U. S. NUCLEAR REGULATORY COMMISSION

REGION V

Report No.	50-397/89-10
License No.	NPF-21
Licensee:	Washington Public Power Supply System P. O. Box 968 3000 George Washington Way Richland, Washington 99352
Facility Name:	Washington Nuclear Project No. 2 (WNP-2)
Inspection at:	WNP-2 Site, Benton County, Washington
Inspection Conducted:	March 20-24, 1989

Inspector: G. A. Brown, Emergency Preparedness Analyst — Date Signed: 4/11/89

Approved By: R. F. Fish, Chief, Emergency Preparedness Section — Date Signed: 4/11/89

Summary:

This was an unannounced inspection in the areas of followup on the February 10, 1989 Unusual Event and seven open items identified during previous inspections and operational status of the emergency preparedness program (procedures, facilities, organization, management control, and document distribution). Inspection procedures 92701 and 82701 were used.

Results:

No deficiencies or violations of NRC requirements were identified. In general the inspector found strength in the relationship the licensee has with offsite agencies in the emergency response program. No negative findings were identified during this inspection.

DETAILS

1. Persons Contacted:

WNP-2 Personnel:

*L. Oxsen, Assistant Managing Director for Operations
J. Baker, Assistant Plant Manager
*R. Chitwood, Manager Emergency Planning
*Y. Derrer, Principal Training Specialist
*J. Hogg, Telecommunications Supervisor
*A. Klaus, Senior Emergency Planner
*D. Mannion, Principal Emergency Planner
*R. Mogle, Senior Emergency Planner
*M. Monopoli, Manager Support Services
*G. Ray, Emergency Planner
*J. Schnell, Supervisor of Procedure Control
D. Smith, Records Management Analyst

Others:

T: Corby, Administrator, Our Lady of Lourdes Hospital
J. Davis, Administrator, Kadlec Hospital
L. Densley, Director Emergency Services, Kennewick Hospital
L. Frazier, Administrator, Kennewick General Hospital
*W. Kiel, Washington State Liaison Officer
D. Olson, Nurse Manager, Emergency Department, Kadlec Hospital
B. Sack, Assistant Administrator, Kadlec Hospital

* Indicates those in attendance at the March 24, 1989 exit interview

2. Follow-up on Previous Inspection Findings (Module 92701)

(Closed) Open Item 88-25-02. Need to clarify phrase "inadequate control of plant" found in Attachment A.C.2.c(3) of EPIP 13.1.1. The licensee has modified the procedure to define inadequate control of the plant as any event compromising the functions of safety systems needed for the protection of the public. This item is closed.

(Closed) Open Item 88-25-03. Licensee's EPIPs make no distinction between initial classification and reclassification notifications. Upon any emergency declaration, 10 CFR 50.72(a)(3) requires notification to the NRC immediately after notification to State and local agencies. 10 CFR 50.72(c)(1) requires immediate notification to the NRC of any reclassification (with no mention of other notifications). This matter was discussed with the Emergency Preparedness Branch at Headquarters and their position is that the interpretation of "immediate" is the same for both sections (i.e. immediately after notification of State and local agencies). Therefore, no change to the licensee's procedures is necessary. This item is closed.

(Closed) Open Item 88-25-04. Procedures don't provide adequate guidance for declaration of an Alert for loss of most or all control room annunciators. EPIP 13.1.1 was amended to include the declaration of an Alert upon failure of control room annunciator panels P601, P602, and P603. This item is closed.

(Closed) Open Item 88-25-05. Need to clarify term "significant failed fuel" discussed in procedures. The licensee has modified its procedures to define significant failed fuel as that greater than 1%. This item is closed.

(Closed) Open Item 88-42-03. Need to improve reliability of CRASH emergency communications system. The licensee performed a comprehensive analysis of the CRASH system and determined the cause to be related to an overload in one circuit. The problem was corrected and subsequent satisfactory weekly tests have verified that the system is now reliable. This item is closed.

(Closed) Open Item IN-89-19. Repair and use of HPN phones. The licensee has received and reviewed this notice and determined that their current method of handling HPN telephone repair meets the concern expressed in the notice. This item is closed.

