Date When Full Compliance Will Be Achieved

Illinois Power is currently in full compliance with regards to restoration from bus outages per CPS 3509.01C001, "Division 1 NSPS Bus Outage Restoration Checklist."

Response to Notice of Violation 50-461/96009-02

The Notice of Violation states:

"Technical Specification (TS) 3.6.2.1.1 requires verification that suppression pool average temperature is within the applicable limits at a frequency of 5 minutes when performing testing which adds heat to the suppression pool.

CPS Procedure 9000.05, "Suppression Pool Temperature Log," required recording suppression pool temperature when performing testing which added heat to the suppression pool.

Contrary to the above, on July 11, 1996, suppression pool temperature was not recorded every 5 minutes during Reactor Core Isolation Cooling System testing, an activity that added heat to the suppression pool."

Background and Reason for Violation

During a maintenance outage in July 1996 for Reactor Core Isolation Cooling System (RCIC), the oil was changed in the RCIC turbine. In order to restore the oil level, it was necessary to roll the RCIC turbine to pump the oil throughout the oil system and remove any air voids. On July 11, 1996, with the plant in Mode 1 (Power Operation), the Line Assistant Shift Supervisor made preparations to perform this evolution. The Residual Heat Removal (RHR) B Pump was started in the suppression pool cooling mode to remove any heat added to the suppression pool during the operation of the RCIC turbine. The operations crew discussed the operation of the RCIC and reviewed Technical Specifications (TS), CPS 9000.05 "Suppression Pool Temperature Log", and sections 6.0 (Limitations to RCIC Operability) and 8.2.5 (Restoring RCIC After Maintenance Outage) of system operating procedure CPS 3310.01, "Reactor Core Isolation Cooling." It was decided that because RCIC would not be operated for a long period of time to restore the oil level, it would not add heat to the suppression pool. The operations crew overlooked step 5.7 in procedure CPS 3310.01 which states that whenever RCIC is operating in Modes 1 or 2, initiate surveillance procedure CPS 9000.05, "Suppression Pool Temperature Log." CPS 9000.05 requires that Suppression Pool temperature be logged every five minutes whenever an evolution is performed that will add heat to the pool. The total RCIC turbine run lasted approximately 17 minutes. The cause of this violation is human error. The Line Assistant Shift Supervisor misdiagnosed the situation and overlooked the requirements of system operating procedure CPS 3310.01 to initiate surveillance procedure CPS 9000.05 whenever Reactor Core Isolation Cooling is operated in Modes 1 or 2 (Plant Startup).

Corrective Steps That Have Been Taken and the Results Achieved

The Line Assistant Shift Supervisor was counseled by the Assistant Director of Operations and the error was pointed out to the operations crew that were involved in the evolution. Operations personnel involved in this evolution readily identified the correct action that should have been taken and have not made this type of error since the event in July 1996.

Corrective Steps to Avoid Further Violations

Clinton Power Station Operations Department Principles and Standards, Principle #2-Compliance and Adherence, was not in effect at the time of this event, but was put in place in December 1996. Principle #2 states that all licensed operators are responsible for complying with the Improved Technical Specifications/Operations Requirements Manual (ITS/ORM) and that operators must develop the practice of reviewing the ITS/ORM prior to execution/manipulation of plant activities or equipment. The implementation of Principle #2 will prevent this event from occurring again since both the Reactor Operator and the Line Assistant Shift Supervisor will be identifying Technical Specification requirements.

Date When Full Compliance Will be Achieved

Illinois Power Clinton Power Station is currently in full compliance of Technical Specification 3.6.2.1.1, "Suppression Pool Average Temperature," and of surveillance procedure CPS 9000.05, "Suppression Pool Temperature Log."

Response to Notice of Violation 50-461/96009-03

The Notice of Violation states:

"10 CFR 50.54(l), " Conditions of Licenses," requires in part, that the licensee shall designate individuals, licensed as senior reactor operators pursuant to Part 55, to be responsible for directing the licensed activities of licensed operators.

