DD-92-05

UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION
OFFICE OF NUCLEAR REACTOR REGULATION

Thomas E. Murley, Director

In the Matter of	)	
	)	
HOUSTON LIGHTING & POWER COMPANY	)	Docket Nos. 50-498 and 50-499
	)	10 CFR § 2.206
(South Texas Project, Units 1 and 2)	)	

DIRECTOR'S DECISION UNDER 10 CFR § 2.206

I. INTRODUCTION

On February 10, 1992, Mr. Thomas J. Saporito, Jr. (the Petitioner) filed a Petition with the U.S. Nuclear Regulatory Commission (NRC) pursuant to 10 CFR § 2.206 requesting actions be taken regarding the South Texas Project, Units 1 and 2 (STP) of the Houston Lighting and Power Company (HL&P or licensee). Specifically, the Petitioner requested the NRC to institute a proceeding pursuant to 10 CFR § 2.202 and to take swift and effective actions because of the Petitioner's concerns in the areas of physical security, maintenance activities, compliance with technical specifications and procedures, and training at STP.

In the area of physical security, the Petitioner requested that the NRC cause the licensee to revoke all escorted access to the South Texas site and to adequately train all employees and security force personnel in using relevant security procedures. With regard to maintenance activities the Petitioner requested that the NRC cause the licensee to invoke an immediate standdown of all maintenance activities, to adequately train personnel in the use of Revision 3 of the Work Process Program, Revision 0 of the Maintenance

Work Practices and Requirements, and Revision 0 of the Planner's Guide. The Petitioner also requested that the NRC take swift and effective actions to cause the licensee to comply with the South Texas Project's technical specifications and procedures. On February 18, 1992, the Petitioner met with the NRC staff in the Region IV offices to discuss certain issues presented in the Petition and other concerns.[1]

On March 24, 1992, I informed the Petitioner that the Petition had been referred to my Office for the preparation of a Director's Decision. I further informed the Petitioner that, after receiving the Petition, the NRC staff immediately evaluated reactor safety at STP and performed a special team inspection to evaluate the concerns raised in the Petition. As a result of the evaluation and inspection, the NRC staff found that the concerns either could not be substantiated, or if they were substantiated did not involve nuclear safety, or were not safety concerns of such importance to warrant the immediate and swift actions requested in the Petition. Therefore, I denied the Petitioner's request for the NRC to take immediate action. I also informed the Petitioner that the NRC would take appropriate action within a reasonable time regarding the specific concerns raised in the Petition.

The licensee also responded to the issues raised in the Petition. The licensee voluntarily submitted information to the NRC on March 11 and May 1, 1992, regarding the issues raised by the Petitioner.

My Decision in this matter follows.

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[1] At this meeting, the Petitioner raised a number of concerns other than those set out in the Petition. Those other concerns have been handled separately by the NRC staff.

II. DISCUSSION

In response to the Petition and other concerns raised by the Petitioner, the NRC staff conducted a special team inspection at STP which included an evaluation of the concerns raised in the Petition. The five-member team was onsite during March 9-13, March 23-27, and April 14, 1992. On June 1, 1992, the NRC staff issued Inspection Report 50-498/92-07; 50-499/92-07 documenting the results of the inspection. In a letter of June 16, 1992 to the NRC Chairman, the Petitioner commended the NRC staff inspection effort as extremely definitive with very comprehensive results.

While the inspection team considered all of the concerns of the Petitioner, this Director's Decision responds only to those issues raised in the Petition, specifically the 12 items listed in the "Basis and Justification" section of the Petition.

In evaluating the physical security concerns during the recent NRC special team inspection, the NRC staff gathered specific information on the training and implementation of the security plan for the areas of concern to the Petitioner, including the control of visitors, the transfer of visitors between escorts, and tailgating. The NRC inspectors reviewed general employee training (GET) lesson plans, the qualification and size of the instructional staff, and the examinations taken by individuals at the end of instruction. The inspectors reviewed lesson plans for both the initial training and requalification training of security personnel. In this way, the team could determine the manner in which the material was presented to the employees and could determine if the employees understood the requirements. In determining how effectively the requirements were implemented, the inspectors reviewed security plans, procedures, and records governing the access and control of

the visitors at STP. The team also interviewed employees who were trained as escorts and those who had been escorted because they had at one time been classified as visitors.

The inspection team found the licensee's staffing for conducting the GET program marginally acceptable. The allocated number of instructors, which had been recently decreased, could cause significant stress on the licensee's staff, especially when large groups of people must be trained within a short time period. The licensee's GET adequately covered the escort requirements that were in effect at the time of the NRC inspection. The licensee addressed the issue of escort changes in the initial training for security personnel although this issue was not reinforced during requalification training. However, the inspection team noted that most of the employees and security officers interviewed could not successfully explain all of the aspects of visitor access and escort control.

