ENCLOSURE 2

NOTICE OF DEVIATION

Wolf Creek Nuclear Operating Corporation
Wolf Creek Generating Station

Docket: 50-482
License: NPF-42

During an NRC inspection conducted on December 31, 1995, through February 10, 1996, one deviation from your Updated Safety Analysis Report was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action," (60 FR 34381; June 30, 1995), the deviation is listed below:

> Updated Safety Analysis Report Section 3.11(B).2.2, Table 3.11(B)-1, lists the minimum operating temperature for the electrical penetration room and the charging pump rooms as 60°F. Section 9.4.3.1.2 requires as part of power generation design basis four that all other areas of the auxiliary building be maintained between 60°F and 104°F.
>
> Contrary to the above, on January 23, 1996, the inspector noted that the temperature in Electrical Penetration Room A was 52°F and on February 6, 1996, the temperature in Charging Pump B room was 52°F (482/9602-01).

Please provide to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555, with a copy to the Regional Administrator, Region IV, 611 Ryan Plaza Drive, Suite 400, Arlington, Texas 76011, and a copy to the NRC Resident Inspector at the facility that is the subject of this Notice, in writing within 30 days of the date of this Notice, (1) the reason for the deviation, or if contested, the basis for disputing the deviation, (2) the corrective steps that have been taken and the results achieved, (3) the corrective steps that will be taken to avoid further deviations, and (4) the date when your corrective action will be completed. Where good cause is shown, consideration will be given to extending the response time.

Because the response will be placed in the NRC Public Document Room (PDR), to the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction. However, if it necessary to include such information, it should clearly indicate the specific information that should not be placed in the PDR, and provide the legal basis to support the request for withholding the information from the public. If personal privacy or proprietary information is necessary to provide an acceptable response, then please provide a bracketed copy of the response that identifies the information that should be protected and a redacted copy of the response that deletes such information. If Wolf Creek Nuclear Operating Corporation (Licensee) requests withholding of such material, Licensee must specifically identify the portions of the response that Licensee seeks to have withheld and provide in detail the bases for Licensee's claim of withholding (e.g., explain why the disclosure of information will create an unwarranted invasion of personal privacy or provide the information required by 10 CFR 2.790(b) to support a request for withholding confidential commercial or financial information). If safeguards

information is necessary to provide an acceptable response, please provide the level of protection described in 10 CFR 73.21.

Dated at Arlington, Texas
this 4th day of March 1996

ENCLOSURE 3

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Inspection Report: 50-482/96-02

License: NPF-42

Licensee: Wolf Creek Nuclear Operating Corporation
P.O. Box 411
Burlington, Kansas

Facility Name: Wolf Creek Generating Station

Inspection At: Coffey County, Burlington, Kansas

Inspection Conducted: December 31, 1995, through February 10, 1996

Inspectors: J. F. Ringwald, Senior Resident Inspector
J. L. Dixon-Herrity, Resident Inspector

Approved: W. D. Johnson, Chief, Project Branch B — Date: 3/4/96

Inspection Summary

Areas Inspected: Routine, announced inspection including plant status, prompt onsite response to events at operating power reactors, operational safety verification, maintenance observations, surveillance observations, onsite engineering, plant support activities, followup - plant support, and licensee event report (LER) review - onsite.

Results:

Plant Operations

- Operators manually tripped the reactor and later declared a Notification of Unusual Event as a result of ice accumulation in the circulating water and essential service water intake bays. NRC management subsequently dispatched an Augmented Inspection Team (Section 2.1).

- The inspector identified weak implementation of Technical Specification Amendment 89. The shift supervisor independently identified the weakness and stopped the implementation (Section 3.1).

Maintenance

- Troubleshooting performed in response to the failure of the turbine-driven auxiliary feedwater pump to start during a postmaintenance test was found to be comprehensive and thorough (Section 4.3).

