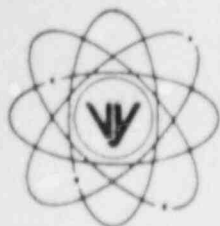


# VERMONT YANKEE NUCLEAR POWER CORPORATION



RD 5, Box 169, Ferry Road, Brattleboro, VT 05301

FVY 88-101

REPLY TO:  
ENGINEERING OFFICE  
580 MAIN STREET  
BOLTON, MA 01740  
(508) 779-6711

December 2, 1988

U.S. Nuclear Regulatory Commission  
Washington, D.C. 20555

Attn: Document Control Desk

References: a) License No. DPR-28 (Docket No. 50-271)  
b) Letter, USNRC to VYNPC, NVY 88-239, Inspection Report  
No. 50-271/88-18, dated 11/4/88

Dear Sir:

Subject: Response to Inspection Report 88-18, Notice of Violation

During a special, radiological safety inspection conducted on October 5-7, 1988, one violation of NRC requirements along with certain programmatic weaknesses were identified. The following information is provided in response to the violation.

## VIOLATION

"Technical Specification 6.5.B states, in part, that radiation control standards and procedures shall be prepared, approved and maintained and made available to all station personnel. These procedures shall show permissible radiation exposure, and shall be consistent with the requirements of 10 CFR Part 20. The radiation protection program shall be organized to meet the requirements of 10 CFR Part 20.

Procedure AP 0502, Rev. 19, "Radiation Work Permits", Section B.6, requires in part that all working party personnel shall observe all posted and written instructions given by the work party supervisor and/or the assigned Chemistry and Health Physics representative.

Contrary to the above, on September 28, 1988, two Instrument and Control (I&C) technicians entered the "A" and "B" recombiner hallways in the Advanced Offgas (AOG) building which were posted "High Radiation Area, RWP Required" without a Radiation Work Permit (RWP)."

## RESPONSE

Immediately after learning of the problem, management conducted a series of meetings to determine the extent of the problem and the appropriateness of the initial corrective actions. As a result of those meetings, it was concluded that the corrective actions were adequate in ensuring immediate radiological

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safety. However, we concluded that an additional investigation was needed to identify the root cause and to recommend long-term corrective actions. An investigation team was assembled consisting of four individuals having various backgrounds and expertise and having no direct involvement with the incident. This team interviewed personnel directly and indirectly involved with the incident to establish the pertinent facts and extent of the problem.

Following the investigation, the team documented their findings in a report which was discussed and provided to the Plant Manager on October 24, 1988.

The investigation of the event revealed that the root cause of the violation was human error in judgement. At the time of the event, before performing the surveillance, the technicians had forgotten the key, were annoyed with that situation and did not take the time to get the key. They made the incorrect judgement that it would be acceptable to bypass the lock because they perceived the real hazard as small based on past experience with radiation levels in the AOG recombiner room hallways.

We have reviewed the Inspection Report and conclude that it accurately reflects the incident and our corrective actions, consequently, that information will not be repeated here. With implementation of these corrective actions, we were in full compliance with our Technical Specifications. The task force report contained a number of recommendations involving procedure enhancements, hardware changes, and management practices. While none of these changes would have prevented this event, they will be considered and dispositioned by the Plant Manager by December 9, 1988 to improve our future overall performance.

The following information describes the status of our efforts to address the programmatic weaknesses identified in the Inspection Report.

- a. An apparent disregard of radiological physical and administrative safety barriers existed.
- b. A lax attitude toward high radiation area controls by plant personnel including radiation protection management existed.
- c. The I&C technician and RP staff actions reflected an apparent weakness in the effectiveness of radiological safety training.

#### Status

Our investigation concluded that where there may have been a lack of sensitivity to certain conservative radiological controls, we found no evidence that would indicate a loss of control of actual high radiation areas. Nevertheless, we recognize the need to ensure personnel comply with all administrative controls and not allow individual discretion. To address this concern, the following actions have occurred or are planned.

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The Plant Manager held a special plant staff meeting on October 4, 1988 to briefly discuss the event and potential serious safety consequences. The Plant Manager clearly stated that this behavior was unacceptable, and that any future events would be grounds for dismissal. This action clearly communicated the seriousness of the event.

The Plant Manager has met individually with each department to discuss the lock tampering incident. This has provided the opportunity for the Plant Manager to re-emphasize management's expectations with regard to administrative control compliance with specific mention of radiological controls.

Retraining of all I&C Department personnel in Radiation Protection requirements has been initiated. This retraining and an evaluation of its effectiveness will be completed by December 31, 1988.

We feel that the corrective actions taken and those that are planned as documented in the task force report not directly associated with the violation, along with the re-emphasis provided during the Plant Manager meetings discussed above, will address this concern.

d. Significant weaknesses were identified in procedures AP 0502, AP 0529, OP 0532, and DP 0537.

- OP 0532 allows the Radiation Protection Assistant to give verbal permission to individuals to enter High Radiation areas without an RWP.

Status: It should be noted that the procedure in effect at the time of the incident did not allow entry into an "actual" high radiation area without an RWP. It did allow the issuance of a key to a posted high radiation area with only verbal authorization if the area was not an actual high radiation area. To ensure personnel compliance with administrative controls, OP J432 was revised to clearly require the proper key, monitoring equipment and radiation work permit when entering any posted high radiation area.

- AP 0502, "Radiation Work Permits", allows work in an area with dose rates as high as 100 mR/hour without RWP authorization.

Status: We have reviewed our current threshold for RWP's and based on our preliminary assessment, we find that we have been able to account for a large percentage of total exposure received on RWP's. It is our plan to more formally review the appropriateness of our current practice following the 1989 refueling outage. This review will be completed by July 1989.

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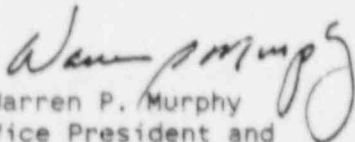
- AP 0529 and DP 0537 do not provide guidance for the timely notification of appropriate management prior to the processing of incident documentation.

Status: AP 0529 and DP 0537 will be reviewed and modified as necessary to provide guidance for timely notification to management by January 1989. In the interim, the need for prompt management notification has been discussed with Radiation Protection department management; significant events are presented and discussed at the weekly department head meeting and additional oversight is being applied to this area.

We trust that the above information adequately responds to the concerns identified in the Inspection Report; should you have questions or desire to review the investigation report at our facility, please do not hesitate to contact us.

Very truly yours,

VERMONT YANKEE NUCLEAR POWER CORPORATION

  
Warren P. Murphy  
Vice President and  
Manager of Operations

/dm

cc: USNRC Regional Administrator, Region I  
USNRC Resident Inspector, VYNPS