JUL 11 1989

In Reply Refer To:
Docket: 50-285/89-12
EA: 89-30

Omaha Public Power District
ATTN: Kenneth J. Morris, Division Manager
Nuclear Operations
444 South 16th Street Mall
Omaha, Nebraska 68102-2247

Gentlemen:

Thank you for your letter of June 22, 1989, in response to our letter and Notice of Violation dated May 23, 1989. We have reviewed your reply and find it responsive to the concerns raised in our Notice of Violation. We will review the implementation of your corrective actions during a future inspection to determine that full compliance has been achieved and will be maintained.

Sincerely,

Gwynn, for:
James L. Milhoan, Director
Division of Reactor Projects

cc:
Fort Calhoun Station
ATTN: G. R. Peterson, Manager
P.O. Box 399
Fort Calhoun, Nebraska 68023

Harry H. Voigt, Esq.
LeBoeuf, Lamb, Leiby & MacRae
1333 New Hampshire Avenue, NW
Washington, DC 20036

Nebraska Radiation Control Program Director

| RIV:FRPS | C:FRPS | C:RPB | D:DRSS | D:DRP |
|---|---|---|---|---|
| DChaney/slr | RBaer | BMurray | BBeach | JMilhoan |
| 7/7/89 | 7/7/89 | 7/9/89 | 7/10/89 | 7/11/89 |



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IE06

bcc to DMB (IE06)

bcc distrib. by R.IV:
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**Omaha Public Power District**
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402/536-4000

JUN 27

June 22, 1989
LIC-89-621

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Mail Station P1-137
Washington, DC 20555

References: 1. Docket No. 50-285
2. Letter from NRC (R. D. Martin) to OPPD (K. J. Morris) dated May 23, 1989

Gentlemen:

SUBJECT: Response to Notice of Violation (Inspection Report 50-285/89-04)

Omaha Public Power District (OPPD) received the subject Notice of Violation. The report identified four violations. These violations, including a review of the root causes and OPPD's proposed corrective actions, were discussed during an enforcement conference held on February 24, 1989 at Region IV office. Attached please find OPPD's response to these items in accordance with 10 CFR Part 2.201.

If you have any questions concerning this matter, please contact us.

Sincerely,

K. J. Morris
Division Manager
Nuclear Operations

KJM/jak

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

IE-89-235

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Attachment 1

RESPONSE TO NOTICE OF VIOLATION

During an NRC inspection conducted January 17-20 and 26, 1989, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C (1988), the violations are listed below:

A. Failure to Follow Procedures

1. Technical Specification (TS) 5.11 requires that the licensee's procedures for personnel radiation protection be consistent with the requirements of 10 CFR Part 20 and approved, maintained, and adhered to for all operations involving personnel radiation exposure.

   Paragraph 3.2.2.1, Section 3.0, Volume VII, of the FCS Operating Manual requires, in part, that any individual permitted to enter a posted high radiation area (any area where a major portion of the body could receive greater than 100 millirem in 1 hour, but less than 1000 millirem in 1 hour is considered a high radiation area and posted as such) shall be provided with or accompanied by one or more of the following:

   a. Continuous health physics technician coverage.

   b. Individuals trained in radiation protection procedures and precautions may enter and perform required tasks after an initial survey has been performed and they are made knowledgeable of the dose rates in the area. These individuals must wear a radiation monitoring device which continuously integrates the dose rate in the area and alarms at a preset integrated dose.

   c. The appropriate access control and monitoring will be specified on the radiation work permit required for entry into high radiation areas.

   d. Health physics must be aware that you are to enter the area and the reason for the entry.

   e. Entrance must be controlled by issuance of a radiation work permit.

   Furthermore, paragraph 3.2.2.2.2 requires, "...that individuals entering a very high radiation area (dose rates greater than 1000 millirem per hour), even though they may be a qualified health physics technician and equipped with proper dosimetry and radiation monitoring instruments, a second person shall always accompany the person entering."

   a. Contrary to the above, the NRC determined that on January 8, 1989, that a contract health physics technician had been left alone in a very high radiation area.

b. Contrary to the above, the NRC determined that on January 26, 1989, a contract electrical maintenance craftsman was found inside of a posted high radiation area without an integrating dosimeter and without the knowledge of the radiation protection staff.

Individually, these are classified as Severity Level IV violations. (Supplement IV) (285/8904-01)

2. Station Operating Manual Volume VII, paragraph IV.3, of Procedure HP-1, "Fast Scan Whole Body Counting," requires, in part, that a termination body count shall be performed when an employee has terminated his/her work at FCS.

Contrary to the above, the NRC determined on January 17, 1989, during a review of 25 personnel exposure records that approximately 12 out of 25 individuals involved had not received termination whole body counts upon completion of work at FCS.

