



WASHINGTON PUBLIC POWER SUPPLY SYSTEM

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February 22, 1996
GO2-96-035

Docket No. 50-397

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

FEB 28 1996

Gentlemen:

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

- References:
- 1) Letter GO2-95-269, dated December 12, 1995, JV Parrish (SS) to US Nuclear Regulatory Commission, "NRC Inspection Report 95-30, Reply To Notice of Violation"
 - 2) Letter, dated November 14, 1995, TP Gwynn (NRC) to JV Parrish (SS), "NRC Inspection Report 50-397/95-30 and Notice of Violation"
 - 3) Letter GO2-95-149, dated August 10, 1995, JV Parrish (SS) to US Nuclear Regulatory Commission, "Submittal of Performance Enhancement Strategy Plan"

Reference 1 submitted the Supply System's reply to the Notice of Violation included in Reference 2, pursuant to the provisions of Section 2.201, Title 10 of the Code of Federal Regulations. That reply is being revised by this letter at the request of the WNP-2 Plant Operating Committee to better define the cause of the violation.

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

Sincerely,

J. V. Parrish
Managing Director (Mail Drop 1023)

Attachments

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

96-0833

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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

The cause of both events was personnel error and lack of adequate self-checking.

Door C-115 is in a shield wall enclosing a radiation area designated as a High-High Radiation (HHR) area, and is required by Technical Specification 6.12.2 to be locked to prevent unauthorized access. On May 7, 1995, Door C-115, although correctly closed and latched, was discovered to be unlocked after having been opened earlier in the day by a Health Physics technician to support a routine operation. 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 prevent its removal. In this event the chain, although padlocked, 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 an independent verification of locking of doors to HHR and Very High Radiation (VHR) areas by signing the Restricted Key Log when the padlock 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 had been independently verified as being locked. Therefore, the cause of this event was personnel error and inadequate self-checking by both the responsible Health Physics technician and the independent verifier.

This event was documented on a Problem Evaluation Report (PER) dated May 7, 1995 which correctly identified the event as a violation of Technical Specification 6.12.2. However, the generic issues associated with this problem were not given adequate consideration, and no immediate corrective action was prescribed. The sole corrective action prescribed was to order that fixed hasps be installed on the HHR and VHR doors and mating door frames so that they could be locked by a padlock through these hasps. This would eliminate the need for chains to secure the door handwheels. Although the fixed hasps had not been physically installed by August 8, 1995, this action would not have prevented the second event which was the result of personnel error as described below. Other corrective actions, such as several discussed below, were not identified as part of the resolution of this PER.

On August 8, 1995, an entry was made through Door C-115 in support of a routine operation. On August 9, 1995, the door, although correctly closed and latched, was not locked, as evidenced by discovery of the chain/padlock on the floor adjacent to the door. This event was documented by a PER dated August 9, 1995 which identified the event as a violation of Technical Specification 6.12.2. Investigation revealed that:

- (1) The door had actually been closed and latched after the activity in the HHR area had been completed, as visually checked by both the responsible Health Physics technician and the operator.
- (2) The technician had been distracted from the task of locking the door by the prospect of another work evolution scheduled to take place in the same area.
- (3) The operator, who was still dressed in protective clothing, had not physically verified that the chain/padlock combination had actually been installed by the technician.
- (4) Review of the Restricted Key Log showed that both the technician and the operator who had entered the HHR area had signed the log on August 8, indicating that the door had been locked.
- (5) Both the technician and the operator clearly understood that the door was required to be locked per Technical Specification requirements.

Consequently, the cause of this second event was personnel error and inadequate self-checking by both the operator and the technician.

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.

Door C-115 and similar doors have been modified to incorporate fixed hasps through which padlocks are used to lock the doors. Padlocks for doors 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. 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 the doors are actually closed and locked. The HHR area padlocks have been marked with green tape, which makes the padlocks highly visible, facilitating this surveillance and minimizing the potential that padlocks removed to permit door opening are inadvertently left uninstalled when closing the door.

The requirements for control and verification of locking doors to HHR and VHR areas have been strengthened to include a physical check of the locked condition of the 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 material, and the applicable plant procedure have been modified to reflect this approach, thereby emphasizing management expectations in regard to details of verifying the locked status of doors to HHR and VHR areas.

The WNP-2 Radiation Protection Manager and the Corporate Radiological Health Officer have reiterated management expectations for control of HHR and VHR areas, and compliance with Technical Specifications. The individuals involved in leaving Door C-115 unlocked were counseled about the importance of self-checking and attention to detail 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. In addition, the verification function has been assigned to the Health Physics technicians.

The individuals involved in 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. Formal training in root cause techniques and coaching were given to Health Physics personnel involved in processing of PERs. The procedure prescribing activities involved in processing PERs was revised to include specific guidance for classifying the significance of identified problems, and to require more comprehensive actions, in the case of significant problems such as those involving a violation of Technical Specifications. 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 prescribed corrective actions are sufficiently comprehensive and 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 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 3, 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.

CATEGORY 1

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

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

SUBJECT: Rev to response to NRC 951114 ltr re violations noted in
 insp rept 50-397/95-30 on 950925-28. Corrective actions: doors
 modified to incorporate fixed hasps through which padlocks
 are used to lock doors.

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