- The failure of the turbine-driven auxiliary feedwater pump trip throttle valve to open during postmaintenance testing due to grease degradation was appropriately recognized and addressed as a problem by the licensee (Section 4.3).

Engineering

- The inspector identified a deviation from a commitment in the Updated Safety Analysis Report. The licensee failed to maintain temperatures in the auxiliary building above the minimum temperatures identified in the Updated Safety Analysis Report. No operability concerns were identified (Section 5.1).

Plant Support

- A licensee identified violation occurred when a radiographer failed to ensure that the radiation area was unoccupied prior to exposing the source (Section 8.1).

Summary of Inspection Findings:

- Deviation 482/9602-01 was opened (Section 6.1).
- Violation 482/9602-02 was opened (Section 8.1).
- Unresolved Item 482/9525-02 was closed (Section 8.1).
- Violation 482/9524-01 was closed (Section 8.2).
- LER 482/95-006 was closed (Section 9).

Attachment:

- Persons Contacted and Exit Meeting

DETAILS

1 PLANT STATUS (71707)

The plant operated at 100 percent power until January 26, 1996, when the plant started coasting down due to the end of life of the fuel. On January 30, 1996, operators manually tripped the plant and cooled to Mode 4 in response to icing in the circulating water bays. The plant entered Mode 5 on January 31, 1996. The licensee began Refueling Outage VIII on February 3, 1996, due to rod control concerns resulting from the trip.

2 PROMPT ONSITE RESPONSE TO EVENTS AT OPERATING POWER REACTORS (93702)

2.1 Reactor Trip Due to Freezing Weather

At 1:49 a.m. on January 30, 1996, operators received alarms on the bays in the circulating water screen house. An auxiliary operator, directed to respond, found that the water level was low in Bay 1 and screens were frozen in Bays 1 and 3. Control room operators started the essential service water pumps in response to service water system pressure oscillations, and isolated service water from the safety-related systems. Operators secured Circulating Water Pump A and Service Water Pump A, and started Circulating Water Pump B, in response to the low levels in Bay 1. When levels decreased to 12 feet below lake level and the low-flow service water pump began vibrating, the shift supervisor directed operators to trip the reactor, secure the condenser, and to control reactor coolant system temperature using the steam generator atmospheric relief valves. Operators tripped the reactor at 3:37 a.m. While performing Emergency Procedure EMG E-0, "Reactor Trip or Safety Injection," Revision 8, operators identified that five rods failed to fully insert. Rods F6 (18 steps), H2 (12 steps), H8 (12 steps), K6 (6 steps), and K10 (6 steps) stopped at the indicated position by digital rod position indication. Operators transitioned to Emergency Procedure EMG ES-02, "Reactor Trip Response," and commenced emergency boration in accordance with Off-Normal Procedure OFN BG-009, "Emergency Boration," Revision 1, at 3:55 a.m. Within 20 minutes of the reactor trip, the rod bottom lights for Rods F6, H8, and K10 illuminated. The rod bottom lights for Rod H2 and Rod K6 illuminated at 4:35 a.m. and 4:57 a.m., respectively.

Following the trip, an auxiliary operator noted that the shaft seal on the south end of the turbine-driven auxiliary feedwater pump failed. Personnel later determined that the packing had been forced out of the gland. Operators secured the pump, declared it inoperable, and entered Technical Specification 3.7.1.2.a. At 7:49 a.m., operators secured Essential Service Water Pump A in response to low discharge pressure and high strainer differential pressure due to suspected icing conditions. As a result, operators entered Technical Specifications 3.7.4 and 3.8.1.1 due to the loss of the safety-related cooling for one train. Because operators had already entered Technical Specification 3.7.1.2.a due to the inoperability of the turbine-driven auxiliary feedwater pump, operators entered Technical

Specification 3.7.1.2.b, for inoperability of Auxiliary Feedwater Pump A due to the loss of its alternate water source and room cooling. This action required operators to achieve hot standby within 6 hours, and hot shutdown within the following 6 hours. Because the plant was already in hot standby, operators determined that Technical Specifications required them to achieve hot shutdown by 1:47 p.m.