The NRC inspectors reviewed the records and found that, on numerous occasions between January 15 and February 19, 1992 (the time period selected for inspection), visitors were transferred from assigned escorts to other escorts, but the visitor escort change logs did not reflect the escort changes. In some instances, the visitors telephoned security badging locations and requested escort changes at the request of the assigned or new escorts. Some security force members admitted they knew that visitors were requesting changes and did not realize such actions conflicted with specific procedural requirements. Some plant employees who directed visitors to contact security for escort changes also indicated that they did not realize this conflicted with the licensee's procedures.

Through interviews, it was confirmed that visitors were not always adequately controlled. It was apparently routine practice in the Instrumentation and Control (I&C) shop to leave visitors within the protected are in the shop while escorts went to adjacent areas (such as restrooms). In one instance, an escort exited the protected area ahead of a visitor. In that instance, the security officer apparently did not realize that this act conflicted with the licensee's procedures and did not take the procedurally required action in response to the incident.

On March 13, 1992, the NRC staff first informed the licensee of the team's initial findings concerning the apparent security violations. After this notification, the licensee briefed security officers in the proper way to conduct escort transfers. During a meeting on April 14, 1992, the NRC staff and the licensee discussed the complete results of the inspection and the apparent violations. The licensee senior management's immediate response to the inspection findings was to discontinue all visitor access. In a letter of May 1, 1992, the licensee informed the NRC that, until making a permanent change, "the supervision of GET training has been temporarily assigned to report to the same manager that directs HP training." This action, the licensee asserted, would allow control and coordination to quickly and easily support additional GET instructors as required. The licensee further informed the NRC that it had revised its escort procedures to require the following: (1) specially qualified escorts, (2) visual contact with the visitor at all times, (3) a card carried by the visitor with the escort's name, and (4) provisions for changing escorts by requiring the new escort to sign the visitor's card. The procedures no longer require the notification of security regarding the transfer of visitor escorts. The NRC staff has concluded that

the organizational changes and revised procedures address the deficiencies noted by the inspection team and will assess their implementation in future routine inspections.

On June 1, 1992, the NRC issued a Notice of Violation to the licensee for two violations based on the aforementioned security inspection results. One violation was for the failure of the licensee's employees to comply with the physical security plan's implementing procedure governing escort view and control of visitors. The second violation was for the failure of the licensee's employees to comply with the procedure governing the transfer or exit of visitors from the protected area.

In evaluating the maintenance concerns of the Petitioner, the NRC special inspection team reviewed both the training and implementation aspects of the concerns. The inspectors reviewed the training procedures listed by the Petitioner, the lesson plans upon which instruction was based, the qualification of the instructors, and the results of tests at the end of the instruction sessions. The inspectors also interviewed other licensee personnel whose jobs were influenced by the maintenance instruction. The inspectors reviewed completed work packages and interviewed licensee personnel, some of whom were associated with the work packages. Others were interviewed to permit the inspection team to assess maintenance implementation at STP.

The inspection team determined that the licensee had a good maintenance work control process program. This program enabled the licensee to find equipment problems, evaluate the effect of these problems on operability and the technical specification limiting conditions of operation, prioritize work activities, plan work orders, conduct maintenance activities, and close

packages. The inspection team concluded that the training provided on Station Procedure OPGP03-ZA-0090, Revision 3 (concern identified by the Petitioner) was appropriate to meet the course objectives. The inspection team concluded that course objectives were based on procedure requirements. In meeting the objectives, the licensee ensured that the fundamental program requirements could be implemented by the I&C technicians, planners, owners (i.e., the licensee's assigned system representatives), and supervisory personnel.

While overall implementation of maintenance activities was adequate, there were instances where personnel did not fully comply with some procedural requirements. For example, there were instances where individuals did not obtain work-start authority before giving work packages to craft people, individuals did not use the configuration control change log for lifting leads, and in two instances technicians worked on work requests without signing the work orders. However, the majority of the procedural requirements were being met.

The identified instances of less than full compliance with maintenance procedures only concerned maintenance performed on non-safety equipment. Examples are the conductivity instrumentation for the makeup dimineralized water and the level switches for the sodium hypochlorite dissolver tank. None of the equipment was required for safe shutdown of the plant, mitigation of accidents, or would affect offsite radiological exposure to the public. Consequently there was no violation of NRC requirements, the STP licenses, or the technical specifications. Nevertheless, the NRC staff was concerned about two aspects of the findings. First, the procedural violations of the licensee's requirements while performing nonsafety-related activities could also occur while performing safety-related activities because a single set of

administrative controls applied to all maintenance activities. However, during interviews with personnel, they indicated that their awareness was enhanced with regard to procedural requirements for safety-related activities and those requirements that could affect personnel safety. There were indications of poor morale (e.g., worker attitudes) among some maintenance workers, but there was no evidence that poor morale had adversely impacted safety related work.

