

Omaha Public Power District
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402/536-4000

June 3, 1988
LIC-88-393

Mr. James Lieberman, Director
Office of Enforcement
U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555

CERTIFIED RETURN RECEIPT

- References:
1. Docket 50-285
 2. Letter from NRC (L. J. Callan) to OPPD (R. L. Andrews) dated March 8, 1988
 3. Letter from OPPD (R. L. Andrews) to NRC (Document Control Desk) dated March 31, 1988 (LIC-88-211)
 4. Letter from NRC (R. D. Martin) to OPPD (R. L. Andrews) dated May 4, 1988

Gentlemen:

Subject: Response to Notice of Violation and Proposed Imposition of Civil Penalties (NRC Inspection Report No. 50-285/88-05 EA88-72)

Omaha Public Power District (OPPD) received the Notice of Violation and Proposed Civil Penalties, Reference 4, dated May 4, 1988. The Notice of Violation involved two Level III violations resulting from a special inspection involving the Fort Calhoun Station radiation protection program, Reference 2. As a result of this inspection, an enforcement conference was held on March 21, 1988 in Arlington, Texas.

OPPD acknowledges the violations and does not contest the proposed civil penalty. Accordingly, please find attached OPPD's response to the Reference 4 violations pursuant to 10 CFR Part 2.201 and a check in the amount of \$112,500.

OPPD has aggressively pursued improvements in our Radiation Protection Program. A project team of OPPD management personnel was formed to develop a comprehensive plan for overall improvement of the Fort Calhoun Station radiation protection program. An assessment of operations of the Radiation Protection (RP) Program has been conducted by OPPD which focused on improvements in accordance with INPO criteria for excellence. This assessment resulted in a better understanding of the status of the RP Program and provided recommendations on areas requiring improvement in order to achieve an excellent program. An assessment of the Fort Calhoun Station Radiation Protection Program has been completed by an independent consultant. The scope of the assessment included regulatory compliance, technical content, and a comparison to best industry practice.

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A policy reinforcing the regulatory requirements regarding control of newly created Very High Radiation Areas (VHRA's) outside of the containment building was clarified. This policy indicates that new VHRA's shall be controlled constantly by an entry watch until such time that a controlled padlock or other controlled locking mechanism can be installed to secure the area.

A technical review of the respiratory protection program, conducted by an independent technical consultant, has been completed. One of the consultant's recommendations, training for instructors in respiratory protection, has been completed. Other recommendations are being evaluated.

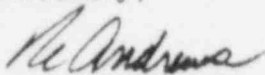
A complete policy statement regarding respirator usage has been implemented. The statement fulfills the requirements of 10 CFR Part 20.103(c)(3), Regulatory Guide 8.15 and NUREG-0041 for a policy statement.

Local alarms will be installed on Very High Radiation Area doors and will be operational by the end of the year. The local alarms will remain in place, after the remote alarm system is operational, as an additional aid to workers in the Radiation Control Area.

A Trending and Root Cause Analysis program development project will be initiated by July 1988. The objective of this project is to establish a formal methodology which will include the systematic tracking and evaluation of unplanned or recurring incidents for possible entry into a root cause determination process. Inherent in this process is an appraisal of the effectiveness of corrective actions.

OPPD is confident that initiatives that have been completed, and those planned, will achieve an excellent Radiation Protection program. If you have any questions concerning this matter, do not hesitate to contact us.

Sincerely,



R. L. Andrews
Division Manager
Nuclear Production

Enclosure

c: LeBoeuf, Lamb, Leiby & MacRae
R. D. Martin, NRC Regional Administrator
P. D. Milano, NRC Project Manager
P. H. Harrell, NRC Senior Resident Inspector

ATTACHMENT

REPLY TO NOTICE OF VIOLATION

A. VERY HIGH RADIATION AREA CONTROL

Technical Specification 5.11.2, requires, in part, that areas with radiation intensities greater than 1000 mrem/hr (Very High Radiation Area) be provided with locked doors to prevent unauthorized entry into such areas.