This violation is a Severity Level IV violation. (Supplement IV) (285/8904-04)

OPPD RESPONSE (Violation A.1.a)

1. Reason for the Violation, if Admitted

OPPD admits the violation occurred as stated.

The reason for violation A.1.a. is poor communication directions to craft personnel by the Radiation Protection (RP) Technician covering the work activities resulting in the technician being by herself. This resulted in the RP Technician having to transverse a very High Radiation area by herself in violation of procedural requirements for the two man rule.

2. Corrective Steps That Have Been Taken and the Results Achieved

This event was discussed with the individual RP Technician involved. The errors of this event were pointed out. In addition, during the weekly radiation protection staff meeting, RP personnel were informed of this incident, the reason for the incident and the procedural requirements. RP personnel were provided a copy of Radiation Protection Manual Section 3.2 "Radiation Controls" and were directed to read this section. The corrective actions taken as a result of this violation have resulted in improved controls over field activities and communications as observed by RP Supervisors during their plant tours.

3. Corrective Steps Which Will be Taken to Avoid Further Violations

Revise the procedural requirements to allow transit through a Very High Radiation Area, by a qualified Radiation Protection Technician, with appropriate monitoring equipment, without a second person. This change will be consistent with industry practice and reduce personnel exposure. This will be completed by September 30, 1989.

4. Date When Full Compliance Will be Achieved

OPPD is in full compliance at this time. The actions to be taken are enhancement items which will help ensure compliance as it applies to this violation.

OPPD RESPONSE (Violation A.1.b)

1. Reason for the Violation if Admitted

OPPD admits the violation occurred as stated.

The reasons for violation A.1.b are as follows:

The investigation of the event indicated that personnel error was the root cause in that established procedures and postings were not followed. Investigation revealed that the personnel read and understood the posting before entering the area.

2. Corrective Steps That Have Been Taken and the Results Achieved

A. The following immediate actions were taken:

1) The plant management evaluated the significance of the event and a decision was made to stop outage work on January 26, 1989.

2) An information meeting which all available employees were required to attend was held to stress the seriousness of this event. The Plant Manager explained the event, strongly emphasized use of proper radiation protection practices, stressed importance of following radiological postings, the need for better pre-job planning and emphasized that workers are their own last line of protection. The Plant Manager also required personnel to attend a refresher training course before re-entry into the Radiological Control Area (RCA) would be permitted.

3) Routine maintenance Radiation Work Permits (RWP's) were rewritten to exclude Very High Radiation Areas and High Radiation Areas to prevent access without specific authorization by the RP Operations Coordinator or his designee.

B. The following additional corrective actions were taken:

1) A refresher course was initiated to cover radiological work practice guidelines followed by a question and answer session. The training re-familiarized employees on general rules of conduct in the RCA, contamination control work practices and

radiation exposure control work practices. The course also covered the new restrictions placed on the use of routine RWP's.

2) Previous Incident Reports related to violation of RWP's or posting requirements were reviewed to assess additional corrective actions that may be warranted. No additional corrective actions were identified by this review.

3) Routine RWP's were revised to prohibit entry into either Controlled Surface Contaminated Area (CSCA's), High Radiation or Very High Radiation Areas with few exceptions (e.g., Operation's rounds, Chemistry and RP RWP's). The use of job-specific RWP's (instead of routine RWP's) is being increased. The Radiation Protection department is also evaluating possibilities to reduce the number of High Radiation Areas. This requirement will be proceduralized by September 30, 1989.

4) Initial and requalification general employee training lesson plans were reviewed to ensure the lesson plans adequately addressed entries into high radiation areas. The conclusion was reached that the lesson plans did adequately address high radiation area entry.

5) This event was discussed in an issue of "Nuclear Notes". "Nuclear Notes" is a bimonthly publication on nuclear related matters that is made available to OPPD nuclear personnel.

6) The RWP procedure was reviewed for upgrading as part of the Radiological Protection Enhancement Program. Present procedures are considered adequate but will be further enhanced by September 30, 1989.

7) Project 1991 will identify corrective actions to be taken to help ensure current postings and station policies are in agreement.

8) Cross training was required for the two personnel involved. Each individual was required to complete the training normally given to contractor Junior Radiation Protection technicians. The training consisted of both classroom training and completion of a qualification manual. This cross-training has proven to be beneficial.

The results achieved based on the corrective actions taken have resulted in a higher awareness for radiation protection requirements, and the need to adhere to there requirements. This event also emphasized to personnel upper managements commitment to radiation protection at Fort Calhoun Station.

3. Corrective Steps Which Will be Taken to Avoid Further Violation

The corrective actions, as listed above, should prevent further recurrence of the violation.

