UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-8064

OCT - 1 1997

Otto L. Maynard, President and
Chief Executive Officer
Wolf Creek Nuclear Operating Corporation
P.O. Box 411
Burlington, Kansas 66839

SUBJECT: NRC INSPECTION REPORT 50-482/97-11 AND NOTICE OF VIOLATION

Dear Mr. Maynard:

Thank you for your letter of September 19, 1997, in response to our letter and Notice of Violation dated August 21, 1997. We have reviewed your reply and find it responsive to the concerns raised in our Notice of Violation. We will review the implementation of your corrective actions during a future inspection to determine that full compliance has been achieved and will be maintained.

Sincerely,

Thomas P. Gwynn, Director
Division of Reactor Projects

Docket No.: 50-482
License No.: NPF-42

cc:
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Wolf Creek Nuclear Operating Corp.
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bcc to DCD (IE01)

bcc distrib. by RIV:

Regional Administrator	Resident Inspector
DRP Director	SRI (Callaway, RIV)
Branch Chief (DRP/B)	DRS-PSB
Project Engineer (DRP/B)	MIS System
Branch Chief (DRP/TSS)	RIV File

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bcc to DCD (IE01) IE06

bcc distrib. by RIV:

Regional Administrator	Resident Inspector
DRP Director	SRI (Callaway, RIV)
Branch Chief (DRP/B)	DRS-PSB
Project Engineer (DRP/B)	MIS System
Branch Chief (DRP/TSS)	RIV File

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WOLF CREEK
NUCLEAR OPERATING CORPORATION

Clay C. Warren
Chief Operating Officer

September 19, 1997

WO 97-0099

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Mail Station P1-137
Washington, D. C. 20555

Reference: Letter dated August 21, 1997, from T. P. Gwynn, NRC, to O. L. Maynard, WCNOC

Subject: Docket No. 50-482: Response to Notice of Violations 50-482/9711-06 and 9711-07

Gentlemen:

This letter transmits Wolf Creek Nuclear Operating Corporation's (WCNOC) response to Notice of Violations 50-482/9711-06 and 9711-07. Violation 9711-06 cites two examples of workers failing to have the correct dosimetry required by the Radiation Work Permit. Violation 9711-07 addresses a failure to assess and report a loss of emergency communications capability within the 1 hour time limit.

WCNOC's response to these violations is provided in the attachment. If you have any questions regarding this response, please contact me at (316) 364-8831, extension 4485, or Mr. Richard D. Flannigan at extension 4500.

Very truly yours,

Clay C. Warren

CCW/jad

Attachment

cc: W. D. Johnson (NRC), w/a
E. W. Merschoff (NRC), w/a
J. F. Ringwald (NRC), w/a
J. C. Stone (NRC), w/a

97-1778

P.O. Box 411 Burlington, KS 66839 Phone (316) 364-8831

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Violation 50-482/9711-06:

"Technical Specification 6.1.1 requires, in part, that radiation workers adhere to procedures for personnel radiation protection consistent with the requirements of 10 CFR Part 20.

Administrative Procedure AP 25B-100, "Radiation Worker Guidelines," Revision 4, Section 6.3.6, states that "Individuals shall comply with the RWP [Radiation Work Permit] requirement."

Contrary to the above:

1. On June 26, 1997, a worker entered the radiologically controlled area without the neutron dosimetry required by Radiation Work Permit 970103.

2. On July 7, 1997, a worker entered the radiologically controlled area without the electronic dosimetry required by Radiation Work Permit 970003."

Reason for Violation:

Example One:

On June 26, 1997, a technician, assigned to perform work in the Containment Building, attended the Containment entry pre-job briefing. During this briefing, dosimetry requirements for Containment entry on Radiation Work Permit (RWP) 970103 were discussed. This discussion included the use of neutron dosimetry in place of the normal thermoluminescent dosimeter (TLD). During the briefing the workers were given neutron dose calculation sheets to document appropriate information. These sheets are also used to document authorization of the workers to the RWP's. After the pre-job briefing was completed, the Health Physics Technicians covering the activity gave the workers authorization for access on the respective RWPs. This required data input through the MAPPER computer, which in turn updates the ARACS computer used by the workers for signing into the RCA. The time it takes the MAPPER computer to update the ARACS computer can be lengthy. Also, when signing in with a neutron TLD, a worker must use the normal TLD, which has the necessary bar code required for signing in through ARACS, and then return the normal TLD to the storage rack and take the neutron TLD from the storage rack in the back of the Health Physics Shift Technician Office.

The technician attempted this ARACS sign in process three times unsuccessfully. After a short break on the fourth attempt, the technician succeeded in the sign in process. Throughout this process the technician was distracted by coworkers who were having the same problem with signing in, and who had become frustrated with the process. The technician then forgot to change the normal TLD for the required neutron TLD, and entered the RCA. Prior to reaching Containment the technician realized the mistake, exited the RCA and reported the occurrence to the Health Physics Shift Technician. The technician did have both a normal TLD and an electronic alarming dosimeter (PD-1), and he did not access the Containment or any other neutron radiation areas. As a result, the Technician was monitored correctly for the areas he accessed, and there was no adverse radiological consequence to this particular entry. The technician was assigned a dose of 0 (zero) for the questioned entry.

The technician was counseled about his mistake, and allowed to go back to work. A Performance Improvement Request (PIR) was initiated to identify, track, and document corrective actions.