Contrary to the above, at approximately 4:25 p.m., on January 25, 1988, the licensee's auxiliary building operator determined that the door leading into room 11 (A Very High Radiation Area) was not locked.

This is a repeat violation.

This is a Severity Level III violation (Supplement IV)

Civil Penalty - \$62,500.

ADMISSION OR DENIAL OF THE ALLEGED VIOLATION

The violation to Fort Calhoun Station Technical Specification 5.11.2 noted above occurred as stated.

REASONS FOR VIOLATION

The violation occurred following personnel exit from the letdown filter room (Room 11) on January 25, 1988. Personnel interviews were conducted to determine the reason for the incident. The interviews identified the following causes:

- A. Personnel did not follow established procedures for control of Very High Radiation Areas (VHRA) which require VHRA barriers to be locked.
- B. Personnel assumed that actions taken by others to latch the VHRA barrier were effective.
- C. Personnel verification of a latched and locked VHRA barrier was not effective.
- D. The scope of previous corrective actions following the September 9, 1987 and October 14, 1987 VHRA barrier incidents was incomplete. The corrective actions in progress include modification of door hardware, improvements in root cause determination, procedures upgrade and the overall management review program.

The circumstances of the event are as follows:

On January 25, 1988 two individuals, qualified as health physics technicians, opened the door to Room 11 from Corridor 4 in accordance with established procedures to check for the presence of expended waste disposal filters ready to be transferred for disposal. Filters were ready

Reply to Notice of Violation (Continued)

for transfer for disposal and staged near the door to Room 11A, which is adjacent to Room 11. The individuals allowed the door to Room 11 to close. One of the technicians left the door and walked to the north end of Corridor 4 to prepare for Room 11A entry. The other technician stated that he checked the Room 11 door and it appeared to be latched and locked. He left the area to assist with the filter transfer from Room 11 to Room 11A. The filters were removed from Room 11 in accordance with approved procedures through Room 11A to minimize radiation exposure. Room 11A is not a Very High Radiation Area.

Approximately two hours later, the door from Corridor 4 to Room 11 was found to be locked, but unlatched, by an OPPD employee.

Hardware modifications which were planned, but not yet complete on January 25, 1988, include replacement of all VHRA door lock mechanisms outside the containment building and installation of a monitored strike system to provide remote alarms when a door is open or unlatched. The door lock replacement is intended to standardize the lock mechanisms to facilitate control and operations. The monitored strike is intended as a personnel aid to ensure doors that should be closed and latched are in that condition.

The procedures upgrade program which was in progress prior to January 25, 1988 was initiated in September 1987. The purpose of the upgrade is to improve the quality and clarity of procedures governing maintenance, operations and health physics activities at the Fort Calhoun Station.

CORRECTIVE STEPS WHICH HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

When the Room 11 door was found unlatched at 4:20 p.m. on January 25, 1988, the following actions were taken immediately:

- A. It was verified that no personnel were in Room 11, the door was closed and verified to be properly latched and locked. This resulted in compliance with Technical Specification 5.11.2.
- B. Fort Calhoun Station management personnel were notified of the incident which resulted in initiation of investigative and corrective actions.
- C. Other VHRA barriers outside containment were verified to be properly closed, locked and latched which resulted in assurance that other VHRA's were properly controlled.
- D. A red padlock under the exclusive control of the Plant HP was placed on the Room 11 door. (Keys for this and other VHRA barrier padlocks are under strict administrative control by the Plant HP and Shift Supervisor.) This resulted in assurance that complete door control was provided.

Reply to Notice of Violation (Continued)

- E. Interviews with personnel were conducted, key logs were reviewed and door hardware was examined by management. This action resulted in identification of the sequence of events and the parties involved with the incident.