10 CFR 55.53(e), "Conditions of Licenses," requires in part, that to maintain active status, the licensee licensed operator shall actively perform the functions of an operator or senior operator on a minimum of seven 8-hour or five 12-hour shifts per calendar quarter.

10 CFR 55.4, " Definitions," defines actively performing the functions of an operator or senior operator to mean that an individual has a position on the shift crew that requires the individual to be licensed as defined in the facility's technical specifications, and that the individual carries out the duties covered by that position.

10 CFR 55.53(f) requires, in part, that if paragraph 55.53(e) is not met then before resumption of functions authorized by a license issued under this part an authorized representative of the facility licensee has completed a minimum of 40 hours of shift functions under the direction of an operator or senior operator as appropriate and in the position to which the individual will be assigned.

Contrary to the above, during the second, third, and fourth quarter of 1996, the licensee designated individuals to be responsible for directing the licensed activities of licensed operators, had neither actively performed the required quarterly shifts nor completed a minimum of 40 hours of shift function under the direction of a senior operator."

Background And Reason for Violation

Prior to October 1996, there was no guidance for proficiency watchstanding for Senior Reactor Operators to differentiate between the Line Assistant Shift Supervisor and Staff Assistant Shift Supervisor positions. The cause of the violation was the failure to realize that the Staff Assistant Shift Supervisor position did not fulfill the Technical Specifications with regard to proficiency. As a result, performance and verification of proficiency for Senior Reactor Operators focused on standing the required number of watches without regard to which position was used. In September 1996, the Staff Assistant Shift Supervisor was changed to the Shift Resource Manager. This change in titles also contained direction that the Shift Resource Manager position could not be used for proficiency. This information was not communicated well to Senior Reactor Operators so some Senior Reactor Operators were still under the assumption that the Shift Resource Manager position could be used for proficiency. Additionally, some Senior Reactor Operators failed to complete the Licensed Operator Watchstanding Record of Completion forms required to document their hours of proficiency. A review of this documentation process also showed that the operations personnel assigned to compile the watchstanding

information for the quarterly "Active License Status" letter had not been trained on the required contents of the letter nor on the Nuclear Training Department Procedure describing the process of filling out a Licensed Operator Watchstanding Record of Completion form. A potential contributor to the cause of this violation was that there was no recent emphasis from Operations supervision to licensed operators regarding their responsibility to assure that "Licensed Operator Watchstanding Record of Completion" forms are completed and properly submitted for the watches they perform.

Corrective Steps That Have Been Taken and the Results Achieved

The Main Control Room log was reviewed to identify when each of the operators had stood watch in the affected period. From this information, the proficiency for eight Senior Reactor Operators, that had performed Shift Resource Manager watches to complete their proficiency, was suspended pending completion of reinstatement requirements specified in CPS 1401.01, "Conduct of Operations," step 8.9.1.2.b, Proficiency Watches.
The eight Senior Reactor Operators have completed their required watchstanding in accordance with step 8.9.1.2.b of CPS 1401.01 and have been reinstated as proficient.

Corrective Steps Taken to Avoid Further Violations

Administrative procedure Clinton Power Station (CPS) 1401.01, "Conduct of Operations," was revised to add section 8.9, "Proficiency Watches," which specifies that the Shift Resource Manager (SRM), previously known as the Staff Assistant Shift Supervisor, does not qualify as a proficiency watchstation.

A letter explaining the addition of section 8.9 to CPS 1401.01 was sent to Senior Reactor Operators from the Assistant Director of Plant Operations. This letter not only explained the differentiation between the Shift Resource Manager and the Line Assistant Shift Supervisor, but also the required steps for reinstatement of proficiency if suspended. Information on the changes to CPS 1401.01 was also given in the Night Orders so that all Operations personnel would have a chance to be informed. The Supervisor of Operations Support briefed the personnel responsible for compiling the watchstanding information for the "Active License Status" letter on the proper method of documenting watchstanding proficiency.

Date When Full Compliance Will Be Achieved

Illinois Power is in full compliance with Operator watch standing in accordance with 10 CFR 50.54 and 10 CFR 55.53, "Conditions of Licenses."