The inspection team found that the work order planning process has been improved to provide uniform guidance on developing work instructions. The work instructions have become more detailed and appeared to restrict some types of wo k activities that had previously been performed by the "skill of the craft." The planning process provided (1) for review of work instructions and, in some cases, an independent technical review, (2) for foremen or planners to make revisions to work instructions depending on scope of the work activity, and (3) for a means of providing feedback on work instructions to the planners and owners. These improvements should not only enhance worker efficiency, but also improve safety in that they should provide additional barriers to human error.

The inspection team ascertained that guidance provided to the plant staff on implementation of equipment clearance orders (ECOs) was not properly received or was not well understood. The licensee's staff, responsible for implementing the equipment clearance program, indicated that the program was generally carried out in accordance with the procedural requirements. Within the scope of the inspection, the team did not find instances of improper execution of ECOs for safety-related equipment. Consequently, there were no cited violations. Because of the potential impact on safety-related

activities, the team recommended that the licensee consider including guidance on implementing the program within the procedure. The licensee's representatives stated that they would review the guidance and expected to conduct training on this matter.

Some signatures and corresponding dates on completed maintenance work packages appeared inconsistent with the times when the packages should have actually been signed and dated. During interviews of I&C technicians, foremen, supervisors, and management, it became clear that the licensee had not established a policy for late signing of a completed work package. The inspection team informed the licensee that this lack of a consistent policy for backdating signatures was a weakness. The licensee subsequently issued a station procedure to instruct employees in the acceptable method for the late signing of documents.

The Petitioner expressed concern with maintenance, primarily regarding the use of the Work Process Program (OPGP03-ZA-0090) Revision 3, which at the time was a recent procedure. On March 9, 1992, the licensee issued Revision 4 of this procedure, in which it had corrected problems that it found in the previous revision. In July 1992, the licensee issued Revision 5, which was intended to further improve use of the procedure. While the Petitioner's major concerns related to Procedure OPGP03-ZA-0090, Revision 3, he also had concerns regarding Maintenance Procedure OPM01-ZA-0040, "Maintenance Work Practices and Requirements," and the Planner's Guide, Revision 0. Through interviews, the inspection team concluded that I&C technicians demonstrated that they understood the program requirements referenced in the procedures.

Although the Planner's Guide is not required by the NRC and is not a controlled document, the NRC staff determined that maintenance activities were being improved through its use.

The inspection team findings related to physical security and maintenance were discussed with licensee senior management on April 14, 1992, and are documented in the special team inspection report IR 50-498/92-07; 50-499/92-07. The NRC staff will continue to monitor licensee performance in these areas as a part of the routine inspection program activities.

The following are the issues raised by the Petitioner, each followed by the NRC staff's evaluation.

A. Current established licensee policies and procedures do not provide reasonable assurances for the "Physical Control of STPEGS"

In 10 CFR Part 73, the NRC specifies the requirements for establishing and maintaining a security program for the physical protection of plants and materials. Before a plant can be licensed, the applicant must submit to the NRC a security plan addressing the requirements of 10 CFR Part 73 and the licensee's policies for the physical protection of the plant. Approval of the security plan is a requirement for plant licensing. Such a plan was submitted by the licensee and approved by the NRC staff. In its Supplement 4 to NUREG 0781, "Safety Evaluation Report Related to the Operation of the South Texas Project, Units 1 and 2," the NRC staff concluded that the protection provided against radiological sabotage by implementing the licensee's plan met the requirements of 10 CFR Part 73 and that the health and safety of the public would not be endangered. Licensees are permitted to make changes to the plan pursuant to 10 CFR § 50.54(p) as long as the changes do not decrease the effectiveness of the security plan.

The NRC periodically inspects each licensee's security program to determine if it is being maintained and implemented in a satisfactory manner. In the most recent Systematic Assessment of Licensee Performance (SALP) for the period ending May 31, 1991, the NRC staff concluded that the licensee management continued to demonstrate a strong commitment to implementing the security program (IR 50-498/91-99; 50-499/91-99). In August 1991, the NRC conducted a team inspection of the security program at STP. The inspection found that, with isolated exceptions, the licensee was meeting its plans and implementing an effective program to protect its facility against radiological sabotage (IR 50-498/91-21; 50-499/91-21).

The recent NRC special inspection team, as discussed above, found instances of improper control of visitors, improper transfer of visitors from one escort to another, and an improper exiting sequence of a visitor and escort, all of which were violations of the licensee's procedures. The team found that certain maintenance workers and security officers had a relaxed attitude toward visitor escort requirements and that certain personnel failed to comply with the implementing procedures for the security plan. The team documented this failure in its Inspection Report (IR 50-498/92-07; 50-499/92-07), and the NRC issued a Notice of Violation with the report. In part the Petitioner's concern was substantiated. However, the NRC staff found no indications of a programmatic breakdown in the plant physical security such that the licensee could not reasonably ensure it was in full control of the site.