Subsequent to January 25, 1988, the following actions have been taken:

- A. The governing procedure for VHRA control, Radiation Protection Manual Section 3.1.7.2.b was reviewed. A requirement for verification and documentation by two individuals (two-man rule) that VHRA barriers are properly closed, locked and latched was implemented in that section of the RPM. This action resulted in a reduction in the probability of failure to close, latch and lock VHRA barriers.
- B. The Plant Health Physicist's field observation of HP activities has increased significantly which results in further assurance of VHRA control. At this time, the Plant HP is spending approximately five hours per day in the Auxiliary Building observing HP activities which will continue as long as management deems appropriate.
- C. An individual with extensive HP experience and qualified to ANSI N18.1-1971 was reassigned to the HP staff from the Training Department to support the Plant HP's supervisory effort. His reassignment has provided additional direct senior level coordination of the HP field activities. He, along with the Plant HP, has emphasized consistent implementation of HP practices.
- D. The first round of Employee-Management conferences, which were designed to improve procedural compliance, have been completed with Station employees. Topics of the discussions included, but were not limited to, strict procedural compliance, the means by which procedural concerns can be brought to Management's attention, and the appropriate actions to be taken to rectify concerns.
- E. Licensee Event Report 88-001 preparation was initiated on January 26, 1988 and submitted to the NRC on February 24, 1988. The LER provided a description of the event and corrective actions that have been accomplished and planned. In addition, this incident was briefly described in OPPD's letter to the NRC dated February 18, 1988 (LIC-88-116). This resulted in a timely, formal notification of the NRC of the incident.
- F. The incident was discussed with the NRC Senior Resident Inspector and later with the NRC Inspection Team during the week of February 1-5, 1988 which resulted in a complete and candid review of OPPD's investigations.
- G. A project team of OPPD management personnel was formed to develop a comprehensive plan for overall improvement of the Fort Calhoun Station radiation protection program. The objective of this task

Reply to Notice of Violation (Continued)

force is to examine and evaluate the radiation protection procedures currently in place, identify generic areas of concern, review specific actions, provide recommendations for improvements and assist in implementation of recommendations.

- H. An assessment of the Fort Calhoun Station Radiation Protection Program has been completed by an independent consultant. The scope of the assessment included regulatory compliance, technical content and a comparison to best industry practice. The assessment plan was written and based primarily upon Temporary Instruction 2500/4, "Health Physics Appraisal Program" from the U.S. Nuclear Regulatory Commission Inspection and Enforcement Manual. Additional guidance for the assessment was drawn from INPO publications and other industry sources.
- I. A policy reinforcing the regulatory requirements regarding control of newly created VHRA's outside of the containment building was clarified. This policy indicates that new VHRA's shall be controlled constantly by an entry watch until such time that a controlled padlock or other controlled locking mechanism can be installed to secure the area. The result of this action is undefined at the present time because no new VHRA's have been created. The intent of this policy is to provide complete control of VHRA's if established.
- J. An assessment of operations of the RP Program has been conducted by OPPD which focused on improvements in accordance with INPO criteria for excellence. This assessment resulted in a better understanding of the status of the RP Program and provided recommendations on areas requiring improvement in order to achieve an excellent program. The recommendations are being evaluated for incorporation into the overall Radiation Protection Improvement Plan being developed.

The overall result of these actions has been positive control of VHRA's and improvements in the implementation of the existing RP Program.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

- A. Replacement of locksets on VHRA doors and barriers outside of containment with mortise-style locksets that have a "storeroom function" (key required for entry) and cannot be reset without total disassembly of the lockset will be completed by September 1, 1988. Due to a labor strike these locksets cannot be supplied sooner. The keys for these locksets will be incorporated into the existing key control program for HP padlock keys.
- B. Lock cylinders with interchangeable cores will be installed in all mortise-style locksets in the Radiation Control Area (RCA) doors outside of containment. This will allow easy changeout of locks if a key is compromised. Since these keys will also be part of the security program, additional time is needed to procure lock cylinders and proceduralize this program. The keys for the new

Reply to Notice of Violation (Continued)

lock cylinders will be controlled under an improved key control program for the entire station. The VHRA door key control program will then be incorporated into the station program. The new lock cylinders and new station key control program will be in service by December 31, 1988.