After reviewing the Emergency Action Levels, the shift supervisor determined that conditions existed that indicated a potential degradation of the level of safety in the plant, but that safety systems were not degraded to the point where increased monitoring was warranted. Per the administrative tree, Block 13-ADM2 of the Emergency Action Levels, the shift supervisor declared a Notification of Unusual Event at 8:46 a.m. The principle conditions considered included the suspected icing conditions in Essential Service Water Train A and the potential loss of two of the three auxiliary feedwater pumps. The NRC entered the Monitoring Mode and dispatched additional inspectors to the site.

The turbine-driven auxiliary feedwater pump was repacked but not tested. It was considered functional at 2:11 p.m. The Unit entered Mode 4 at 3:31 p.m. Train A of essential service water was declared operable at 5:45 p.m. after filling, venting, and running the system. Supplemental heating was in place in the screen house and fire watches were posted to watch for icing and to monitor the diesel-fired heaters. The Notification of Unusual Event was terminated at 5:58 p.m.

The Train A essential service water pump was again secured at 7:23 p.m. because of oscillations in flow and pressure. The Train A suction bay level was noted to be lower than normal. Later that evening, the Train B suction bay level decreased below normal at times. On January 31, at 10 a.m., the shift supervisor declared a Notification of Unusual Event following a report from divers that ice buildup completely blocked the Train A essential service water trash racks. During the day, plant personnel applied sparging air to the trash racks and pumped hot water to the area to break up and dissipate the ice. At 8:45 p.m. divers reported the trash racks to be clear of ice.

Mode 5 was entered at 10:48 p.m. on January 31. The Notification of Unusual Event was terminated at 10:05 a.m. on February 1, 1996.

Although degraded, safety systems responded, as required, to maintain the plant in a safe condition throughout the event. As a result of the control rod concerns resulting from the trip, licensee management decided to transition into Refueling Outage VIII, which had been scheduled to start on March 2, 1996. NRC management dispatched an Augmented Inspection Team, and further details of this event will be addressed in NRC Inspection Report 50-482/96-05.

3 OPERATIONAL SAFETY VERIFICATION (71707)

The inspectors reviewed plant activities using Inspection Procedure 71707.

3.1 Improper Technical Specification Amendment Implementation

On January 8, 1996, after learning that the licensee implemented Technical Specification Amendment 89, the inspector determined that document services personnel had not implemented a concurrent change to the Updated Safety Analysis Report. As a result, requirements that were being moved from the Technical Specifications to the Updated Safety Analysis Report were being removed from the Technical Specification without a concurrent change to add them to the Updated Safety Analysis Report. The inspector subsequently learned that when document services personnel attempted to make this change to the control room copy of the Technical Specifications, the shift supervisor recognized that documented requirements were being removed from the control room, and directed document services personnel not to implement Technical Specification Amendment 89. Licensing personnel initiated PIR 96-0095. The inspector concluded that this represented a weakness in implementing Technical Specification Amendment 89. The inspector further concluded that the shift supervisor's recognition of the problem and corrective action was good.

4 MAINTENANCE OBSERVATIONS (62703)

Using Inspection Procedure 62703, the inspectors observed portions of the following work activities:

- 107348-003 Valve Operation and Test Evaluation System testing of Auxiliary Feedwater Valve AL HV-009
- 107367-001 Breaker inspection and testing of Auxiliary Feedwater Pump Breaker NB00105
- 108794-001 Replace degraded turbine-driven auxiliary feedwater pump drain line
- 103153-001 Auxiliary feedwater turbine bearing oil temperature Modification 05038
- 105730-001 Replace relays on turbine-driven auxiliary feedwater pump controls
- 105805-001 Relocate turbine-driven auxiliary feedwater pump resistor
- 108953-001 Troubleshoot turbine-driven auxiliary feedwater pump failure
- 109087-001 Turbine-driven auxiliary feedwater pump shaft sleeve nut restoration

- 109043-001 Retest of refueling water storage tank low switchover channel

- 100166-001 As-found Valve Operation Test and Evaluation System test on Valve AL HV007

- INC C-1000 Calibration of GK AIS-223

Selected observations from the activities witnessed are discussed below.

