U.S. NUCLEAR REGULATORY COMMISSION

REGION V

Report No.	50-397/89-32
Docket No.	50-397
License No.	NPF-21
Licensee:	Washington Public Power Supply System P. O. Box 968 Richland, Washington 99352
Facility Name:	Washington Nuclear Project No. 2
Inspection at:	WNP-2 Site, Benton County, Washington
Inspection Conducted:	November 13-17, 1989

Inspected by: _____ 11-29-89
G. R. Cicotte, Radiation Specialist — Date Signed

Approved by: F. A. Wenslawski 11/30/89
F. A. Wenslawski, Chief — Date Signed
Facilities Radiological Protection Section

Summary:

Inspection during the period of November 13-17, 1989 (Report No. 50-397/89-32)

Areas Inspected: Routine unannounced inspection by a regionally based inspector of Control of Radioactive Material, Contamination, Surveys, and Monitoring; tours of the facility; and follow-up. Inspection procedures 30703, 83726, and 92701 were addressed.

Results: No violations were identified in the three areas addressed. The licensee's radioactive material control had improved since the last inspection of this program area. Overall, the licensee's programs appeared fully capable of meeting their safety objectives.

DETAILS

1. Persons Contacted

*C. M. Powers, Plant Manager
*J. A. Baker, Assistant Plant Manager
*J. R. Allen, Health Physics (HP) Craft Supervisor
*J. D. Arbuckle, Compliance Engineer
*R. G. Graybeal, HP/Chemistry (HP/C) Manager
*D. A. Kerlee, Principal Quality Assurance (QA) Engineer
*D. R. Kobus, Plant QA Manager
*R. L. Koenigs, Technical Manager
*D. E. Larson, Radiological Programs and Instrument Calibrations (RPIC) Manager
R. F. Patch, ALARA Coordinator
*D. J. Pisarcik, HP Support Supervisor
*L. A. Pritchard, HP Craft Supervisor
*R. L. Wardlow, Radiological Services Supervisor

NRC

*C. J. Bosted, Senior Resident NRC Inspector
*G. R. Cicotte, Radiation Specialist
*C. R. Sorensen, Resident NRC Inspector
*J. F. Burdoin, Reactor Projects Inspector

*Denotes those present at the exit interview held on November 17, 1989.

In addition to the individuals identified above, the inspector met and held discussions with other members of the licensee's staff.

2. Control of Radioactive Material, Contamination, Surveys, and Monitoring (83726)

A. Audits and Appraisals

The findings of the licensee's corporate licensing and assurance audit 89-500, "Radioactive Process Control Program", dated October 26, 1989, was reviewed. The audit had been completed, but not yet issued for distribution, at the time of the inspection. The licensee had included among the auditors individuals who were knowledgeable in the areas audited. The audit appeared to be thorough and required responses to significant problem areas. The inspector noted, however, that some of the findings were of long-standing problems which had not been corrected, such as the procedural deficiencies regarding recirculation times for some liquid waste tanks, first identified in 1988.

B. Surveys and Monitoring

Representative surveys of the licensee's facility from November, 1989, were reviewed. Few examples of surveys not performed at the

periodicity of the licensee's schedule were observed. All field instruments in use were observed to be in current calibration and were being properly response checked prior to use.

Calibration and response capabilities were discussed with licensee HP personnel, who were familiar with the equipment available to them for performance of surveys of equipment and personnel.

Calibration of dosimeters was observed to be in accordance with the licensee's Radiological Programs Instruction (RPI) 7.13, "Calibration of Xetex Model 415A/B Audible Alarm Dosimeters," Revision 4, dated October 20, 1989. The Eberline 1000B Calibrator was being used to irradiate the dosimeters to specified doses. RPI 7.19, "Operation of Eberline 1000B Multiple Source Gamma Calibrator," Revision 0, dated April 8, 1983, stated in part that if the "safe" indicator light is not on when the source is retracted, the operator is to: "notify the I&C Technician and the Radiological Services Supervisor." The operator was not aware of the requirement, and did not recall how long the "safe," "exposed," and "power" lights had been missing, when observed by the inspector. The technician immediately informed the RSS and lights were installed soon thereafter. The inspector noted also that RPI 7.19 allows use of an uncalibrated ratemeter to verify retraction of the source prior to reaching into the calibrator. The technician, however, was using a calibrated instrument. The HP&C Manager stated that the procedure would be revised to disallow the practice of using an uncalibrated instrument.