- C. An electrically supervised monitored strike system will be installed on RCA doors outside of containment to alarm at a remote location if either "door open" or "latch bolt not engaged" condition occurs. Since most of the doors serve as fire barriers, special fire rated assemblies must be obtained. The strikes will be installed in conjunction with Modification MR-FC-85-049 "Site Security Upgrade" by September 1, 1988. The alarm termination points will be located in the Security Alarm Stations to provide alarm functions. This remote alarm capability will be completed by June 30, 1989.
- D. Local alarms will be installed on VHRA doors and will be operational by December 31, 1988. These local alarms will serve as an interim measure to the operability of the remote alarm system described in C, above. The local alarms will remain in place after the remote alarm system is operational, as an additional aid to workers in the RCA.
- E. Other actions identified by the OPPD management project team regarding improvements to VHRA control and procedural compliance are as follows:
1. Isolate the VHRA at the back of the truck bay next to the spent fuel pool area to remove the balance of railroad siding from VHRA status and provide more positive control of the localized VHRA. This task will be completed by August 1, 1988.
 2. Revise the Radiation Protection Manual to be consistent with NUREG-0761. This will provide a policy section and an implementing procedures section that will be clearer and easier to use. Implementation of the revised Radiation Protection Plan (policy section) has been scheduled in the RIP Program Plan and will be complete by October 15, 1988. Implementing procedures will be developed and issued over a 2-3 year period and completed by October 31, 1991.
 3. Provide team building and communications skills training to the health physics staff. This was planned under another program for all Station personnel but is being expedited for the HP staff and will be complete by August 1, 1988.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

The Omaha Public Power District is in full compliance. Enhanced hardware and administrative controls are in place which have prevented recurrence and should prevent further occurrences.

Reply to Notice of Violation (Continued)

B. RADIATION PROTECTION PROGRAM DEGRADATION

B.1 Failure to Provide Training

Technical Specification 5.4.1 states, in part, that a retraining program for the plant staff shall be maintained and shall meet or exceed the requirements of Section 5.5 in ANSI N18.1-1971. Training Program Master Plan 14, Section 8.2.2, states, in part, that radiation protection technicians will complete the minimum requalification training requirements yearly (not to exceed 15 months) as defined for their current job position.

Contrary to the above, as of February 5, 1988, three radiation protection technicians had not completed requalification training requirements since August 1986, August 1984, and August 1983, respectively, as defined for their current job position.

Collectively, these violations (B.1 - B.5) have been categorized as a Severity Level III violation (Supplement IV).

Cumulative Civil Penalty - \$50,000 (assessed equally among the violations).

ADMISSION OR DENIAL OF THE ALLEGED VIOLATION

The violation did occur.

REASONS FOR THE VIOLATION

- A. Unclear training manual requirements.
- B. Management misinterpretation of training requirements.

The RP technician requalification training program currently in place in Section 8.2.2 of the Training Program Master Plan (TPMP) is designed for technicians assigned to the rotating shift. There is no requalification program in place for non-shift technicians. The three individuals referenced above are non-shift technicians working in the area of radioactive waste management. The misinterpretation of training requirements by management resulted in the lack of a requalification program for non-shift technicians while implementing a requalification program for shift technicians.

The training manual provides the Supervisor - Chemical and Radiation Protection (C/RP) with the authority to determine the training and retraining requirements for the various job functions within the C/PP department. Given this, it had been determined that non-shift technicians would not be required to participate in the requalification program defined in Section 8.2.2 of the TPMP. The training manual did not clearly state that all RP technicians working in the Fort Calhoun Station shall be requalified in accordance with TPMP Section 8.2.2 regardless of job function. This lack of clarity allowed the Supervisor - C/RP to make the determination described above.

Reply to Notice of Violation (Continued)

CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

- A. Prior to March 21, 1988, the training records of health physics technicians were reviewed which resulted in the determination that two of the three individuals referenced above were unqualified to perform certain tasks. The review showed that the third individual had completed requalification in September 1987 and that his training record was approved in October 1987. The tasks for which the two individuals are unqualified are:

1. Operation of the whole body counter.
2. Operation of the pulmonary function test equipment.
3. Operation of the mask fit test equipment.