Response to Notice of Violation 50-461/96009-04

The Notice of Violation states:

"10 CFR 50, Appendix B, Criterion XVI, requires, in part, that measures shall be established to assure that conditions adverse to quality are promptly identified and corrected.

Contrary to the above, conditions adverse to quality were not promptly corrected in that errors in safety tagging resulted in unintended isolation of power for security lighting on July 25, September 6, and September 29, 1996."

Background and Reason for the Violation

On July 26, 1996, a Security Force Member (SFM) discovered the outside lights on the north and south side of the Service Building were not lit. Immediate actions were taken to install temporary lighting. Investigation revealed that operations personnel tagged out the breaker for these lights without realizing the impact on security lighting. Further investigation showed that the appropriate electrical drawings did not address that this breaker fed outside lighting. Condition Report 1-96-07-066 was written to address this issue and was not considered 'Significant' in accordance with the significance criteria provided in administrative procedure CPS 1016.01, "CPS Condition Reports." The cause of the lights not being lit is attributed to an error on the electrical prints which included the outside lighting.

On September 6, 1996, a SFM observed that the exterior lighting on the north and south sides of the Service Building were not lit. Once again, temporary lighting was installed to correct the deficiency. Condition Report 1-96-09-013 was written and then added into the previous condition report, 1-96-07-066,which was the same breaker that had been erroneously de-energized on July 26, 1996. The cause of this lighting outage was also attributed to the error in the electrical prints which include the outside lighting of the Service Building. This condition report was not considered "Significant" in accordance with administrative procedure CPS 1016.01, "CPS Condition Reports." Since these occurrences were not considered "Significant" individually, there was no requirement to take action to prevent recurrence. Corrective action for the first incident on July 26, 1996, was to update the electrical prints to reflect actual plant design. This action also pertains to the second isolation on September 6, 1996. However, the prints were not changed in a timely manner to prevent the second occurrence.

On September 29, 1996, a SFM noticed that the exterior lighting on the north and west side of the turbine building were not lit causing light deficient areas. Temporary lighting was installed to illuminate the deficient areas until the normal lighting could be restored. Condition Report 1-96-09-204 was written to address this event. Because the affected areas were not the same, this condition report was not investigated like the first two condition reports. This condition report was also not considered "Significant" in

accordance with CPS 1016.01, "CPS Condition Reports." The third isolation of lighting on September 29, 1996, was due to a poor coordination effort between Operations and North American Energy Services (NAES). It was understood that maintenance requiring the electrical distribution panel to be deenergized would be complete before nightfall. The cause of this portion of the violation is attributed to a lack of communication between the NAES craft and operations about when the maintenance work would be completed to preclude the loss of lighting on the north side of the turbine building. Unlike the previous two events, the breaker on this particular tagout was clearly labeled as affecting lighting and the impact was known.

Corrective Steps That Have Been Taken and the Results Achieved

In all three instances, the corrective action taken was to place temporary lighting in the areas that were not illuminated enough to meet the criteria of the Clinton Power Station Security Plan and increase surveillance of the affected areas. The associated tagouts were lifted and the lighting restored until the issue could be resolved.

Corrective Steps Taken to Avoid Further Violation

The corrective action taken to resolve the site inadequacies in safety tagging is being addressed by Condition Report 1-96-01-371. This condition report states that the safety tagging program was inadequate in providing tracking of root causes and guidance to operators. Training will be performed to improve the understanding of the expectations of the program.

Electrical prints were changed to reflect actual plant design and annotates that the circuit involves security lighting.

Classroom mockup training will be used. This should include the entire process from tagging request to removal. Reverse role playing is to be incorporated into the training, i.e., Operations will perform the maintenance roles and Maintenance will perform the operations roles. This is expected to convey to the respective departments the steps necessary to perform tagouts.

Date When Full Compliance Will Be Achieved

Illinois Power is in full compliance with the safety tagging procedures in accordance with administrative procedure CPS 1014.01, "Safety Tagging."