C. Radioactive Materials and Contamination Controls

The licensee's methods of trending personnel contaminations was reviewed, including procedures for recording contaminations and representative records of contamination incidents. Contamination control techniques were observed in use in the Radwaste Building (RWB). Activities to prepare a radioactive waste shipment were observed and the associated records were reviewed. The licensee's efforts to minimize waste, in the form of instructions to workers to take only necessary materials into the Radiologically Controlled Area (RCA), were also observed. Surveys of potentially contaminated personnel and materials were observed to be consistent with licensee procedures and good practices, though some HPTs appeared to scan materials very quickly.

See paragraph 3, below, for discussion of tours of the licensee's facility.

The licensee's program appeared fully capable of meeting its safety objectives. No violations or deviations were identified.

3. Tours of the Facility

Tours of the Radwaste Building (RWB), Reactor Building (RB), and Turbine Building (TB), were conducted. Independent radiation surveys were performed with NRC ion chamber survey instrument model #RO-2, serial

#015844, due for calibration on December 27, 1989, and NRC micro-R meter model #PRM-7, serial #008596, due for calibration on April 17, 1990.

Radiological postings, contamination control stepoff pads, and other access controls which were observed appeared to have improved over previous inspections and were consistent with the licensee's procedures and TS requirements. Housekeeping appeared adequate. Only one area, on the 522' elevation of the RB, was observed to have significant accumulation of used contamination control materials left on the floor. However, some contaminated areas appeared to have increased in size. The traversing in-core probe (TIP) drive machine area appeared much improved, although the size of the contaminated area was unchanged.

Overall, the licensee's program appeared fully capable of meeting its safety objectives. No violations or deviations were identified.

4. Follow-up

A. Follow-up on Inspector Identified Problems

While touring the 572' elevation of the RB, one of the Standby Gas Treatment System filtration units, SGT-FU-1A, was observed to have what appeared to be improper flange alignment between the last two modular filtration components in the train, such that the tops of the flanges were approximately 4 cm apart, while the flanges converged approximately 40 cm down from the top. Bolts and nuts on the flange in the misaligned area had various amounts of thread engagement. Further examination by the inspector and by the Senior Resident Inspector (SRI) found several of the access door retaining devices, "dogs," loose. Both SGT-FU-1A and SGT-FU-1B had loose dogs. One dog on SGT-FU-1B was out of position such that it was not providing sealing pressure on the door. Additionally, the last access door in the train for SGT-FU-1A had a piece of a cleaning cloth caught in the sealing area.

The observations were brought to the attention of the licensee, who sent an Equipment Operator to the area to correct the dogs and the foreign material in the seal area. When the matter was later discussed with the licensee, they stated that the units had been satisfactorily modified to meet the leakage criteria. The inspector verified that the filtration housings had been leak tested in 1983. The resident inspectors will follow up on other issues related to the condition of the SGTS.

B. 50-397/85-20-04(Unresolved): This refers to iodine plateout in effluent sample lines during an accident (see Inspection Report 50-397/85-20). The licensee had received the formal results of the initial tests performed during the refueling outage. The licensee stated that laboratory testing was in the final approval process, and provided a copy of the initial test results to the inspector. This matter will remain unresolved pending review of laboratory tests and rationale.

An unresolved item is one about which more information is required in order to determine if it is an acceptable item, a violation, or a deviation.

No specific violations or deviations were identified by the inspector.

5. Exit Interview

The inspector met with those individuals, denoted in paragraph 1, at the conclusion of the inspection on November 17, 1989. The scope and findings of the inspection were summarized. The licensee was informed that the resident NRC inspectors would follow up on the status of the SGTS, as described in paragraph 4, above.