The two individuals noted above are not performing tasks for which they are unqualified.

Subsequent to March 21, 1988, further review showed that four additional individuals, for a total of six people, were not qualified to perform the three tasks shown above. Memoranda stating the lack of qualification and prohibiting performance of those three tasks have been issued to two of the six people with copies placed in their training files. Requalification training was instituted for four of the unqualified technicians at an accelerated pace which resulted in completion of their requalification by March 24, 1988.

Further review subsequent to March 31, 1988 determined that the two individuals (with memoranda stating their lack of qualification) would not adequately maintain their ANSI Qualification without this training. Therefore, the 1987 Requalification Program has been instituted for these two individuals. The program will be completed by the two by June 15, 1988. As of that date, all non-exempt personnel in the RP group with ANSI Qualification will have completed the 1987 Requalification Program.

- B. The work history of each of the six unqualified technicians was reviewed to determine if they had performed work for which they were unqualified during the period since their last requalification. The resultant determination was that none of the six had performed work for which they were not qualified.
- C. The training manual requalification requirements for health physics personnel were reviewed in detail and discussed by the Training Supervisor responsible for HP training, the Plant Health Physicist and the Supervisor - C/RP. This resulted in the conclusion and agreement that the HP requalification program of TPMP Section 8.2.2 applies to all non-exempt, ANSI qualified HP personnel.

Reply to Notice of Violation (Continued)

- D. The Training Supervisor responsible for HP training has begun providing periodic reports of HP technician requalification status. This practice results in the Plant HP and the Supervisor - C/RP being fully cognizant of HP personnel training status such that only fully qualified personnel are performing HP functions.

The overall result has been to place OPPD in compliance with the training and requalification program for Health Physics qualified technicians.

CORRECTIVE STEPS WHICH WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

The Requalification Program for 1988 has been developed in accordance with the INPO November 1987 Guidelines. Topics will include: selected systems reviews, fundamentals reviews, PEC's, special topics and industry event documents. Non-exempt ANSI qualified HP personnel will be scheduled to complete this training by December 31, 1988.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

The Omaha Public Power District will be in full compliance with the existing training and requalification programs for non-exempt, ANSI qualified HP personnel by June 15, 1988.

B.2 Very High Radiation Area Key Control

Technical Specification 5.11.2, requires, in part, that areas with radiation intensities greater than 1000 mrem/hr (Very High Radiation Area) be provided with locked doors 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, as of February 4, 1988, while locked doors were provided for Very High Radiation Areas, the licensee did not maintain keys for these doors under the administrative control of the shift supervisor on duty and/or the plant health physicist.

ADMISSION OR DENIAL OF ALLEGED VIOLATION

The violation of Technical Specification 5.11.2 occurred as stated above.

REASONS FOR THE VIOLATION

This violation occurred for the following reasons:

- A. Lack of management oversight to ensure Technical Specification compliance with respect to VHRA barrier key control.
- B. Lack of a proceduralized key control system for VHRA keys.

Reply to Notice of Violation (Continued)

The lack of key control was discovered during investigations into incidents of Very High Radiation Area (VHRA) barriers being left unlocked. The investigations revealed that various individuals possessed VHRA barrier keys that had been obtained to facilitate work in the Radiation Controlled Area.

Keys were given out by personnel other than the Shift Supervisor or Plant HP, or just taken from the key locker. This was the result of B, above.

