



TUELECTRIC

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File # 10130
IR 95-29
Ref. # 10CFR2.201

February 29, 1996

C. Lance Terry
Group Vice President

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

SUBJECT: COMANCHE PEAK STEAM ELECTRIC STATION (CPSES)
DOCKET NOS. 50-445 AND 50-446
NRC INSPECTION REPORT NOS. 50-445/95-29; 50-446/95-29
RESPONSE TO NOTICE OF VIOLATION

Gentlemen:

TU Electric has reviewed the NRC Inspection Report and attached Notice of Violation dated February 8, 1996, concerning the inspection conducted by Resident Inspectors Messrs. A.T. Gody, Jr., H.F. Freeman, and Ms. V.L. Ordaz-Purkey during the period of November 26 through January 6, 1996.

The Notice of Violation describes a failure to follow procedures which resulted in failure to perform necessary radiological surveys to ensure adequate knowledge of radiological conditions prior to job performance and subsequent radiological exposure to three workers. Our response is attached.

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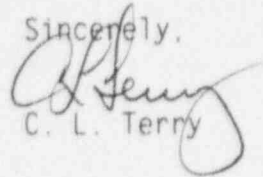
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Please do not hesitate to contact Neil Harris at (817) 897-5449 to coordinate any additional information you may need to facilitate closure of this issue.

Sincerely,



C. L. Terry

NSH:nsh

Attachment

cc: Mr. L. J. Callan, Region IV
Mr. W. D. Johnson, Region IV
Resident Inspectors

RESTATEMENT OF THE NOTICE OF VIOLATION
(50-445/95-29; 50-446/95-29)

During an NRC inspection conducted on November 26 through January 6, 1996, one 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 restated below:

CPSES Technical Specification 6.11.1 states that procedures for personnel radiation protection shall be prepared consistent with the requirements of 10 CFR Part 20 and shall be approved, maintained, and adhered to for all operations involving personnel radiation exposure.

Procedure RPI-602, "Radiological Surveillance and Posting," Section 6.1.2, states that nonroutine surveys be performed as required to ensure adequate knowledge of radiological conditions prior to, during, and/or after any evolution involving exposure or potential exposure to radiological hazards.

Radiation Work Permit, 95000500, "Waste Processing", item 4, issued on June 6, 1995, states that "RP (Radiation Protection) technicians providing coverage shall perform and document necessary surveys in accordance with Procedure RPI-602."

Contrary to the above, on December 11, 1995, the licensee found that radiation protection technicians failed to perform necessary surveys to ensure adequate knowledge of radiological conditions of Spent Resin Sluice Filter 01 prior to and during filter removal and consequently replaced the filter without using a shielded transfer assembly as required by the radiological conditions and procedures.

REPLY TO NOTICE OF VIOLATION
(50-445/95-29; 50-446/95-29)

TU Electric accepts the violation. While the actual radiation exposures received during this incident were minimal, they were unanticipated. The radiological coverage for this evolution was not in accordance with TU Electric's expectations and the failure to survey is considered a serious event. A Plant Incident Report (PIR), including a Human Performance Evaluation (HPES) has been performed and corrective actions initiated to preclude a recurrence of this type of event. The information requested is provided as follows:

1. Reason for the Violation

Background:

On December 11, a radiation protection technician surveyed the incorrect discharge filter which ultimately led to the removal of a more radioactively contaminated discharge filter without using a shielded transfer system. In addition, another radiation protection technician did not perform surveys during filter removal.

Prior to the filter change-out activity, the TU Electric did not survey the correct filter "Spent Resin Sluice Filter X-01" (Tag Number TBX-SPFLRS-01). The on-shift Lead Radiation Protection (RP) technician instructed a field RP technician (Technician A) to survey the spent resin sluice filter. Technician RP-A thought the lead technician said "spent resin sluice pump filter" rather than "spent resin sluice filter." Technician A incorrectly surveyed the "steam generator blowdown spent resin sluice pump filter 01".

Technician A measured the dose rate on the incorrect filter and reported to the Lead RP technician that the dose rate on the "steam generator spent resin sluice pump filter" was less than 0.1 millirem per hour. The use of noun names to identify equipment instead of tag numbers resulted in a preliminary survey of the wrong component.

Technician A was not qualified to cover the filter change out and the Lead RP technician assigned another field RP technician (Technician B) to support the filter change out. Since the incorrect filter was initially surveyed and the assumed dose rate would be negligible, Technician B assisted in the filter change out by holding the plastic bag into which the mechanics would place the filter, rather than providing direct radiological protection coverage prior to and/or during the filter removal.

During the filter change-out, all electronic dosimeters began to alarm (set at 50 mR/hr). The RP Technician had received 8 mR. Mechanic A had received 1 mR and Mechanic B had received 4 mR. The total measured exposure to personnel associated with the unsurveyed filter change out was 21 mR with a maximum exposure to a single individual of 12 mR. The electronic dosimeters alerted the workers to the actual radiological conditions and assisted the RP technician in appropriately directing the activities which minimized the dose to all personnel involved.

Conclusion:

Based on the above assessments, the following synopsis of causes are given. (a) The use of filter noun names which are similar in sound and designation, contributed to the incorrect filter being surveyed and subsequent personnel exposure. (b) Technician B relied on information passed verbally and did not perform a start of job survey. (c) RPI-110-3 form, "Radiation Protection Job Assignment Sheet", used to facilitate communication of instructions regarding work on components that require specific identification, was not used for either the preliminary survey or the filter removal. (d) The Radiation Protection Lead Technician was performing routine activities normally assigned to subordinates and failed to prioritize his work activities to account for tasks with potentially higher radiological consequences.

2. Corrective Steps Taken and Results Achieved

(a) Instruction RPI-206, "Liquid Process Filter Control", has been changed to require a start of job survey for all filters removed. (b) instructions have been issued to appropriate personnel reemphasizing the use of the RPI-110-3 form, "Radiation Protection Job Assignment Sheet". Due to these corrective actions, start of job surveys are being taken and documented and surveys are performed on the correct components.

3. Corrective Steps Taken to Avoid Further Violation

A lessons learned on this event will be provided to appropriate personnel regarding:

- (a) the appropriate use of tag numbers and/or noun names to identify components.
- (b) reemphasize management's expectation to stop and assess the situation prior to continuing when the situation encountered is different from what was expected.
- (c) assure Radiation Protection personnel understand the potential results of failing to identify the radiological conditions to be encountered prior to commencing a work activity, and
- (d) to reemphasize management's expectation that radiological conditions will be assessed prior to commencing work.

4. Date of Full Compliance

TU Electric will complete all corrective actions by May 15, 1996.