Response to Notice of Violation 50-461/96009-05

The Notice of Violation states:

"10 CFR 50, Appendix B, Criterion V, requires, in part, that activities affecting quality shall be accomplished in accordance with instructions, procedures, or drawings.

Contrary to the above, on November 3, 1996, while performing Clinton Power Station (CPS) 3882.01, " Diesel Generator Overspeed Trip Test," an activity affecting quality, personnel performing the activity did not follow procedural steps 8.3.a and 8.3.i."

Background and Reason for the Violation

On November 5, 1996, operations personnel prepared to perform CPS 3882.01, "Diesel Generator Overspeed Trip Test," on the Division 1 Diesel Generator 16 cylinder diesel. This was a retest as the diesel tripped below the acceptable range in a previous test performed November 3, 1996. Prior to this retest a briefing was held and three operators were dispatched to perform the test. During the preparation for this retest, the Diesel Generator shaft safety guards were not removed per step 8.3.a because a different portable tachometer was being used to monitor shaft speed. During the performance, the operator in control of the fuel racks initially pulled on the fuel racks lever thus causing the diesel speed to decrease to less than 900 rpm. The operator with the portable tachometer noticed the decrease in speed and used previously established hand signals to tell the fuel racks operator to push on the control lever to increase diesel speed. The operator controlling diesel speed then pushed on the fuel racks lever to increase the speed. The operator with the portable tachometer was having difficulty resetting the instrument once 900 rpm was reached. Due to his lack of knowledge on the instrument and lack of a technical manual for that particular instrument, the operator failed to get the tachometer to read greater than 900 rpm when the diesel tripped on overspeed. According to the computer analysis, the trip occurred at an acceptable level according to the system engineer.

The root cause for all three errors was personnel error by the operators involved in this test:

- The operators failed to change step 8.3.a when a different type of portable tachometer was used. Instead of changing the procedure, a short cut was used and the step was just "noted out." At the time, the operators did not feel that the discrepancy between step 8.3.a and the method they were going to use met the criteria for a Temporary Procedure Change (TPD), that is, it would not "prohibit the completion of the activity" as stated in the CPS 1005.01, "Procedure Use and Adherence."

- The operator controlling the fuel racks pulled on the lever and decreased diesel speed contrary to step 8.3.i that directs the operator to push on the lever to increase diesel speed.

- The operator who was using the portable tachometer failed to properly monitor the diesel speed. The operator had trouble operating the tachometer at the beginning of the test, but did not stop and seek guidance.

Corrective Steps That Have Been Taken and the Results Achieved

The system engineer questioned the outcome of this trip test due to the initial decrease and then increase in diesel speed prior to the trip. Those equipment responses were not normal occurrences when implementing the procedure and therefore the results were questionable. The test was performed a third time with satisfactory results.

Corrective Steps Taken to Avoid Further Violations

To lessen the likelihood of a recurrence of human error, CPS 3882.01 has been revised to accommodate the use of the varying styles of portable tachometers available for use in this test. In addition, technical manuals for the Monarch Portable Tachometer will be available at the point of issue for this device to provide operators with guidance on use of the device. Also, signs have been placed on the diesel fuel racks giving direction for the operator to increase/decrease diesel speed with lever operation.

CPS 1005.01, "CPS Procedures and Documents," has been revised to prevent the "noting out" of a step that cannot be performed. The operators involved were involved in a discussion concerning their errors during the critique, MS-96-014.

In accordance with Engineering Change Notice 29951, the trip range of all diesel generators was changed to prevent the diesels from being operated unnecessarily. Also, a maintenance work request was implemented to determine and implement a better method to read diesel speed locally.

Date When Full Compliance Will Be Achieved

Illinois Power is now in full compliance with the operation of the Divisional Emergency Diesel Generators when performing the CPS 3882.01, "Diesel Generator Overspeed Trip Test."

Reason for Violation 50-461/96009-07

The Notice of Violation states:

"10 CFR 50, Appendix B, Criterion XVI, requires, in part, that measures shall be established to assure that conditions adverse to quality are promptly identified and corrected.

