VERMONT YANKEE NUCLEAR POWER CORPORATION



Ferry Road, Brattleboro, VT 05301-7002

ENGINEERING OFFICE 580 MAIN STREET BOLTON, MA 01740

September 5, 1995 BVY 95-99

U.S. Nuclear Regulatory Commission Attn: Document Control Desk Washington, D.C. 20555

(b)

References:

(a) License No. DPR-28 (Docket No. 50-271)

Letter, USNRC to VYNPC, NRC Inspection No. 50-271/95-18, dated 8/7/95

Subject: Reply to a Notice of Violation - Inspection Report No. 50-271/95-18

This letter is written in response to Reference (b), which documents that our activities were not conducted in full compliance with NRC requirements. This violation, classified as Severity Level IV, was the result of an NRC inspection conducted on June 20-22, 1995. Our reply to the Notice of Violation is provided below.

VIOLATION:

Technical Specification (TS) 6.5.B.1 states in part, "In lieu of the 'control device' or 'alarm signal' required by paragraph 20.203(c)(2), each high radiation area in which the intensity of radiation is 1000 mrem/hr or less shall be barricaded and conspicuously posted as a high radiation area and entrance thereto shall be controlled by requiring issuance of a Radiation Work Permit.", and "The above procedure shall also apply to each radiation area in which the intensity of radiation is greater than 1000 mrem/hr. In addition, locked doors shall be provided to prevent unauthorized entry into such areas and the keys shall be maintained under the administrative control of the Shift Supervisor on duty and/or the Plant Health Physicist."

Contrary to the above, on May 17, 1995, the access door to the area around the steam tunnel entrance in the reactor building was discovered unlocked, and access was not otherwise controlled to prevent unauthorized entry. The duration of this condition was approximately nineteen hours. Actual maximum dose rates in the steam tunnel area exceeded 1000 mrem/hr and were found to be up to 1500 mrem per hour at a distance of 30 centimeters from the source of the radiation.

This is a Severity Level IV violation.

RESPONSE:

Reason for the Violation

Vermont Yankee does not contest this violation. This event is attributed to personnel error as the responsible individual, a Radiation Protection Technician, appropriately trained on governing procedures, failed to comply with the requisite controls for locked high radiation area (LHRA) doors and keys. Interviews with the Radiation Protection Technician immediately following discovery of the

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condition indicated that the LHRA key was returned before the work at the LHRA doorway had been completed.

Immediate Corrective Actions

Upon discovery of the unlocked door on May 17, 1995, the door was immediately locked and an investigation of the event commenced. Dosimetry records were reviewed for the period the door had been left unlocked. Personnel dose and dose rate history records from this search indicated that no entries into this high radiation area had been made. The individual responsible was counseled and disciplined for this failure to comply with site procedures and the Radiation Protection Manager conducted a briefing with the Radiation Protection Technician staff to inform them of the event and the sensitivity expected for all high radiation area work and controls.

Further, on June 21, 1995 the procedure for control of LHRA's was modified to require dual, independent verification of the closure of all LHRA doors upon exit. This additional verification has been effective in proventing recurrence.

Continuing Corrective Actions

In addition to the immediate corrective actions, Vermont Yankee has sought to deepen the defense against the impact of personnel errors on control of high radiation areas.

Vermont Yankee's Event Report root cause analysis process has been employed for this event in order to identify the underlying causes so that our corrective actions are effective in preventing recurrence. This process has identified two additional changes which will be implemented into the procedure for control of access to LHRAs. A requirement will be added to provide the recipient of a LHRA key with a copy of key-holder responsibilities as defined in the procedure requirements for access to and exit from an LHRA. This will aid those workers who infrequently enter LHRAs in focusing on the specific procedural requirements. Additionally, to preclude loss, a large tag will be attached to each LHRA key upon issuance. These procedure revisions will be implemented by 10/18/95.

A self-assessment team under the direction of the Radiation Protection Manager, comprised of a multidisciplined group of site radiation workers has been formed to assess if other obstacles to worker compliance with radiation protection requirements exist. The areas of focus will include training and radiological protection effectiveness, worker attitudes and awareness. Recommendations from this assessment will be incorporated into site training material and procedures by January 1, 1996.

We trust that the enclosed information is satisfactory; however, should you have any questions or desire additional information on this issue, please do not hesitate to contact us.

Sincerely,

VERMONT YANKEENUCLEAR POWER CORP.

Donald A. Reid

Vice President, Operations