(Open) Open Item 88-42-02. Need to improve EP Department capability for root cause analysis. The licensee has sent two of its staff to training in root cause analysis and is now developing a program. This item will remain open pending final implementation of the program.

3. Operational Status of the Emergency Preparedness Program (Module 82701)

The inspector reviewed this program area to determine if any changes to the emergency preparedness (EP) program had decreased the overall state of emergency preparedness. Changes to the implementing procedures, emergency facilities, organization and management control, and offsite support agencies of the EP program were reviewed during this inspection.

a. Changes to the Emergency Preparedness Program

1) The following emergency preparedness implementing procedure changes had occurred since the last inspection (December 5-9, 1989):

EPIP 13.2.1, Revision 5
EPIP 13.2.3, Revision 4
EPIP 13.2.4, Revision 4
EPIP 13.3.2, Revision 4
EPIP 13.3.3, Revision 4
EPIP 13.3.4, Revision 4
EPIP 13.4.1, Revision 7

EPIP 13.5.1, Revision 5
EPIP 13.5.2, Revision 5
EPIP 13.7.1, Revision 4
EPIP 13.7.3, Revision 5
EPIP 13.7.5, Revision 6
EPIP 13.10.4, Revision 6
EPIP 13.10.10, Revision 4
EPIP 13.11.1, Revision 5
EPIP 13.11.3, Revision 5
EPIP 13.11.9, Revision 5

The changes were determined not to have decreased the effectiveness of the emergency preparedness program.

b. Emergency Facilities, Equipment, Instrumentation, and Supplies

Touring the licensee's emergency response facilities, the inspector found the equipment, instruments and supplies in good working condition, within calibration dates, and in accordance with procedures.

c. Organization and Management Control of the Emergency Preparedness Program

There had been no major staffing or organizational changes since the last inspection (December 5-9, 1988).

d. Offsite Support Agencies

The inspector interviewed the emergency response staff at three area hospitals who have contracted to provide support during an emergency. These individuals are identified in Section 1 of this report. The licensee appears to have an exceptionally good interface with these institutions since all of them were enthusiastic in their support of the licensee's emergency response program.

4. Follow-up on February 10, 1989 Notice of Unusual Event

BACKGROUND: When operators were unable to confirm the closure of a pressure core spray system valve within the four hours allowed, the licensee initiated a plant shutdown and declared an unusual event in accordance with applicable procedures. Subsequently, notifications to governmental agencies were made as required by Procedure 13.4.1. However, within 30 minutes of the declaration, incorrect information, i.e., that a "Chernobyl-like" accident had occurred at the Hanford Project, was verbally communicated to certain Washington State legislators. While the incorrect information was corrected before it reached the media and the general public, it resulted, briefly, in concern by some state legislators and the licensee.

The licensee reviewed the circumstances that led to the incorrect information and determined that the message sent out by the state to

notify emergency response agencies of the unusual event declaration was incorrectly interpreted by a member of the Washington State Patrol. This patrolman notified the head of the Washington State Patrol, who was attending a legislative committee hearing, that there was a "Chernobyl-like" event underway at the Hanford Project. The head of the State Patrol in turn informed legislators who were participating in the review. The incorrect information spread among the legislators but was quickly corrected through vigorous efforts by the licensee and State Division of Emergency Management.

Mr. Curtis Eschels, Chairman of the Energy Facility Site Evaluation Council, examined actions of State officials with emergency response duties. He concluded that emergency management personnel acted promptly to control the rumors, but recommended that periodic refresher training be provided to State officials involved in the emergency response plan. Among other things, he also recommended that the public information office staff discuss rumor control issues during unusual events, and that additional communications channels be established in order to provide timely and accurate information.

5. Exit Interview

An exit interview was held on March 24, 1989 with licensee representatives. Attendees of this interview are identified in Section 1 of this report. The licensee was advised that no violations or deviations were identified during this inspection. The findings and observations described in Section 3 of this report were also discussed during this interview.