On March 13, 1992, the NRC inspection team initially informed the licensee of apparent violations regarding the visitor escort procedure. In a meeting on April 14, 1992, the NRC staff further discussed these issues with

the licensee. The licensee senior management immediately discontinued all escorted access until it revised the procedures and trained the personnel. In its letter of May 1, 1992, the licensee informed the NRC staff that its revised procedures for escorting individuals took effect on April 15, 1992. The revised procedures required the following: (1) specifically qualified escorts, (2) visual contact with the visitor at all times, (3) a card carried by the visitor with the escort's name, and (4) provisions for changing escorts by requiring the new [receiving] escort to sign the visitors' cards. The licensee trained the identified escorts and implemented the new procedure. Upon conducting the reviews and inspections, the NRC staff concluded that the licensee's policies and procedures for physical security, properly implemented, would provide reasonable assurance that the South Texas Project is adequately protected. Implementation will be monitored through future NRC inspections.

B. Licensee employees are not adequately trained and knowledgeable of existing STPEGS security procedures which address escort responsibilities.

In reviewing the licensee's GET program, the special inspection team reviewed security training including staffing, lesson plans, student materials, and tests. The licensee's GET adequately addressed the requirements for visitor escorts.

The inspectors reviewed the licensee's GET tests and found that they typically included two to four questions pertaining directly to escort responsibilities. Conceivably, individuals could miss one particular area of the test year after year and still receive a passing grade. However, upon reviewing successive test results for selected individuals, the inspectors

found no patterns suggesting that individuals did not know the requirements. Moreover, as part of the training program, the trainees signed statements affirming that they had been informed of the correct answers to the questions that they had missed. In spite of this information, the inspection team noted that most of the employees interviewed could not successfully explain all of the necessary aspects of visitor access and escort control. The Petitioner's concern was substantiated. However, the NRC staff concluded that implementing the revised procedures as discussed in A. above will adequately satisfy the escort requirements.

C. Licensee employees are not adequately trained and knowledgeable of existing STPEGS security procedures which address tailgating in protected and vital station areas

The special inspection team found the licensee's GET training, which included instructions for properly entering and exiting the plant acceptable. However, the team found that the staffing levels for providing the training were marginal. The licensee addressed this issue in its May 1, 1992, letter through organizational changes that will provide for additional instructors as discussed above.

Further, the inspection team reviewed the access control records from the period of January 1, 1992 through February 15, 1992. The NRC staff found only one possible tailgating event in the records reviewed. The records of this event did not show that a visitor entered a vital area but indicated that the assigned escort had entered that vital area. However, at the next vital door requiring access, both the visitor and escort badges were recorded. Consequently, the visitor apparently did not attempt to surreptitiously enter a vital area. The Petitioner's concern was not substantiated.

D. Licensee's security force personnel are not adequately trained and knowledgeable of existing STPEGS security procedures which address escort responsibilities

The licensee's security personnel were initially trained through the GET followed by training specific to the security staff. The special inspection team also reviewed the specific training for security personnel and found it to contain all the requirements necessary for a security officer to understand and effectively perform duties concerning visitor access and escort control requirements. However, the team noted that, during the requalification training, the licensee did not reinforce the training objectives from the initial training regarding escort transfers. As discussed above, the team found that members of the security force had failed to comply with the procedures for escorting visitors. During interviews, the team found that some security personnel did not fully understand all aspects of the procedures for escorting visitors. The Petitioner's concern was substantiated.

Responding to the NRC findings, the licensee briefed all security officers on the proper way to transfer visitors between escorts and posted signs to remind personnel of escort requirements. The licensee revised the procedures for escorting visitors and completed training on the new procedures. The NRC staff concluded that the changes in escort procedures are acceptable. Initial implementation has been satisfactory. The continued implementation will be monitored by the NRC staff through the routine inspection program.

E. Licensee's security force personnel willfully and intentionally falsified STPEGS security documents.

During the February 18, 1992 meeting, the Petitioner gave the NRC staff the date of the alleged willful falsification, a reference to the falsified document, and the identity of the responsible person. The inspection team inspected the subject document, interviewed the involved personnel, and found no indication of the escort record being falsified. The Petitioner's concern was not substantiated.

F. Licensee's security force personnel willfully violated STPEGS security procedure.

As noted in the response to Concern D, examples were found where security personnel were not fully knowledgeable of all aspects of the procedures regarding the escorting of visitors. The staff determined that, for some instances of notification of escort transfer by telephone, security force members did not know that it was the visitors who requested the changes. The security force members documented the transfers because all of the information provided concerning badge numbers and names appeared correct. Some security force members admitted knowing that visitors were requesting changes and did not realize such actions conflicted with specific procedural requirements. It appeared to the NRC inspection team that instances of failure to adhere to procedures by security personnel recording transfer of escorts resulted from a lack of reenforcement during requalification training, cumbersome procedure, and difficulty in verifying personnel identities on the telephone. However, there were no indications the actions of the security personnel were willful or that the security personnel intentionally tried to compromise physical security at STP. The Petitioner's concern that security

procedures were violated was substantiated. However, the inspection team did not substantiate that the licensee willfully violated procedures.