CORRECTIVE STEPS WHICH HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

- A. It was determined that it was not possible to account for all keys used prior to January 26, 1988 for VHRA door control. Therefore, all VHRA barriers outside containment have been augmented with padlocks. The padlocks are exclusively controlled by the Plant Health Physicist and the keys for the padlocks are strictly controlled by the Plant HP and Shift Supervisor on duty. Key control for the padlocks was verified to have been maintained prior to implementation of this action. These actions result in positive control of VHRA barriers and the keys to these barriers.
- B. General procedural compliance is being stressed through management-employee conferences which have been conducted. This has reinforced adherence to the interim key control program for VHRA door locks and Technical Specification compliance in general.
- C. The project team of OPPD management personnel, discussed previously, was assigned guidance responsibility for development of improved key control. This has resulted in acceleration of the development process for improving key control.
- D. A policy governing the use of HP padlocks and control of the padlock keys has been developed by the Health Physics Supervisor. This has resulted in a clear and complete understanding by health physics qualified technicians of the use of the HP padlocks and control of the padlock keys.

The overall result of these actions has been the reestablishment of positive key control for VHRA barriers.

CORRECTIVE STEPS WHICH WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

- A. An improved key control program for the entire Station is being developed by the Security department of the Fort Calhoun Station in conjunction with HP personnel and under the guidance of the OPPD management project team. The developers include an individual who possesses extensive knowledge and experience in positive key control measures. The new program will be proceduralized and implemented by December 31, 1988.

Reply to Notice of Violation (Continued)

- B. Replacement of locksets on VHRA doors and barriers outside of containment with mortise-style locksets that have a "storeroom function" (key required for entry) and cannot be reset without total disassembly of the lockset will be completed by September 1, 1988. Due to a labor strike these locksets cannot be supplied sooner. The keys for these locksets will be incorporated into the existing key control program for HP padlock keys.
- C. Lock cylinders with interchangeable cores will be installed in all mortise-style locksets in the Radiation Control Area (RCA) doors outside of containment. This will allow easy changeout of locks if a key is compromised. Since these keys will also be part of the security program, additional time is needed to procure lock cylinders and proceduralize this program. The keys for the new lock cylinders will be controlled under an improved key control program for the entire station. The VHRA door key control program will then be incorporated into the station program. The new lock cylinders and station key control program will be in service by December 31, 1988.
- D. An electrically supervised monitored strike system will be installed on RCA doors outside of containment to alarm at a remote location if either "door open" or "latch bolt not engaged" condition occurs. Since most of the doors serve as fire barriers, special fire rated assemblies must be obtained. The strikes will be installed in conjunction with Modification MR-FC-85-049 "Site Security Upgrade" by September 1, 1988. The alarm termination points will be located in the Security Alarm Stations to provide alarm functions. This remote alarm capability will be completed by June 30, 1989.
- E. Local alarms will be installed on VHRA doors and will be operational by December 31, 1988. These local alarms will serve as an interim measure to the operability of the remote alarm system described in D, above. The local alarms will remain in place after the remote alarm system is operational, as an additional aid to workers in the RCA.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

The Omaha Public Power District is presently in full compliance. Enhanced administrative controls for VHRA key control will be in place by December 31, 1988.

B.3 Failure to Follow Procedures

Technical Specification 5.11 states, in part, that procedures for personnel radiation protection shall be approved, maintained, and adhered to for all operations involving personnel radiation exposure. Procedure RPM 3.1.7.2.b.1 states, in part, that a second person shall always accompany an entry by a qualified health physics technician into a very high radiation area and in all cases

Reply to Notice of Violation (Continued)

the two persons must maintain line-of-sight or other communications while one or both persons remain within the Very High Radiation Area.

Contrary to the above, on February 4, 1988, an NRC inspector observed a health physics technician exit a very high radiation area and not maintain line-of-sight or other communications with a second person within the very high radiation area.

ADMISSION OR DENIAL OF THE ALLEGED VIOLATION

The violation occurred as stated above.

REASONS FOR THE VIOLATION

The individual forgot about the new requirement that the two individuals involved in a VHRA entry be in line-of-sight or other communication.

On February 4, 1988, an individual was observed exiting a VHRA by the Fort Calhoun Station Plant HP and two members of an NRC Inspection Team. The individual was asked by the Plant HP if there was anyone else in the VHRA. The individual acknowledged that there was, and then immediately returned to the area.