Contrary to the above, corrective actions to correct a lack of timeliness in performing use history analyses (UHAs) identified in 1994, June 1995, January 1996, and August 1996 failed to correct the issue. Specifically, on October 25, 1996, 57 UHAs of measuring and test equipment had not been performed in a timely manner."

Background and Reason for Violation

Problems associated with the timeliness of Use History Analysis (UHA) dispositions were identified in June 1995 under Nuclear Assessment Department (NAD) Surveillance Report Q-17130. Condition Report (CR) 1-95-07-007 was written to document this timeliness condition, as well as, several other deficiencies with the Measuring and Test Equipment (M&TE) program. Several actions were initiated to improve the timeliness issues as a result of CR 1-95-07-007. These actions included; implementing a UHA audit to assess the performance of the M&TE program, allowing the Control and Instrumentation Calibration Laboratory to evaluate equipment that has been lost or damaged and that is not susceptible to instrument drift (this was done to reduce the number of UHAs sent out for disposition), and publishing a periodic status of outstanding UHAs to management and the performers of UHAs. While these actions did provide some improvement to the timeliness issue, program compliance was not achieved because of the continued perception of UHAs being a "low priority." Publication of the status report was supposed to gain management's attention to delinquent UHAs; however, the report was only sent to the Supervisor-Electrical/Controls & Instrumentation(E/C&I). This action was ineffective because the personnel who perform UHAs don't work for the Supervisor-E/C&I. According to an interview with the Supervisor-E/C&I, the UHA audit status is no longer published.

A lack of management attention and poor program management were determined to be the root causes for this violation based on the fact that personnel performing the UHAs never felt any real sense of urgency to complete them in a timely manner and delinquent UHAs were not identified via the corrective action program.

Corrective Steps That Have Been Taken and the Results Achieved

A review of the UHA log identified 57 UHAs that had not received a disposition. Immediate corrective action performed was to disposition the 57 delinquent UHA's and determine any rework required. There was no other test equipment found out of calibration. Also, a briefing given to Control and Instrumentation Calibration Laboratory

personnel in regard to UHA tracking and CR generation in accordance with the administrative procedure CPS 1512.01, "Calibration and Control of Measuring and Test Equipment."

Corrective Steps Taken to Prevent Further Violations

Administrative procedure CPS 1512.01, "Calibration and Control of Measuring and Test Equipment," was revised to require generation of a CR in accordance with CPS 1016.01, "CPS Condition Reports," for any UHA forms not completed within 21 days. Direction has been issued to all departments utilizing M&TE from the Calibration Laboratory on the new requirements added to CPS 1512.01. The changes to CPS 1512.01 will also keep the responsible management informed of UHA status, and allows trending to identify violations of the UHA timeliness requirements.

Date When Full Compliance Will Be Achieved

Illinois Power is in full compliance of its Use History Analysis program and CPS 1512.01, "Calibration and Control of Measuring and Test Equipment."

Response to Violation 50-461/96009-09

Notice of Violation States:

"Technical specification 5.4.1.a requires, in part, that procedures be implemented for activities recommended in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978.

Regulatory Guide 1.33, Revision 2, Appendix A, Paragraph 7.e(4), requires that contamination controls be covered by procedures.

CPS Procedure 1024, "Contamination Control," required, in part, that protective clothing was required for entry into contamination areas.

Contrary to the above, on October 3, 1996, an individual failed to wear protective clothing when they crossed a contamination boundary while pushing a potentially contaminated laundry bag."

Background and Reason for Violation

On October 3, 1996, an individual handling a bag of laundry from a cart to a Sea-Land carrier, crossed a contamination boundary with an unprotected foot to force the bag further into the contamination zone. The individual in question stated that they did not breach the boundary; however, in order to adjust the bag of laundry in the contamination zone the boundary must have been crossed. The cause of this violation was an apparent misjudgment of Radiation Worker work practices, and a failure to follow station procedures by the worker. A contributing factor to the cause was that the bag of laundry in question was a clean bag that came from a clean cart and so the potential of contamination spread was minimal.

