The Light company
Houston Lighting & Power South Texas Project Electric Generating Station P. O. Box 289 Wadsworth, Texas 77483

April 1, 1993
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File No.: G02.04
10CFR2.201

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

South Texas Project
Unit 1 and 2
Docket Nos. STN 50-498; STN 50-499
Reply to Notice of Violation 9235-05
Regarding Failure to Follow
Radiological Procedures and Postings

Houston Lighting & Power Company (HL&P) has reviewed Notice of Violation 9235-05 dated March 3, 1993, and submits the attached reply.

If you have any questions, please contact Mr. C. A. Ayala at (512) 972-8628 or me at (512) 972-7921.

W. H. Kinsey, Jr.
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RAD/pla

Attachment: Reply to Notice of Violation 9235-05

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I. Statement of Violation:

Technical Specification 6.11.1 states that procedures for personnel radiation protection shall be prepared consistent with the requirements of 10CFR20 and shall be approved, maintained, and adhered to for all operations involving personnel radiation exposure. Two examples of violating this requirement are stated below:

1. Procedure OPGP03-ZR-0002, Revision 9, "Radiological Controlled Area Access and Work Control," Step 5.5, states, in part, that, when exiting the radiologically restricted area, personnel will use a personnel contamination monitor and, if not available, will perform a whole-body frisk as directed by Health Physics.

   Contrary to the above, on December 7, 1992, a licensee worker exited the Unit 1 radiologically restricted area without utilizing a personnel contamination monitor or performing a whole-body frisk.

2. Procedure OPRP02-ZX-0007, Revision 5, "Radiological Posting and Warning Devices," Paragraph 4.2.2, requires, in part, that, the radiological posting signs be hung from barriers such that the posting is clearly visible when approaching the area. Paragraph 4.3 establishes areas as requiring radiological postings as any area where access is controlled by HP for purposes of protection of individuals from exposure to radiation and/or radioactive materials. Areas outside the main Units 1 and 2 radiologically controlled area (RCA) should be identified as an RCA if the dose rates at 18 inches exceed 0.5 mr/hr.

   Contrary to the above, on December 4, 1992, the radiological posting was not adequate to restrict personnel access from an area outside the main Units 1 and 2 RCA where dose rates exceeded 0.5 mr/hr at 18 inches. During a radiation monitor calibration, while the source was exposed, a licensee employee entered into the Unit 2 control room through the south door and violated the radiological posting in place for the surveillance. The radiological posting sign had been hung from the door and not from barriers such that the posting was not clearly visible when approaching the door.

   This is a Severity Level IV violation. (Supplement I) (498;499/9235-05)

II. Houston Lighting & Power Position:

HL&P concurs that this violation occurred.

III. Reason for Violation:

1. The cause of this event was failure of the worker to follow standard radiological work practices, as described in, 0PGP03-ZR-0002, Revision 9, "Radiological Controlled Area Access and Work Control," Step 5.5. The individual exited the radiological controlled area (RCA) without performing a whole body frisk.

   Contributing to the event was that the equipment was being loaded through the Mechanical Auxiliary Building (MAB), 351 door, which is located on a platform on the 60' elevation, approximately 30 feet above the ground. The area in which the work was being performed (60' MAB and loading platform) is a radiological "clean" area; i.e., not contaminated. The workers could not permanently exit the RCA without traversing the MAB and exiting through the normal RCA egress and through the personnel contamination monitors.

   In addition, a positive barrier was not established to remind workers where the RCA boundary was located.

2. The cause of this event was a failure of an employee to identify and follow a radiological posting. Contributing to the event was that the radiation area was outside the main Unit 1 and 2 RCA. In addition, the posting was not hung on a barrier other than the door used for normal control room access. Health Physics technicians providing job coverage for the radiation monitor calibration stopped the individual prior to his actual entry into the Unit 2 control room. The dose rates in the area of the door threshold were ≤ 0.2 mR/hr.

IV. Corrective Actions:

1a. Health Physics personnel verified that the workers involved were free of contamination. No contamination was found on personnel.

1b. The Health Physics Operations General Supervisor issued night orders to Health Physics personnel which emphasized the procedural requirement to perform a whole-body frisk prior to exiting the RCA and provided guidance on the transfer of material through the MAB, 331 doors.

1c. A Technical Services Training Bulletin was issued to Health Physics personnel describing the event and explaining performance expectations for job coverage/work control of the loading/unloading of material through the MAB, 331 doors.

1d. General Employee Radiation Worker Training (GET II) will be enhanced to provide training on controls for alternate access points to the RCA, such as, the MAB 331 doors, Reactor Containment Building equipment hatch, Fuel Handling Building truckbay, and radioactive waste yards. The enhanced training will be in effect by June 30, 1993.

1e. A review of RCA monitoring and access control requirements will be performed. Additional guidance will be provided based on the results of the review. This will be completed by November 19, 1993.

2a. Access to the control room through the south door was suspended by the Shift Supervisor and a radiological barrier (magenta and yellow rope) was suspended across the door's threshold with the posting attached to the barrier. Also, the card reader allowing door access was disabled to preclude possible breaches of the posting.

2b. Health Physics personnel initiated Radiological Occurrence Report 2-92-0131 and suspended the individual's RCA access pending counseling of the individual by a Health Physics Supervisor and the individual's Supervisor.

IV. Corrective Actions: (con't)

2c. The Training Bulletin described in action 1c above included a description of this event and explained performance expectations for radiological postings outside the main Units 1 and 2 RCA boundaries, including the construction of a positive barrier, such as magenta and yellow rope, which is different from normal access barriers. The Training Bulletin described in actions 1c and 2c will be discussed at biweekly crew meetings. This will be completed by April 30, 1993.

0PRP02-ZX-0007, Revision 5, "Radiological Posting and Warning Devices," will be revised to clarify the use of positive barriers for radiological postings outside the main Units 1 and 2 RCA and for movement of RCA boundaries to allow transfer of material. The procedure will be revised and effective by May 31, 1993.

The lessons learned from these events will be discussed in General Employee Training GET I and GET II requalification training. The lesson plans will be revised by June 30, 1993.

V. Date of Full Compliance:

HL&P is in full compliance at this time..