Example Two:

On July 7, 1997, an employee, while signing into the Radiological Control Area (RCA) on Radiation Work Permit RWP 970003, was distracted when the Health Physics Shift Technician asked a question concerning his work. The employee then accidentally left his PD-1 on the reader and entered the RCA with just a TLD. A short time later the employee noticed the absence of the PD-1, exited the RCA and reported to the Health Physics Shift Technician. The PD-1 was then located in one of the storage racks at Access Control. The employee had a TLD, which is used for legal dose tracking, in possession at all times. The potential exposure was evaluated, and a dose of zero was assigned. A Performance Improvement Request (PIR) was initiated to identify, track, and document corrective actions.

Root Cause

The root cause of these events was inattention to detail caused by on the job distractions during RCA sign in process. A contributing factor was the lack of a strong continuing training program for all radworkers.

Corrective Steps Taken and Results Achieved:

- Each worker in the examples cited above notified the Health Physics Shift Technician immediately upon discovering the dosimetry discrepancies. This resulted in a potential reduction of exposure, and allowed Health Physics to evaluate and perform corrective action in a more timely manner.

- Dose calculations were performed for the two workers. No exposure resulted from these two incidents.

- Both workers involved were counseled on the company's expectations for all workers to follow radiation work practices and procedures. They are now fully cognizant of the need for not letting distractions interfere with correct compliance.

Corrective Steps To Be Taken And Date When Full Compliance Will Be Achieved:

- WCNOC is currently monitoring and challenging workers entering the RCA. This is a short term action that will be implemented until further evaluation can be performed.

- A stronger emphasis is being placed on initial and requalification training for radworkers.

- "Just-In-Time" training is being conducted to reinforce Radiation Protection policies and supplement radworker training. This training includes a practical factors qualification for radworkers to demonstrate the correct login, dressout, undress and RCA exit procedures. Personnel currently qualified as TLD holders are expected to complete this "Just In Time" training by October 2, 1997, or they will not be allowed access to the RCA until the training is completed.

- The Manager of Radiation Protection has given direction for Health Physics department personnel to question radworkers on expected standards.

- In an effort to improve human performance in the Access Control area, WCGS Health Physics will submit a proposed facility change to be evaluated using the design change process. This proposal will be submitted by January 1, 1998.

Violation 50-482/9711-07:

"Title 10 Code of Federal Regulations 50.72(b)(v) requires, in part, that licensees report as soon as practical and in all cases within 1 hour of the occurrence of any event that results in a major loss of emergency communications capability.

Administrative Procedure AP 26A-001, "Reportable Events - Evaluation and Documentation," Revision 3, Attachment A, defines a major loss of emergency communications capability as a loss of 3 or more of the 11 emergency plan sirens.

Contrary to the above, on June 16, 1997, at 1:03 a.m., a storm caused 6 of the 11 emergency plan sirens to be inoperable and the licensee failed to report this condition within 1 hour. Due to inadequate assessment, the licensee initially believed that only two sirens were inoperable until July 16, 1997, when the event notification was made."

Reason for Violation:

On June 16, 1997, a severe thunderstorm struck the Coffey County area. At 0130 hours, the Burlington substation, which supplies power to four of the eleven Emergency Preparedness sirens, was struck by lightning and did not supply power to these four sirens for approximately five hours. Power to these four sirens was not completely restored until 0555 hours.

It was also determined that there was a momentary loss of power from the Burlington City Substation which supplies power to two sirens within the city of Burlington. Since the Burlington City substation has backup power, and was able to quickly restore power to its two sirens, a notification to the Coffey County Sheriff's Dispatcher was not required.

Root Cause

The WCGS program for determining when sirens are without power is based on formal letters of agreement between the Coffey County Emergency Preparedness Organization and the utilities supplying the power. Each of the four utilities supplying power to the WCGS sirens are required to notify the Coffey County Sheriff's Dispatcher upon identifying a siren power loss. The required notification of the loss of power from the Burlington substation was not made to the Coffey County Sheriff's Dispatcher. This was the root cause of the failure to make the one hour notification to the NRC required by 10 CFR 50.72 (b) (1) (v)

It was identified during subsequent investigation that if a WCNOC employee had not awakened during the storm, and questioned the loss of power and its potential effect on emergency sirens, the loss of power to the six sirens would never have been known.

Although the event did not affect the plant or plant personnel safety, it could have impeded the ability to notify members of the public in the event of an emergency classification of a Site Area or General Emergency. Had there been an emergency classification during this time, the backup means of providing notification to the public --- the Sheriff's Department dispatching of squad cars to the affected areas --- would have been used.

Corrective Steps Taken and Results Achieved:

- The Coffey County Emergency Preparedness Organization has agreed to reaffirm the letters of agreement with each of the utilities that provide power to the alert and notification system sirens.

- As an aid to each utility, instructions providing guidance for reporting siren power outages were generated by WCGS personnel and given to Coffey County Emergency Preparedness for distribution to the utilities. These instructions are unique to each utility, and contain a list of the sirens located within that utility's power distribution system, the power circuit or substation which provides power to each siren, and the phone number of the Coffey County Sheriff.

- Coffey County Emergency Preparedness has agreed to modify the Coffey County emergency plan, to ensure there is a firm commitment for the Coffey County Sheriff's Dispatcher to contact the WCGS Control Room in the event of a loss of power to any of the Wolf Creek sirens.

- WCGS has provided to the Coffey County Emergency Preparedness organization a complete list of all eleven sirens' power sources for use by the Sheriff's Dispatcher.

Corrective Steps To Be Taken And Date When Full Compliance Will Be Achieved:

- To provide a means to quickly and easily identify which sirens are effected by the various power supplies, AI 26A-001, Revision 0, "WCNOC Reportability Handbook" will be revised to include additional guidance on siren power supplies. This revision will be completed by October 30, 1997.

- WCNOC is evaluating the benefits of installing a system which would allow constant monitoring of the sirens.