Omaha Public Power District
444 South 16th Street Mall
Omaha, Nebraska 68102-2247
402/636-2000

August 24, 1995
LIC-95-0159

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

References: 1. Docket No. 50-285
2. Letter from NRC (J. E. Dyer) to OPPD (T. L. Patterson) dated July 25, 1995

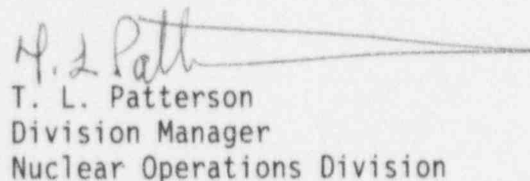
Gentlemen:

SUBJECT: NRC Inspection Report No. 50-285/95-09, Reply to a Notice of Violation

The subject report transmitted a Notice of Violation (NOV) resulting from an NRC inspection conducted May 21 through July 1, 1995 at the Fort Calhoun Station. Attached is OPPD's response to this NOV.

If you should have any questions, please contact me.

Sincerely,



T. L. Patterson
Division Manager
Nuclear Operations Division

TLP/epm

Attachment

c: Winston and Strawn
L. J. Callan, NRC Regional Administrator, Region IV
S. D. Bloom, NRC Project Manager
W. C. Walker, NRC Senior Resident Inspector

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Employment with Equal Opportunity

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REPLY TO A NOTICE OF VIOLATION

Omaha Public Power District
Fort Calhoun Station

Docket: 50-285
License: DPR-40

During an NRC inspection conducted on May 21 through July 1, 1995, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," (60 FR 34381; June 30, 1995), the violation is listed below:

> 10 CFR Part 50, Appendix B, Criterion V, and the Fort Calhoun Quality Assurance Plan, Revision 3, Section 2.1, Paragraph 4.2.1, state, in part, that activities affecting quality shall be prescribed by documented instructions or procedures and shall be accomplished in accordance with these instructions or procedures.
>
> Standing Order SO-G-101, "Radiation Worker Practices," Section 5.6.2, states, in part, that personnel are not to reach across contamination area boundaries.
>
> Contrary to the above, on June 12, 1995, a radiation protection technician, located inside a contaminated area, reached across a contamination area boundary and touched a clipboard in the hands of another person located in a clean area.

This is a Severity Level IV Violation (285/9509-01) (Supplement I).

OPPD Response

A. The Reason for the Violation

The violation occurred during the process of preparing to transfer an equipment sipping cask from the Spent Fuel Pool (SFP) to the Railroad Siding (RRS) area. The persons involved in the violation included the Radiation Protection (RP) technician who was inside the posted contaminated area of the SFP preparing for the transfer, an individual, from the training department (in the clean area), who was assigned to conduct an self-assessment of the radiation protection activities, and an additional RP technician who was located in the clean area outside of the SFP area.

The RP technician, located in the SFP area, the assessor and the RP technician, located outside the contaminated area, were discussing plans to upgrade the SFP from a Contaminated Area to a Highly Contaminated

Area/High Radiation Area. The RP technician, located outside the contaminated area, had rope and a new posting for the SFP railing. During a discussion of the new area boundaries the RP technician, who was located inside the contaminated area, broke the plane of the contaminated area boundary with a gloved hand while speaking with the assessor and the second RP technician. In subsequent discussions the RP technician, located inside the contaminated area, again reached across the contaminated area boundary, this time physically touching the notepad of the assessor. This incident occurred while the RP technician inside the contaminated area was attempting to clarify area postings that had been sketched on the assessor's pad. The assessor was holding the notepad within one foot of the boundary so the RP technician inside the contaminated area could see the drawing. Neither the assessor nor the technician located outside the contaminated area corrected the actions of the technician located inside the contaminated area, on the spot, in accordance with management expectations.

A Human Performance Evaluation System (HPES) evaluation of the event was conducted and reached the following conclusions; (1) The activities surrounding the event were disorganized and rushed; (2) Although the RP technician who was located in the contaminated area was an experienced technician who was familiar with fuel sipping jobs and related job coverage, there was an insufficient degree of attention to job detail applied by that technician; (3) Confusion resulting from a change in job coverage duties, changes in personnel at the job site, and a general lack of pre-job planning contributed to the incident; and (4) the assessor, who was assisting in his first assessment was unaware of management's expectations regarding immediate correction of performance deficiencies.

The RP technician who was located outside of the contaminated area stated that he did not notice either of the boundary infractions.

B. <u>Corrective Steps Which Have Been Taken and the Results Achieved</u>

1) Appropriate disciplinary action has been administered to the Radiation Protection (RP) technician who violated the contamination boundary.

2) The individual who had been conducting the assessment was counseled by his immediate supervision on management expectations concerning immediate correction of performance deficiencies.

3) A briefing was conducted with RP operations technicians on the

incident and management expectations for procedural compliance and attention-to-detail. RP operations technicians are only those technicians who provide RP coverage at the job sites.

4) The incident was also included in a Radiation Protection Departmental meeting where management expectations of attention to detail and procedural compliance were again reinforced.

5) The training department has verified that the subject of reaching across contamination boundaries is adequately covered in general employee training.

6) Articles were published in the station's "On-line," a weekly publication, reinforcing attention-to-detail while in the Radiologically Controlled Area (RCA) and emphasizing the requirements for not reaching across boundaries of contaminated areas.

Subsequently, the Quality Assurance (QA) organization has completed one surveillance of the RP department where this type of problem has specifically been evaluated. Another QA surveillance is looking into problems of this nature. No boundary violations have been observed since implementing the immediate corrective actions by either of these surveillances.

C. <u>Corrective Steps Which Will be Taken to Avoid Further Violations</u>

1) A Human Performance Enhancement System (HPES) evaluation of this event is being performed (HPES # 95-032). Recommendations from the HPES report will be evaluated and an implementation schedule developed by September 15, 1995.

2) A plant wide procedure providing guidance on how to conduct self-assessments is being written. This procedure will provide managements expectations on how and when to correct the personnel being assessed. The assessor(s) will be briefed on the requirements of this procedure prior to participating in a self-assessment. This procedure will be implemented prior to November 1, 1995.

3) RP supervisory personal are discussing this incident and management expectations with RP personnel during RP weekly continuing training. This training will be completed by October 31, 1995.

4) The RP department will conduct a surveillance during the month of February 1996 to assure that the long term actions being taken are effective. The surveillance will be completed by March 1, 1996.

D. Date When Full Compliance Will Be Achieved

OPPD is currently in full compliance.