The licensee was first informed of the team's findings on March 13, 1992. On March 27, 1992, the licensee briefed security officers in the proper way to conduct escort transfers. Subsequently, the licensee temporarily discontinued visitor access, then made organizational and procedural changes and conducted training on the procedural changes. The corrective actions as described above, are considered adequate.

G. Licensee's employees willfully and intentionally violated STPEGS security procedures.

The inspection team found instances where employees violated security procedures for controlling visitors. As mentioned earlier, there were instances where the receiving escort telephoned security to transfer a visitor or where visitors telephoned security badging locations at the request of the assigned or new escort to request escort changes. Also, there were instances in the I&C shop when visitors were left within the protected area in the shop while the escorts went to adjacent areas. However, during interviews with plant personnel, it did not appear that there was an effort made to specifically subvert the security procedures and the special inspection team noted that the personnel believed that they maintained adequate control of their visitors. Instead, the NRC staff found that employees did not fully comply with procedures because they did not completely understand them or believed that they were complying with the intent of the procedures in escorting their visitors. The inspection team did substantiate that there were procedural violations in this area. However, the team did not substantiate that the procedures were willfully and intentionally violated

with the intent to subvert the security at STP. As mentioned previously, the escort procedures have been revised adequately to address the concerns.

H. Your licensee's current work practices do not provide reasonable assurance for the safe operation of STPEGS and therefore, the health and safety of the general public

The maintenance portion of the special team inspection was in response to Petitioner's Concerns H through L, addressed in this Decision, and specific information obtained during a meeting of February 18, 1992 with the Petitioner regarding other concerns. The inspection team concluded that the licensee had established a good maintenance work control process for finding equipment problems, evaluating the effect of these problems on equipment operability and the technical specification limiting conditions for operation, prioritizing work activities, planning work orders, conducting maintenance activities, and closing maintenance work packages. Some personnel did not fully adhere to some procedural requirements as noted previously. However, most of the procedural requirements were being met. The licensee adequately completed work activities. In general, the personnel interviewed believed that shift turnovers were adequate and that their awareness was enhanced for procedural adherence with regard to procedural requirements for safety-related activities and those requirements that could affect personnel safety. During interviews with some maintenance employees the inspection team found some evidence of poor morale. This issue was previously discussed in NRC Inspection Report 50-498/91-16; 50-499/91-16. Principal issues adversely affecting maintenance workers' attitudes were the move to a new building, upcoming realignment of and duration of shift schedules, and the perceived limited training opportunities for journeymen. There was no evidence that the concerns had

adversely impacted safety-related work. These matters were discussed in general terms with the licensee's senior management on April 14, 1992. The Petitioner's concern was not substantiated.

Although the maintenance activities described by the Petitioner during the February 18, 1992 meeting were conducted on nonsafety-related systems, the team expressed concern that the licensee used the same administrative controls for both safety-related and nonsafety-related activities. Carryover problems from non-safety to safety-related maintenance have not been identified. Nevertheless, the NRC staff will continue to monitor licensee performance in this area as part of the routine inspection program activities.

I. Licensee employees are not adequately trained and knowledgeable of the current STPEGS Work Process Program (OPGP03-ZA-0090) Revision 3

During the first part of 1992, the licensee made several changes to its work process program. The principal change was to consolidate into one procedure the various procedures for finding and requesting work activities and for conducting and closing out work packages. The licensee revised Station Procedure OPGP03-ZA-0090, "Work Process Program," several times. Revision 3 of Station Procedure OPGP03-ZA-0090 became effective January 31, 1992.

During interviews, the instrumentation and control (I&C) technicians described the training as appropriate to meet the course objectives. When completing the training, many I&C technicians believed they could properly implement the procedural requirements of the maintenance process. However, when called upon to use the procedure, several I&C technicians said they had to use the maintenance process flow chart (distributed during training) to assist them in implementing the procedure.

To assess the quality of training given regarding this procedure, the inspection team reviewed the procedure, lesson plans used by the instructors, student materials, examinations, and course critiques. The team interviewed instructors, numerous planners, I&C technicians, and supervisory personnel who had received training on the procedure.

In the meeting on February 18, 1992, the Petitioner stated several concerns with training on the Work Process Program Procedure. The Petitioner alleged that the training was insufficient and included incorrect information in some cases, that testing was inadequate, and that instructors did not resolve concerns. The Petitioner objected to the licensee's definition of "unplanned exposure to radiation" and stated that (1) the licensee gave incorrect information to the class regarding the composition of lubricants used at the plant, (2) the licensee's policy of adherence to procedures was vague, and (3) training was inadequate to test the worker's knowledge because the workers were allowed to complete the examination using materials distributed previously.