The requirements for the presence of two individuals in a VHRA was implemented January 26, 1988, approximately seven working days prior to the incident. Notification of the change was distributed via departmental memorandum with the procedure attached which was reviewed by each health physics qualified technician who verified by signature that the procedure had been reviewed and was understood.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

- A. The individual was immediately questioned by the Plant HP and was reminded of the new entry procedure for VHRA entry. As a result, the individual immediately returned to the VHRA.
- B. The individual's training on the new procedure was reviewed. The review confirmed that he had received training on the new procedure. His training had been completed two days before the incident.
- C. The individual's qualification to escort into VHRA's was denied pending additional training, which resulted in the individual not providing VHRA escort. Additional training on VHRA escort and access has been provided to the individual involved with this incident. This training was in conjunction with other training activities related to his job function and was completed before May 15, 1988.

Reply to Notice of Violation (Continued)

- D. The first round of Employee-Management conferences, discussed previously, have been completed with Station employees to emphasize procedural compliance.

The overall result has been full procedural compliance with the two-man rule.

CORRECTIVE STEPS WHICH WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

No additional actions are planned.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

The Omaha Public Power District is presently in full compliance because monitoring and training systems are in place to assure no unqualified worker can be the HP escort into a VHRA.

B.4 Failure to Follow Procedures

Technical Specification 5.8.1 states, in part, that written procedures and administrative policies shall be established, implemented, and maintained that meet or exceed the minimum requirements of Appendix A of USNRC Regulatory Guide 1.33. Procedure HP-9, Section C.1.c.1 of Appendix A states, in part, that controlled surface contaminated areas be conspicuously posted.

Contrary to the above, on February 3 and 4, 1988, an NRC inspector observed a temporary area in Room 23 set off as a controlled surface contaminated area that was not conspicuously posted.

ADMISSION OR DENIAL OF THE ALLEGED VIOLATION

The violation occurred as stated.

REASONS FOR THE VIOLATION

- A. Inadequate methods were used to anchor the rope supporting the surface contamination posting signs.
- B. Inadequate procedure and training for posting and controlling surface contamination areas.
- C. Inadequate management oversight.
- D. Inadequate communication with management.
- E. Inadequate HP shift turnover process.

On February 3, 1988, an NRC Inspector entered Room 23 and found the surface contamination area posting signs lying on the floor. Therefore, the area was improperly posted. The inspector notified

Reply to Notice of Violation (Continued)

a health physics technician of the degraded posting along with several other concerns. The technician resolved the inspector's concerns except the degraded posting. The afternoon shift HP was not informed of the inadequate posting by the day shift HP during shift turnover. HP shift turnover is not well defined and proceduralized. The quality of the turnover is dependent upon the individuals involved.

The rope supporting the signs was anchored to a concrete wall with tape. This practice had been successful in the past and so was continued. In this case, the tape was not strong enough to hold the rope and signs. The rope slid through the tape and the posting fell down.

The improper posting was found by the night shift HP who reattached the rope to the wall during the night shift on February 3-4, 1988, again using tape. When the room was checked at 0930 on February 4, 1988 by the NRC Inspector, the signs were again down. This led him to believe no action had been taken to correct the improper posting.

Adequate management oversight would have assured proper posting methods were proceduralized and training provided. In addition, adequate management oversight would have ensured the HP shift turnover process was formalized with procedures and guidelines. A formalized turnover process would have communicated deficiencies identified but not corrected during the preceding shift.

Better communication between the technician and management would have alerted management to the existence of a problem and triggered follow-up on the corrective actions taken.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

- A. On February 4, 1988, the tape anchor was replaced with a metal stanchion to which the support rope was tied. Thus, the area posting stayed in place until the area was decontaminated and the posting removed.
- B. The use of duct tape for anchoring of ropes has been phased out. Thus, no duct tape is being used to support ropes for postings. In some cases, duct tape is used to attach a sign directly to a wall or a door. This practice is also being phased out by installation of other means to support signs.
- C. To completely address concerns with this violation OPPD has identified that the HP shift turnover process should be improved. Therefore, OPPD implemented an informal HP shift turnover system prior to March 31, 1988.