Corrective Steps That Have Been Taken and the Results Achieved

The employees involved were counseled by both direct supervision and the Radiation Protection Shift Supervisor. This counseling consisted of emphasizing Radiation Worker practices, handling of potentially contaminated materials, and the potential for the spread of contamination. Surveys of the effected area, including possible routes the individual may have taken to and from the area, were performed and no contamination was found.

Corrective Steps Taken to Prevent Further Violations

Sections were added to the training guideline to provide further instruction on the specific handling of potentially contaminated laundry bags (i.e., do not drag or kick bags). Employees were encouraged to seek help when working with heavy loads and to not take inappropriate risks to quickly solve a problem. The Radiation Protection department is researching the current setup of handling laundry bags and is looking into improving the contamination zone setup within the Sea-Land carriers so that personnel have less difficulty in depositing bags of potentially contaminated laundry.

Date When Full Compliance Will Be Achieved

Illinois Power is in full compliance with regards to radiation worker practices and contamination controls.

Response to Notice of Violation 50-461/96009-10

Notice of Violation States:

"Technical Specification 5.4.1.b requires, in part, that written procedures shall be established, implemented, and maintained covering the emergency operating procedures (EOPs) required to implement the requirements of NUREG-0737 and NUREG-0737, Supplement 1.

Contrary to the above, on November 16, 1996, it was identified that EOP-8, "Secondary Containment Control," was not properly maintained in that it contained errors in Table U that had not been corrected."

Background and Reason for Violation

Emergency Operating Procedure(EOP)-8, "Secondary Containment Control," has several Entry Conditions, one of which is Area Radiation above maximum normal limits as specified in Table U. This table specifies the locations of the detectors that are monitored, the method of monitoring, the maximum normal limit of four to five time the routine survey results, and the maximum safe limit of 25 R/hour for areas requiring access and 400 R/hour for areas not requiring access. Some of the methods of monitoring listed are Area Radiation/Process Radiation (AR/PR monitors). However, some of the monitors are listed incorrectly. The RHR Equipment Room A is listed as being monitored by 1RIX-AR010 address 009. However, this monitor is located outside RHR Equipment Room B not A. Furthermore, the monitor itself is labeled incorrectly as RHR Equipment Room A when in fact it is outside RHR Equipment Room B. The RHR Equipment Room B is listed as being monitored by 1RIX-AR011 address 010. However, 1RIX-AR011 is located outside the RHR Equipment Room A not B. In addition, 1RIX-AR011 has been inoperable since May 2, 1996, due to spurious high alarms. A Maintenance Work Request has been generated to correct the spurious high alarm condition and is scheduled to be completed in June 1997. The Control Rod Drive service area is listed as being monitored by 1RIX-AR018 address 017. However, this monitor has been removed from the system.

Corrective That Have Been Taken and the Results Achieved

There was no necessary immediate action since there was no impact on operational response since the discrepancy was identified during a review by the Radiation Protection Shift Supervisor. The operators rely on Radiation Protection to provide local radiation readings.

Corrective Steps Taken to Prevent Further Violations

The monitors do not provide the function that the EOP-8 states. A review of the Updated Safety Analysis Report (USAR) reveal in part that section 6.2.4.2, "Containment Isloation System - System Design," which states: "...each compartment contains area temperature monitors which alarm in the control room...." Since the USAR description is not physically possible with the design of the AR/PR system, the USAR will be updated to reflect actual plant design.

Given the current plant design and capabilities of these monitors, the continued use of these instruments on the EOP-8 flowchart is evaluated to be a misapplication of the monitoring equipment for the intended EOP actions. Procedure CPS 4979.02, "Abnormal High Area Radiation Levels," provides the necessary triggers to initiate surveys of the areas, and refer to and enter the EOPs as appropriate. To alleviate further confusion, these monitors were removed from the EOP-8 Table U.

An engineering change notice was initiated to provide proper labels for the monitors.

Date When Full Compliance Will Be Achieved

Illinois Power Emergency Operating Procedures are now in full compliance with the Updated Safety Analysis Report and with respect to the area radiation monitors located outside residual Heat Removal rooms A and B and the Control Rod Drive Rebuild room.