



WASHINGTON PUBLIC POWER SUPPLY SYSTEM

P.O. Box 968 • 3000 George Washington Way • Richland, Washington 99352-0968 • (509) 372-5000

December 12, 1995
GO2-95-269

Docket No. 50-397

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

DEC 18 1995

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Gentlemen:

Subject: WNP-2, OPERATING LICENSE NPF-21
NRC INSPECTION REPORT 95-30
REPLY TO NOTICE OF VIOLATION

- References: 1) Letter, TP Gwynn (NRC) to JV Parrish (SS), "NRC Inspection Report 50-397/95-30 and Notice of Violation" dated 14 November 1995
2) Letter, JV Parrish (SS) to US Nuclear Regulatory Commission, "Submittal of Performance Enhancement Strategy Plan", dated 10 August 1995

The Supply System's reply to the referenced Notice of Violation is attached pursuant to the provisions of Section 2.201, Title 10, Code of Federal Regulations.

Should you have any questions or desire additional information regarding this matter, please call me or D.A. Swank at (509) 377-4563.

Sincerely,

J. V. Parrish (Mail Drop 1023)
Vice President, Nuclear Operations

CJF/lam

Attachments

cc: LJ Callan - NRC RIV
KE Perkins, Jr. - NRC RIV, Walnut Creek Field Office
NS Reynolds - Winston & Strawn
JW Clifford - NRC
DL Williams - BPA/399
NRC Sr. Resident Inspector - 927N

96-0428

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ATTACHMENT

VIOLATION

During an NRC inspection conducted on September 25-28, 1995, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions." (60 FR 34381: June 30, 1995), the violation is listed below:

- Technical Specification 6.12.2 requires, in part, that, in addition to the requirements of Technical Specification 6.12.1, areas accessible to personnel with radiation levels such that a major portion of the body could receive in 1 hour a dose greater than 1000 mrem shall be provided with locked doors to prevent unauthorized entry.

Contrary to the above, on May 7 and August 8, 1995, the licensee failed to lock Door C-115 to an area on the 437-foot elevation of the radioactive waste building in which radiation levels were such that a major portion of the body could receive in 1 hour a dose greater than 1000 mrem.

This is a Severity Level IV violation (Supplement IV) (397/9530-01)

RESPONSE TO THE VIOLATION

The Supply System accepts this violation.

REASON FOR THE VIOLATION

Door C-115 is in a shield wall enclosing a radiation area designated as a High-High Radiation (HHR) area, and is required by the Technical Specifications to be locked to prevent unauthorized access. On May 7, 1995, Door C-115, although correctly closed and latched, was discovered to be unlocked. The latching mechanism is operated by a handwheel which does not have locking provisions. The method of locking the door was to secure the handwheel with a chain, and padlock the chain to itself to prevent its removal. In this event, the chain, although padlocked correctly, was installed such that it did not secure the handwheel. Consequently, the door was actually unlocked although the handwheel appeared to be correctly secured. Plant procedures require documenting the independent verification of locking of doors to HHR and Very High Radiation (VHR) areas by signing the Restricted Key Log when the key is returned after use. A review of the Restricted Key Log showed that a person had signed the log, indicating that Door C-115 was independently verified as being locked. This event was documented on a Problem Evaluation Report (PER) dated May 7, 1995, but neither the dispositioning manager nor the multi-discipline team charged with assigning PERs for disposition classified the PER as a significant problem. Consequently, a formal root cause analysis was not performed for the event.

On August 9, 1995, Door C-115, although correctly closed and latched, was discovered to be unlocked. In this event, the chain and padlock were found on the floor adjacent to the door. On August 8, an entry had been made to the HHR area through the door, in support of a routine

operational activity. Review of the Restricted Key Log showed that a person had signed the log, on August 8, 1995, indicating that the door had been independently verified as being locked. This event was documented on a PER dated August 9, 1995, which was correctly classified as a significant problem, which requires completion of a formal root cause analysis.