The inspection team confirmed that the licensee gave incorrect information regarding the lubricant composition. As part of maintenance equipment qualification training (on January 30, 1992, following Lesson Plan MSS108.01), the class watched a film on the use of lubricants at nuclear power facilities that was produced by the Electric Power Research Institute. The film included a statement that oils consisted of 80 to 98 percent base oil and the remainder was additive. The examination following the training contained a test question asking the percentage of base oil required at the licensee's facility. The correct answer, 90 percent, was not discussed by the instructor during the training. Possible answers to the examination question regarding

site-specific requirements included multiple choices that were within the range of values given in the film. Consequently, four to five trainees answered the examination question incorrectly. As a result of student comments on the course critique, the licensee agreed to take action to emphasize that the information in the film was general and to highlight the site-specific value, which was within the range given in the film.

During interviews, the team found that some individuals did not fully understand the licensee's policy on procedural compliance. The petitioner contended that guidance involving instruction on the licensee's policy of adherence to procedures was vague. Revision 1 of the trainee handout used with Lesson Plan MSS108.01 stated: "Verbatim compliance allows no deviation from procedural steps....Procedural adherence implies meeting the intent....Deviation is expected in cases where; A. Personnel safety... B. Equipment safety" [is placed at risk]. No other discussion was included. Workers receiving work process program training had mixed responses when questioned about their understanding of these terms and as to which term described the policy in effect at the licensee's facility. While all understood that the licensee's policy was that there should be procedural adherence, some were not sure about verbatim compliance and one stated that verbatim compliance was expected. Instructors pointed out that the issue was not listed as an objective in that specific training; therefore, no examination questions addressed the issue to test (and document) workers' knowledge of the policy.

In response to the uncertainty of some employees regarding the definitions of procedural compliance and verbatim compliance, the licensee's Revision 2 of the trainee handout (dated February 28, 1992) expanded the

discussion of the terms and defined verbatim compliance as "A term used in the past to demand that the performance of steps in a procedure were done exactly as they were written; without deviation. ...[and added] STPEGS will no longer use the term." It stated: "Field application of procedural adherence implies every individual responsible for independent performance of a procedure controlled task shall meet the intent of the procedure.... Anyone SHALL perform the steps of that procedure as written unless such performance would violate the intent of the procedure." These concerns of the Petitioner were substantiated; however, the licensee took acceptable action to resolve this matter.

The team questioned licensee personnel, including members of the health physics organization, about the definition of "unplanned exposure," as referred to in the lesson plans. Licensee personnel stated that, while the term had not been explicitly defined, the meaning was clear when considered in the context of the examples of industry events given in the student materials. The team reviewed the industry events described in the student materials and noted that they were consistent with the manner in which the term was applied at the STP. Other workers who had received the training expressed no misunderstandings or concerns regarding this training. The Petitioner's concerns were not substantiated.

With regard to the use of reference materials during examinations, licensee personnel stated that they designed the examinations to test the ability of the individuals to work within the work control process, not their ability to memorize the procedure. They also stated that if workers have access to references or procedures in the field, it is appropriate to allow

them to demonstrate the use of such references during the examination. The NRC staff considers this testing method to be acceptable.

The team found that in general the classroom training on Station Procedure OPGP03-ZA-0090 Revision 3 was appropriate to meet the course objectives, which were based on the procedural requirements. The team did not substantiate the Petitioner's concern that the employees were not adequately trained.

J. Licensee employees are not adequately trained and knowledgeable of the current STPEGS maintenance work practices and requirements (OPMP01-ZA-0040) Revision 0

On January 31, 1992, the licensee implemented Maintenance Procedure OPMP01-ZA-0040, Revision 0, "Maintenance Work Practices and Requirements." This procedure contained the guidelines for conducting corrective and preventive maintenance activities in accordance with applicable site procedures and policies, conducting testing activities after maintenance to verify function and operability, and performing minor maintenance activities.

The procedure included a summary of maintenance practices and requirements and included appropriate references to supporting maintenance programs, supporting procedures, and applicable sections. The training on procedure OPMP01-ZA-0040, was incorporated with the training for OPG03-ZA-0090, which was discussed in the response to Item I above. The training was found to be appropriate to meet the course objectives, which were based on the procedure requirements.

Two of the I&C technicians interviewed about the requirements and guidance in Maintenance Procedure OPMP01-ZA-0040 could not recall having reviewed the procedure, and the remaining I&C technicians could not recall the

details in the procedure. However, I&C technicians demonstrated that they understood the program requirements referenced in the procedure, including the requirements for equipment clearance orders, configuration control, and plant labeling. The concern of the Petitioner that employees were not adequately trained and knowledgeable with regard to this procedure was not substantiated.