4.1 Motor-Operated Valve Testing

On January 3, 1996, the inspector observed a portion of the as-found Valve Operation and Test Evaluation System data collection for Valve AL HV0007, Motor-Operated Auxiliary Feedwater Pump B flow control valve to Steam Generator A. The inspector noted that the electricians stroked the valve from approximately 10 percent open to fully shut twice to obtain calibration traces. One electrician then decided that in order to obtain a representative as-found stroke, the valve should be shut with typical closing inertia. The electrician opened the valve approximately 50 percent, then shut it. Then, as a result of a switch manipulation error, the technician fully opened the valve, then shut it. The valve was then opened and shut again to obtain the as-found data.

The inspector questioned whether these valve manipulations exercised the valve, and thus prevented the electricians from obtaining true as-found data. Maintenance and engineering personnel evaluated this question and responded by stating that this may affect the trending data. However, the vendor software and procedures required the electricians to perform a calibration trace prior to obtaining as-found data. In addition, the electrical maintenance superintendent stated that in the process of turning a valve over to maintenance for testing, operators at times must manipulate the valve. The inspector determined that there were no requirements to obtain true as-found data. During discussions, the electrical maintenance superintendent stated that efforts were underway to determine whether changes could be made to the vendor's software and procedures to permit the calibration traces to occur after the as-found stroke. The inspector concluded that these actions were adequate.

The inspector also questioned whether the procedure permitted the electrician to intentionally open the valve approximately 50 percent, then shut it. While it was clear that Procedure MGE LT-099, "MOV [Motor Operated Valve] Diagnostic Testing," Revision 0, did not intend for electricians to perform this stroke, Step 4.3 permitted steps to be repeated and performed out of order. Consequently, the inspector concluded that the unintended manipulation of this valve did not constitute a failure to follow the procedure. The inspector noted that the electrician decided to perform this valve partial stroke without discussions with the other electricians in the room or discussions with the work group supervisor. The electrical maintenance superintendent,

and the maintenance manager both stated that this did not meet their expectation. The superintendent initiated PIR 96-0328, to address this concern. The inspector concluded that these actions were appropriate.

4.2 Foreign Material Exclusion

On January 25, 1996, the inspector observed various scheduled maintenance tasks performed on the turbine-driven auxiliary feedwater pump. Maintenance technicians performed the work in accordance with the appropriate procedures. The inspector noted that the mechanic preparing the turbine drain line section for welding took appropriate action in notifying management after identifying paper fibers on the valve seat. The fibers were deposited on the seat when an auxiliary operator closed the valve on the paper foreign material exclusion plug the technician had installed to protect the system, as required, by the procedure during filing and grinding. The mechanics removed as much of the material as possible. Quality control personnel reviewed the sections being worked and found that they met Cleanliness Class C requirements. The inspector concluded that the mechanic had appropriately followed procedures in addressing foreign material exclusion concerns.

4.3 Turbine-driven Auxiliary Feedwater Pump Failure

On January 26, 1996, the turbine-driven auxiliary feedwater pump failed to start during the performance of postmaintenance testing. The personnel performing the test and the operators in the control room indicated that they heard a relay picking up and dropping out, and that the trip throttle valve switch in the control room indicated mid-position, but never indicated full open. Operations personnel isolated steam from the turbine and re-established the clearance order on the pump. While attempting to perform the surveillance, personnel noted that the pump shaft sleeve nut was loose and appeared to have been in that condition for some time. They determined that this was not related to the failure of the pump to start. Mechanical maintenance retightened the nut under the observation of quality control personnel.