Reply to Notice of Violation (Continued)

- D. Team building and communications training has been initiated for the HP staff. These training sessions focus on personality types and better communication methods for those personality types. The importance of good immediate communication is being emphasized to ensure management and coworkers are cognizant of problems. As a result, the communications during shift turnover have greatly improved.
- E. A revision of Procedure HP-9 is planned as discussed below. During the interim, the Plant HP or his designate is reviewing and approving all newly established radiological postings. Deficient postings are corrected. The result of this action has prevented the establishment of deficient radiological postings.

The overall results of these actions have been no further instances of postings of contamination or radiation areas being down or otherwise incorrect.

CORRECTIVE STEPS WHICH WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

- A. Group sessions will continue after completion of the initial team building and communications training noted above. These will serve as a forum for communication of problems and personnel concerns to management. Significant problems and concerns will be brought to management's attention outside of the group sessions to affect timely resolution.
- B. A formalized HP shift turnover system, which will include guidance as to appropriate content, will be developed and implemented by July 1, 1988.
- C. Procedure HP-9 is being revised to provide minimum standards for postings and support of postings for surface contamination areas. The policy of not using duct tape will be included in the revision. The revised procedure will be issued by July 1, 1988.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

The Omaha Public Power District will be in full compliance by July 1, 1988.

B.5 Respiratory Protection Policy

10 CFR Part 20.103(c)(3) states, in part, that a written policy statement on respirator usage shall be issued covering such things as the use of practicable engineering controls instead of respirators.

Contrary to the above, as of February 5, 1988, the licensee had not issued a written policy statement covering the use of practicable engineering controls instead of respirators.

Reply to Notice of Violation (Continued)

ADMISSION OR DENIAL OF THE ALLFGED VIOLATION

The violation occurred as stated above.

REASONS FOR THE VIOLATION

This violation results from:

- A. A lack of attention to detail.
- B. A lack of adequate management controls.

The plant staff identified that OPPD's policy regarding respirator usage was fragmented and required a review of different portions of three different manuals to gain a complete understanding of the policy. It was decided to consolidate the respirator policy into one manual, the Radiation Protection Manual (RPM), and delete the portions appearing in other manuals. The various parts of the policy appearing in manuals other than the Radiation Protection Manual were deleted and a complete policy statement was not added to the RPM during the revision process. Adequate management controls and attention to detail would have prevented this from occurring.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

- A. A complete policy statement regarding respirator usage was implemented March 21, 1988 in Standing Order T-11, rather than the RPM. The statement fulfills the requirements of 10CFR Part 20.103(c)(3), Regulatory Guide 8.15 and NUREG-0041 for a policy statement. In addition, a statement of the regulatory requirements being implemented by S.O. T-11 was included in the "Purpose" section of this Standing Order. This action resulted in compliance with the regulatory requirements.
- B. A technical review of the respiratory protection program, conducted by an independent technical consultant, has been completed. One of the consultant's recommendations, training for instructors in respiratory protection, has been implemented. Other recommendations are being evaluated.

CORRECTIVE STEPS WHICH WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

- A. OPPD is developing a Commitment Tracking System which will improve access to historical commitments to the NRC and INPO. This system will include the capability to reference implementing procedures and other related documents. A database including commitments from historical correspondence will be available by July 31, 1988.
- B. The procedures upgrade program which was in progress at the time of the violation will verify compliance with requirements.

Reply to Notice of Violation (Continued)

- C. To further improve management control and oversight of the Radiation Protection Program at the Fort Calhoun Station, the organizational structure and reporting relationship of the C/RP department has been evaluated. The result of this evaluation has led to development of a different Radiation Protection organization. The new organization includes a Respiratory Protection Specialist position which will administer and maintain the respiratory protection programs for the Fort Calhoun Station. This organizational change and appointment to the position will become effective July 1, 1988.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

The Omaha Public Power District is presently in full compliance with the requirements of 10 CFR Part 20.103(c)(3).