K. Licensee employees are not adequately trained and knowledgeable of the current STPEGS Planner's Guide, Revision 0

The licensee issued the Planner's Guide to enhance the maintenance program. The guide was not required by the NRC and was not a controlled document. The licensee developed the Planner's Guide to document good practices, guidance, and reference material in the different maintenance disciplines for performance standards, the planning and writing of work documents, material requirements, computer applications available to planners, and scheduling and expediting.

During informal group meetings, supervisors would instruct I&C technicians in using the Planner's Guide and Station Procedure OPGP03-ZA-0090 in writing work packages. The I&C technicians would review selected areas by reading them and discussing them in groups. Many I&C technicians noted that the work packages were more uniform since the licensee implemented the Planner's Guide. All the individuals interviewed indicated that the licensee had increased the detail in the work instructions. While some believed that the increased detail limited use of the "skill of the craft," many believed that management had done this to reduce the number of personnel errors. The inspection team found that there was more consistent use of cautionary statements in work packages than before implementation of the Planner's Guide.

The licensee's managers established maintenance planning expectations, one of which was that the planners would "walk down" the work orders as part of the planning process for safety-related and most other work packages. I&C technicians noted seeing planners more frequently in the plant and indicated that the quality of the work packages had improved. This indicated the successful use of the Planner's Guide.

NRC does not require use of the Planner's Guide, which was developed to enhance the maintenance process. Although the Guide was not a controlled document, the licensee appeared to be using it to improve maintenance. The licensee provided acceptable training on the document and used it properly.

Training and knowledge of the STP Planner's Guide is not required. The Planner's Guide was being implemented at STP and appeared to be enhancing the maintenance process. This concern was not substantiated.

L. Licensee employees are engaged in continuing work practices which are in violation of the STPEGS Work Process Program (OPGP03-ZA-0090) Revision 3

In implementing the Work Process Program, the licensee at times did not comply with its procedures. As mentioned in the introductory portion of the Discussion, examples included work start authority not obtained before work packages were given to crafts people, inadequate use of configuration control change log, and not following procedure regarding signing onto work orders. However, the majority of the procedural requirements were being met. Further, with one exception (the boric acid tank level transmitter calibration), the maintenance for the work packages reviewed was performed on nonsafety equipment, (e.g., equipment not required for safe shutdown of the plant, mitigation of accidents, or equipment that could affect offsite radiological

exposure to the public). During its inspection, the inspection team determined that because of the administrative nature of deficiencies in procedure implementation coupled with the application to nonsafety equipment, it did not find indications of a compromise in the quality of work or of a threat to the public health and safety. The licensee identified the need to make some improvements through its own evaluations. Before the special inspection, the licensee had issued Revision 4 to the procedure to address several implementation difficulties. To clarify the maintenance process, the licensee issued Revision 5 to OPGP03-ZA-0090 in July 1992. The inspection team found no evidence that current work failed to adhere to the maintenance Work Process Program.

III. CONCLUSION

In responding to the concerns raised by the Petitioner, the NRC staff conducted a special team inspection.

The NRC special inspection team concluded that training for both the plant employees and the security personnel was appropriate although the security requalification training did not address escort transfers. However, the team did substantiate some of the Petitioner's concerns. The licensee did not adequately implement the procedures for controlling visitors, and particularly those for escorting visitors. The team concluded that procedures governing the transfer of visitor escorts were not always followed, visitor control in the I&C shop area was sometimes not rigorous, and, in one instance, an escort exited the protected area ahead of a visitor. These conclusions prompted the NRC to issue a Notice of Violation to the licensee. The team did not substantiate the Petitioner's concerns that security documents had been intentionally falsified and that licensee personnel (both general and

security) willfully violated security procedures. The violations which were cited did not indicate a programmatic breakdown of security and did not significantly compromise the security at STP. Responding to the inspection team's findings, the licensee took corrective actions which appear to be acceptable.

In reviewing the maintenance program, the NRC staff concluded that the licensee had a good maintenance work control program and appropriate training. However, there were two instances, (oil composition and procedural adherence) which were identified by the Petitioner, where instructional information presented in the classroom was confusing. The licensee made changes to the lesson plans to clarify the information. The inspection team did recommend to the licensee a refinement of the methods for reviewing course content to ensure that conflicting or inadequate information was not presented to workers. The team reviewed the implementation of maintenance procedures and found that the implementation was done in general compliance with the procedures. However, the team did find examples of less than full compliance in the implementation of maintenance procedures as applied to nonsafety equipment and substantiated some of the Petitioner's concerns. The examples of less than full compliance with procedures were essentially administrative in nature. Because they were administrative in nature or were applied to equipment not required for safe shutdown of the plant, mitigation of an accident, or equipment which could affect offsite radiological releases, there were no violations of regulatory requirements associated with the affected maintenance activities. The NRC staff did note a concern that the same administrative controls on procedural compliance were in place for both safety and nonsafety maintenance. However, the NRC staff has not found instances

where maintenance on safety equipment has been compromised as a result of the commonly applied administrative procedures. In response to its own findings as well as those of the inspection team, the licensee took actions to resolve these matters. Several implementation difficulties were addressed in Revision 4 to OPG03-ZA-0090 (April 1992). Revision 5 to OPG03-ZA-0090 was issued in July 1992 to improve usuage of the procedure. Training on the new revision was also conducted in July. The actions appear to be acceptable. Routine inspection of maintenance activities at STP by the NRC staff will continue on an ongoing basis and will monitor the implementation of the new revision as well as the general conduct of maintenance at the site.