The inspector observed troubleshooting activities. The electrical engineering supervisor led the troubleshooting task. Engineering and maintenance personnel reviewed each of the turbine-driven auxiliary feedwater pump work packages performed the previous day to determine how they could have affected the pump. Operators successfully stroked the trip throttle valve early in the morning and thus eliminated it as a possible cause of the failure. During the afternoon, after the engineers had developed a possible hypothesis and instrumented the controls to collect data, operators attempted to stroke the valve again. The valve failed to open and the relay chattered, as noted during the earlier failure. The cause was narrowed down to the torque switch on the trip throttle valve or the relay that caused the valve to latch.

Electrical maintenance and engineering personnel who specialized in motor-operated valves assisted with troubleshooting. While the valve was being stroked, the engineer noted that the grease was a probable concern due

to the condition of the grease on the shaft. The grease used in the trip throttle valve sliding nut degraded and solidified when the valve cooled. This problem had been discussed in detail in NRC Inspection Report 50-482/95-22. The system engineer trended temperatures on the piping prior to this event. During pump standby conditions, when the steam lines were heated, the temperature of the valve averaged approximately 350°F. After the valve cooled during maintenance, the temperature dropped to approximately 150°F.

Maintenance personnel prepared a work package to clean the shaft and lubricate the sliding nut and shaft. After this work was completed, the valve was successfully stroked at the lower temperature. Electricians also conservatively replaced the coil for the relay that caused the valve to latch. As a result of the previous problems with the grease, the licensee had already planned to disassemble the valve during Refuel Outage VIII, remove all of the old grease, and to replace it with a lithium based high temperature grease. To ensure that the grease was the only problem and that the corrective actions planned would appropriately address the concerns, the plant manager appointed an incident investigation team to investigate the cause of the valve failure. The plant manager directed the team to identify procedure, operation and design inadequacies, recommend corrective actions to prevent recurrence, and provide assurance that the as-left condition of the affected equipment met operability requirements.

The inspector concluded that the troubleshooting was comprehensive and thorough. Although the possibility of the grease being the cause could have been addressed sooner due to previous problems; the valve stroke, early in the analysis, indicated that the valve worked as expected. The inspector also concluded that the significance of the valve's failure to open after it cooled down, while it was out of service for maintenance was low. After each incident, the valve performed its safety function after it was returned to its normal operating temperature. The inspector finally concluded that the corrective actions planned should address the identified concerns. The issues associated the loose shaft sleeve nut will be addressed in NRC Inspection Report 50-482/96-05.

5 SURVEILLANCE OBSERVATIONS (61726)

Using Inspection Procedure 61726, the inspectors observed portions of the following surveillance tests:

- STS IC-701D Response Time Test of Loop 4, Protection Set IV, T_{COLD} RTDs
- STS EM-100B Safety Injection Pump B inservice pump test
- STS IC-204 ACOT 7300 Instrumentation Protection Set IV
- STS RE-007 Rod drop time measurement

5.1 Instrumentation and Controls Test Device Drift

On January 9, 1996, the inspector observed portions of Procedure STS IC-204. During the test, the inspector noted that the at one point, the transmitter simulator output drifted slightly above the setting required by the procedure. The technician did not note this drift prior to recording data. The inspector asked the technician if the drift affected the data. The technician responded by stating that, while it did not affect the test in progress, it could affect other surveillance tests. The inspector also noted that the procedure did not require the technicians to monitor the output of the transmitter simulator prior to recording the data. The inspector concluded that test equipment drift has the potential to generically affect other surveillance tests. The inspector also concluded that this surveillance satisfactorily demonstrated the applicable Technical Specification surveillance requirements, and that the observed drift in this case had no impact on the results of this test. The instrumentation and control supervisor discussed this issue with the technicians involved, and directed all of the instrumentation and control first-line supervisors to discuss the potential for input signal source drift with all instrumentation and control technicians. The inspector concluded that these corrective actions were appropriate.