4. Date When Full Compliance Will be Achieved

OPPD is currently in full compliance. Improvements with the radiation protection department program to further ensure continued compliance are expected with the completion of the Radiation Protection Enhancement Program. The Radiation Protection Enhancement Program projected completion date is September 30, 1989.

OPPD RESPONSE (Violation A.2)

1. Reason for the Violation if Admitted

OPPD admits the violation occurred as stated.

The reason for violation A.2 is that until recently, guidance did not exist to ensure compliance with paragraph IV.3 of procedure HP-1.

2. Corrective Steps Which Have Been Taken and the Results Achieved

Recently the radiation protection department was re-organized and expanded to include personnel resources and supervision for the management of records within the radiological health (dosimetry) program. The following corrective actions were taken by the new radiological health group responsible for record-keeping:

a. A written statement was developed to notify personnel obtaining dosimetry of the need to contact the radiological health group upon termination. Personnel must sign this notification on the proper methods for termination during inprocessing.

b. The radiological health coordinator responsible for record-keeping initiated a program to notify responsible supervisors of personnel who have failed to comply with OPPD's termination policy.

c. Efforts were made to return individuals from the local area with incomplete terminations to the site for proper termination. To date, five of 28 have returned for exit whole body counts.

3. Corrective Steps Which Will be Taken to Avoid Further Violations

As part of OPPD's Radiation Protection Enhancement Program, the following items will be implemented:

a. A formal program for the termination of personnel from dosimetry (RP-603, Exposure Monitoring Termination and Reports) is being developed.

b. The radiological occurrence reporting program (RP-903, Radiological Occurrences Reporting and Trending) under development will be used as an accountability method for improper termination. In addition to the current on-going corrective steps, the radiological health group will continue to obtain baseline whole body counts from other licensed facilities requesting exposure information for individuals who have been identified with incomplete terminations.

4. Date When Full Compliance Will be Achieved

OPPD is currently in full compliance. Improvements within radiation protection department to further ensure continued compliance are expected with the completion of the Radiation Protection Enhancement Program. The Radiation Protection Enhancement Program projected completion date is September 30, 1989.

B. Failure to Submit Accurate Personnel Monitoring Information to the NRC

10 CFR Part 50.9 requires, in part, that information provided to the Commission (NRC) by a licensee shall be complete and accurate in all material aspects.

10 CFR Part 20.408 requires, in part, that licensees shall transmit to an employee upon termination of employment with the licensee or upon termination of work at the licensee's facility information as to the results of monitoring of an employee for exposure to radiation and radioactive materials.

10 CFR Part 20.409 requires, in part, that the licensee shall also transmit to the NRC the same information as transmitted to the employee in accordance with 10 CFR Part 20.408.

NRC Generic Letter 85-08 May 23, 1985 requested that the licensee voluntarily use the standard NRC Form 439 for submitting exposure data for termination reports. Instructions for completing NRC Form 439 specifically state that "The time to be covered by this report is that period of employment or work assignment in your facility(ies) which ended with the most recent termination and was not interrupted by any previous termination during which personnel monitoring was required..." Part III of NRC Form 439 specifically requires that Item 12 be checked, in the box provided, if the licensee had not performed monitoring for exposure to radioactive material. Any monitoring results are entered in Item 13.

Contrary to the above, the NRC determined on January 17, 1989, that the licensee had routinely indicated on radiation exposure termination reports (licensee Form FC-285 - equivalent to NRC Form 439) sent to individuals and the NRC that personnel were monitored for internal radioactivity and the results were "No detectable activity." However, a random review of about 50 personnel monitoring records revealed that 12 individuals had not been whole body counted upon termination at FCS in order to establish the presence of any detectable activity.

This is a Severity Level V violation. (Supplement IV) (285/8904-02)

OPPD RESPONSE (Violation B)

1. Reason for Violation if Admitted

OPPD admits the violation occurred as stated.

The reasons for violation B are as follows:

Prior to the establishment of radiological health (dosimetry) recordkeeping group, heavy reliance was placed on contractor support. Review of the training and qualifications of the contracted staff revealed limited overall experience and no site specific training on the requirements for preparing NRC Form 439 properly.

2. Corrective Steps Which Have Been Taken and the Results Achieved

A radiological health group was formed with the task of preparing and managing dosimetry records. In addition, a radiological health coordinator has been hired to provide oversight of the dosimetry records management.

The newly formed radiological health record management group has received written guidance concerning the specific requirements for the preparation of NRC Form 439.

All NRC Form 439's that are currently prepared now require independent verification before transmittal.

OPPD's on-going audit of personnel dosimetry records now include a review of transmitted Form 439's for accuracy and appropriate corrections are being made.

3. Corrective Steps Which Will be Taken to Avoid Further Violations

The corrective actions, as listed above, should prevent further recurrence of the violation.

4. Date When Full Compliance Will be Achieved

OPPD is in full compliance.