Several of the Petitioner's concerns were substantiated. When informed of the concerns, the licensee took corrective action to revise procedures and retrain employees, as needed, in the proper implementation of the procedures.

The institution of proceedings pursuant to 10 CFR § 2.202, as requested by the Petitioner, is appropriate only where substantial health and safety issues have been raised. See Consolidated Edison Company of New York (Indian Point, Units 1, 2, and 3), CLI-75-8, 2 NRC 173, 175 (1975) and Washington Public Power System (WPPS Nuclear Project No. 2), DD-84-7, 19 NRC 899, 923 (1984). As discussed above, there is reasonable assurance the South Texas Project, Units 1 and 2 are being operated with adequate protection of the public health and safety. Therefore, I find no basis for instituting a proceeding pursuant to 10 CFR § 2.202 to modify, suspend, or revoke the NRC licenses held by HL&P in the areas stated by the Petitioner. This decision is based on the minimal safety significance of the concerns stated by the Petitioner and substantiated and the adequacy of corrective actions initiated by the licensee. For these reasons also, I have concluded that it is not

necessary for the NRC to cause the licensee to revoke all escorted access at the South Texas site or for the NRC to cause the licensee to invoke an immediate stand-down of all maintenance activities, as requested by the Petitioner. To this extent, I have decided to deny the Petitioner's request for action pursuant to 10 CFR Section 2.206.

However, the Petitioner also requested that the NRC take swift and immediate actions to cause the licensee to comply with facility technical specifications and procedures and to assure adequate procedures and training in the areas of physical security and maintenance. Based on the NRC inspection activities discussed above, which substantiated a number of the concerns raised by the Petitioner, a Notice of Violation was issued to the licensee to provide assurance that the licensee will comply with regulatory requirements. In addition, in response to the NRC inspection findings, the licensee temporarily discontinued all visitor access at South Texas, revised procedures and conducted additional training of its staff in the physical security and maintenance areas. To this extent, the Petitioner's request for action pursuant to Section 2.206 has been granted.

A copy of this Decision will be filed with the Secretary of the Commission for the Commission's review in accordance with 10 CFR § 2.206(c).

FOR THE NUCLEAR REGULATORY COMMISSION

Thomas E Murley

Thomas E. Murley, Director
Office of Nuclear Reactor Regulation

Dated at Rockville, Maryland
this 5th day of October 1992

7590-01

UNITED STATES NUCLEAR REGULATORY COMMISSION

DOCKET NOS. 50-498 AND 50-499

HOUSTON LIGHTING & POWER COMPANY

SOUTH TEXAS PROJECT, UNITS 1 AND 2

ISSUANCE OF DIRECTOR'S DECISION UNDER 10 CFR 2.206

Notice is hereby given that the Director, Office of Nuclear Reactor Regulation, has taken action with regard to a Petition for action under 10 CFR 2.206 received from Mr. Thomas J. Saporito, Jr., dated February 10, 1992, with regard to the South Texas Project, Units 1 and 2.

The Petitioner requested that the NRC institute a proceeding pursuant to 10 CFR 2.202 and take a number of immediate and swift actions in the areas of physical security, maintenance activities, compliance with Technical Specifications and procedures, and training.

The Director of the Office of Nuclear Reactor Regulation has determined to grant the Petition in part and to deny the Petition in part. The reasons for this decision are explained in the "Director Decision Pursuant to 10 CFR 2.206," (DD-92-05) which is available for public inspection at the Commission's Public Document Room, the Gelman Building, 2120 L Street, N.W., Washington, D.C. 20555, and at the Local Public Document Room for the South Texas Project, Units 1 and 2, located at the Wharton County Junior College, J. M. Hodges Learning Center, 911 Boling Highway, Wharton, Texas 77488. A copy of the decision will be filed with the Secretary for the Commission's review in accordance with 10 CFR 2.206(c) of the Commission's regulations. As provided by this regulation, the Decision will constitute the final action of

the Commission 25 days after the date of issuance of the Decision unless the Commission on its own motion institutes a review of the decision within that time.

Dated at Rockville, Maryland, this 5th day of October 1992.

FOR THE NUCLEAR REGULATORY COMMISSION

Thomas E Murley

Thomas E. Murley, Director
Office of Nuclear Reactor Regulation