Procedure STS IC-204 contained two different methods of designating test switches in the solid state protection set cabinets. The instrumentation and control supervisor initiated a change to the procedure to eliminate the inconsistency, and directed instrument and controls personnel to review other instrumentation and control surveillance procedures for generic applicability. The inspector concluded that these corrective actions were appropriate.

6 ONSITE ENGINEERING (37551)

The inspectors reviewed and evaluated engineering activities using Inspection Procedure 37551.

6.1 Minimum Room Temperatures

On January 23, 1996, while touring the auxiliary building, the inspector noted that the electrical penetration rooms on the 2026 foot level were being maintained at different temperatures. The temperature in Electrical Penetration Rooms A and B were approximately 52°F and 80°F, respectively. The inspector discussed the concern with the shift supervisor. The shift supervisor found that Updated Safety Analysis Report, Table 3.11(B)-1 contained maximum (104°F) and minimum (60°F) normal operating temperatures for the electrical penetration rooms. The shift supervisor initiated PIR 96-0205 to evaluate the effects of maintaining the room below 60°F.

The system engineer found that Updated Safety Analysis Report, Section 9.4.3.1.2 also contained a requirement to maintain the rooms between 60°F and 104°F in power generation design basis four. The engineer explained that the only basis for the lower limit was that the equipment was capable of

maintaining the room above that temperature. As a result of the concern, operations management provided guidance to the operators to manually turn the electrical penetration room coolers on and off as needed to maintain temperature. The electrical penetration room coolers were designed to start automatically upon receipt of a safety injection signal.

The system engineer for the ventilation systems explained that the equipment in the room should not be affected by operating at lower temperatures. The inspector reviewed the equipment in the room and agreed with the determination with the possible exception of the dampers located in the room. The engineer found that the limiting components on the dampers were the seals, which remained operable in temperatures down to 40°F. The inspector noted that existing procedures did not provide protection or ensure that temperatures would not decrease to this level.

On February 6, 1996, the inspector reviewed the procedure change which provided guidance to operators for operation of electrical penetration room coolers. The inspector noted that the temperature range specified in the Updated Safety Analysis Report applied to all rooms in the auxiliary building where other temperature limits were not identified. During a tour on February 6, 1996, the inspector noted the temperature in Charging Pump B room was 52°F, below the required 60°F. The system engineer explained that the room cooler controls were interlocked with the pump so that the cooler was on when the pump was running. The inspector noted that during Fuel Cycle 8, operators normally ran Charging Pump A or B.

The inspector discussed the concern with the failure to meet the Updated Safety Analysis Report commitments with the Vice President Plant Operations. The Vice President acknowledged the concern and stated that the performance improvement request (PIR) would be expanded to address the concern to ensure that there were no operability concerns and that one possible outcome would be a change to the Updated Safety Analysis Report.

The inspector found that the corrective actions would address the concern and that no operability concerns were identified. The inspector concluded that failure to maintain the room temperature within the limits called out in Updated Safety Analysis Report, Section 9.4.3.1.2 and Table 3.11(B)-1, was a deviation from Updated Safety Analysis Report commitments (482/9602-01).

7 PLANT SUPPORT ACTIVITIES (71750)

The inspectors reviewed and evaluated plant support activities using Inspection Procedure 71750.

