Nebraska Public Power District

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June 12, 1992

U. S. Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, DC 20555

Gentlemen:

Subject: NPPD Response to Inspection Report 50-298/92-06 (Reply to a Notice of Violation)

During an NRC inspection conducted March 8, 1992, through April 18, 1992, one violation was issued for failure to meet the requirements of the Special Work Permit procedure. Following is a statement of the violation and our response thereto in accordance with 10CFR2.201.

Statement of Violation

Technical Specification 6.3.4 states, in part, that radiation control procedures shall be maintained.

On February 17, 1992, licensee personnel failed to maintain radiation control procedures during entry into a heater bay, a high radiation area, to operate a system, as discussed below:

A. Section VIII.C.1 of Procedure 9.1.1.4, "Special Work Permit," states, in part, that the individual in charge of the job is responsible to notify health physics prior to work start in a special work permit area.

Contrary to the above, a radiation control procedure was not maintained in that operations personnel entered a high radiation area to operate a plant system without prior notification to health physics.

B. Section 8.1.4.1.c of Procedure 9.1.1.1, "Radiation Protection at CNS", states, in part, that the shift supervisor shall ensure that all work to be performed which involves known or potential hazards, has received review by health physics.

Contrary to the above, a radiation control procedure was not maintained in that operations personnel performed work in a high radiation area that involved potential radiological hazards and a review was not performed by health physics prior to initiation of the work.

This is a Severity Level IV violation. (Supplement IV) (298/9206-02)

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Reason for Violation

Members of the operating crew entered the heater bay to investigate why the level in feedwater heaters A-3 and A-4 would not control automatically. They discovered the air inlet filter to air operated valve CD-AOV-LCV61A (A-4 heater) had come apart causing the valve to fail open. The Shift Supervisor, after assessing the situation, decided to take manual control of the heater levels by manually manipulating CD-AOV-LCV61A. The crew did not interpret this manipulation to be "Work" as described in Procedure 9.1.4, Protective Clothing (Anti-C).

The Shift Supervisor did not consider this evolution to pose a "Potential Hazard" because the evolution had been performed in the past with minimal personnel exposure and because the heater bay is part of the operator's daily rounds. Therefore, in his view, the health physics reviews called for in Procedure 9.1.1.1, Radiation Protection at CNS, were not required.

In summary, the reasons for the violation were a difference in interpretation of the definition of "Work", and the Shift Supervisor not considering this evolution to pose a "Potential Hazard".

Corrective Steps and the Results Achieved

During a routine review of Special Work Permits, health physics noted an unusually high personnel exposure for several operators who made heater bay entries on February 17, 1992. In order to determine the cause of this high exposure, a Radiological Safety Incident Report (RSIR 92-1) was generated and a multidisciplinary Root Cause Task Force was appointed to investigate the incident.

The evaluation of this RSIR resulted in the recommendation of several action items to preclude recurrence. Those items that have been completed are:

- Review of the existing Shift Supervisor and on-duty Health Physics technician communications technique.

- The procedural discussion of what constitutes "Work" and what constitutes "Tour and Inspection" has been clarified and moved from Procedure 9.1.4, Protective Clothing (Anti-C), to Procedure 9.1.2.4, Access Control-Radiological.

- The Division Manager Of Nuclear Operations has publicized "Maintaining a Questioning Attitude" by issuing a letter to all CNS personnel discussing this event and the need for a Questioning Attitude.

In addition, discussions were held with the Shift Supervisor in charge at the time of this incident and the person providing on-shift health physics coverage. The Division Manager Of Nuclear Operations, as a result of these conversations, issued a letter to the Operations Crew enforcing the importance of following procedures. A similar letter was issued to the Radiological Department emphasizing the importance of maintaining a questioning attitude toward unanticipated radiation exposures during plant evolutions.

Corrective Steps Which Will Be Taken To Avoid Further Violations

The following actions are in progress:

- A discussion of what constitutes "Work" and what constitutes "Tour and Inspection" is being added to Procedure 2.0.1, Operations Department Policy.

- The Training Department has been directed to perform the following:

  A. Incorporate this event into Industry Events training for both the Operations and Radiological Departments, with emphasis on maintaining a "Questioning Attitude".

  B. Expedite the CNS ALARA program training currently scheduled.

  C. Upgrade the feedwater heater level control system training program.

- Senior operations management is in the process of conducting meetings with operations management and supervisory personnel (including shift supervisors) emphasizing the importance and adherence to the questioning attitude concept.

Date Station Operator Compliance Will Be Achieved

NPPD is currently in compliance with the requirements stated in the violation. The remaining corrective steps identified in the "Corrective Steps Which Will Be Taken To Avoid Further Violations" section will be completed by August 31, 1992.

Should you have any questions concerning this matter, please contact me.

Sincerely,

G. R. Horn
Nuclear Power Group Manager
Cooper Nuclear Station

GRH:cl-24B

cc: Regional Administrator
U. S. NRC - Region IV

NRC Resident Inspector
Cooper Nuclear Station