Corrective action prescribed to address the first event was to install fixed hasps on the door and door frame such that the door could be locked by a padlock through these hasps, thus eliminating the need for a chain on the handwheel. However, the corrective action for the first event did not prevent a second similar event because the fixed hasps had not been installed by August 8, and no other corrective actions had been prescribed due to lack of in-depth consideration such as would have occurred if a root cause analysis had been performed. Therefore, the cause of the violation is ineffective implementation of established programs and corrective action.

CORRECTIVE ACTION TAKEN AND RESULTS ACHIEVED

In both events, Door C-115 was locked immediately upon discovery of the unlocked condition. No unplanned radiation exposures were identified for either event as resulting from the unlocked door. The individuals involved in inadequately classifying and dispositioning the PER for the first event were counseled regarding their responsibilities with respect to investigation and identification of all issues pertinent to a problem covered by a PER. The individuals involved in leaving Door C-115 unlocked were counseled about the importance of self-checking and attention to details in regard to locking of doors to radiation areas. The requirements for locking of HHR and VHR area doors were emphasized in a quarterly training session for all Health-Physics personnel. Formal training in root cause techniques and coaching were given to Health-Physics personnel involved in processing of PERs. Doors to HHR and VHR areas that are recorded as having been opened during a previous shift are now specifically checked each subsequent shift by Health-Physics personnel to verify that the doors are actually closed and locked.

Door C-115 and similar doors have been modified to incorporate fixed hasps through which padlocks are used to lock the doors. Padlocks to HHR and VHR areas have been rekeyed and changed to the type that prevents removal of the key until the padlock is locked. These changes eliminate the use of chains as locking devices, and prevent leaving padlocks inadvertently unlocked as could occur if the key could be removed when the padlock is unlocked. The HHR area padlocks have been marked with green tape, which makes the padlocks highly visible, facilitating the surveillance indicated above and minimizing the potential that padlocks removed to permit door opening are not inadvertently left uninstalled when closing the door.

As an interim step in strengthening the corrective action program, WNP-2 Quality Assurance presently reviews all PERs regardless of significance classification, to assure that corrective actions will address the cause of the event on a timely basis. This oversight function was initiated on June 20, 1995, to be re-evaluated after a six months period in light of the development of the corrective action program improvement initiatives outlined in Reference 2. The procedure prescribing activities involved in processing of PERs was revised on September 18, 1995 to include specific guidance for

classifying PERs as to significance; such guidance had not been formalized at the time of the first event. The revised procedure also requires that all significant PERs be independently reviewed by a Corrective Action Review Board to assure that corrective actions will be effective and that human performance issues are addressed. These initiatives have significantly strengthened the WNP-2 corrective action program.

CORRECTIVE ACTION TO BE TAKEN TO AVOID FUTURE VIOLATIONS

The requirements for control and verification of locking of doors to HHR and VHR areas will be strengthened to include a physical check of the locked condition of padlocks as the prescribed method for verifying the locked status of such doors. The material each Health-Physics technician is required to read, the periodic formal training program material, and the applicable plant procedure will be modified to reflect this approach. This will emphasize the importance of implementing established programs effectively and clarify management expectations as to details of verifying the locked status of doors to HHR and VHR areas.

The issue of ineffective corrective action is being addressed by the Supply System on a company-wide basis as part of the recent implementation of an extensive performance improvement program identified as the Performance Enhancement Strategy (PES). The PES implements comprehensive improvement initiatives designed to improve functional performance in all plant activities, including but not limited to implementing effective corrective action. The PES program was formally docketed by Reference 2, and has been reviewed by NRC staff and the NRC WNP-2 Oversight Panel. .

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

The Supply System has been in full compliance since August 8, 1995 when door C-115 was locked immediately after it was discovered to be unlocked.

PRIORITY 1

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 PARRISH, J.V. Washington Public Power Supply System
 RECIP. NAME RECIPIENT AFFILIATION
 Document Control Branch (Document Control Desk)

SUBJECT: Responds to NRC 951114 ltr re violation noted in insp rept
 50-397/95-30 on 950925-28. Corrective actions: Door C-115 &
 similar doors modified to incorporate fixed hasps through
 which padlocks used to lock doors.

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