Reactor Coolant System Activity

On January 4, 1996, the inspector noted that the licensee entered Action Level II of Procedure ADM 01-221, "Failed Fuel Action Plan," Revision 4, after the fuel reliability indicator value reached levels above 6.9 E-3 for a period

of 7 days. The inspector noted that the licensee had already been accomplishing all the actions required at Action Level II prior to reaching this level, and had been closely monitoring the changing coolant activity trends. The licensee continued to estimate that the fuel contained a small number of leaking fuel pins, and that the defects continued to slowly open toward the end of the fuel cycle. Prior to the event discussed in Section 2.1 of this report, chemistry personnel did not expect the fuel reliability indicator to reach Action Level III prior to the projected start date of Refueling Outage VIII. The inspector concluded that the chemistry monitoring of failed fuel had been good and that the licensee response had been appropriate.

8 FOLLOWUP - PLANT SUPPORT (92904)

8.1 (Closed) Unresolved Item 482/9525-02: Radiography Area Not Cleared of Personnel

This item involved the discovery of technicians inside a radiography boundary, but outside the high radiation area boundary during radiography operations. Health physics personnel controlled the activity using Radiation Work Permit 95007, Revision 2, which required the radiographer to comply with Procedure AP 25B-200, "Radiography Guidelines," Revision 0. Step 5.1 of Procedure AP 25B-200 required the radiographer to ensure that the area was unoccupied after radiological postings had been established and prior to exposing the radiography source. During discussions, the inspector learned that the radiographer and the radiographer's assistants checked accessible areas and shook locked doors as part of their verification that the posted area was unoccupied. Since the technicians in the electro-hydraulic room did not respond when the radiography personnel shook the door, they assumed that the room was unoccupied. The licensee initiated significant PIR 95-3024, stopped radiography, developed and implemented immediate corrective actions, and has subsequently completed additional radiography in the turbine building successfully.

Step 5.5 of Procedure AP 25B-200, required the shift supervisor to ensure that appropriate announcements were made on the Gaitronics plant communication system. Although, the radiographer performed radiography at the north end of the turbine building, the radiographer posted the entire 2065 foot elevation of the turbine building as a radiography area. However, the shift supervisor's announcement only stated that radiography had been taking place at the north end of the turbine building. Consequently, the technicians in the electro-hydraulic room, knowing that they were near the south end of the turbine building, did not understand that they were inside the radiography boundary. The inspector concluded that, while the Gaitronics announcements accurately identified the location of the actual radiography, they did not correlate with the posted radiography, and thus contributed to the confusion.

The inspector concluded that the failure of the radiographer to ensure that the radiography area was unoccupied prior to exposing the source is a violation of Technical Specification 6.11 (482/9602-02).

8.2 (Closed) Violation 482/9524-01: Resin Spill - Inadequate Radiation Work Permit

This item involved the failure of health physics personnel to provide an adequate radiation work permit for resin sampling. The violation listed two examples where the applicable procedure had been violated. In the response the licensee agreed with the violation, but expressed concern with the characterization of one of the examples. The example discussed the sampling activity as a system breach. The licensee asserted that the sampling activity was not a system breach, and acknowledged that the procedure had contained a weak definition of system breach. The licensee further stated that the procedure had been revised to more clearly define a system breach. The inspector concluded that an improved definition will enhance the ability of licensee personnel to comply with the procedure.

The licensee concluded that the root cause was personnel error in the preparation of the radiation work permit. Corrective actions included revising the radiation work permit, counseling the personnel responsible for preparing radiation work permits, and entering the details of the event into the training IMPACT system to evaluate the applicability of this event on future training. The inspector concluded that the corrective actions addressed the concerns raised by this violation.

9 LER REVIEW - ONSITE (92700)

(Closed) LER 482/95-006-00/01

This item involved the loss of a safety-related 4160 volt alternating current bus as a result of moisture intrusion in a switchyard control cabinet. This event was discussed in NRC Inspection Report 50-482/95-24, Section 2.2. During the evaluation, the licensee identified work coordination issues with the Western Resources System Operations organization that performed work in the switchyard. The inspector reviewed the licensee's corrective actions, and concluded that they appeared adequate to address these coordination concerns. The inspector did not identify any other new issues in the LER and concluded that the licensee's corrective actions were appropriate.