

August 4, 1998

Mr. John Denson
[]
Lockheed Martin Idaho Technologies Company
P.O.Box 1625
Idaho Falls, ID 83415

Subject: Enforcement Letter
Noncompliance Report NTS-ID--LITCOSITEW-1998-0001

Dear Mr. Denson:

This letter refers to the Department of Energy's (DOE) evaluation of the Lockheed Martin Idaho Technologies Company (LMITCO) subject Noncompliance Tracking System (NTS) report for noncompliances with the requirements of 10 CFR 830.120, "Quality Assurance Requirements." The NTS report addresses a repetitive problem of maintaining the operability of radiation monitoring instrumentation and systems referenced in nuclear facilities authorization basis documents. The repetitive problem was identified by LMITCO on February 27, 1998, and reported to DOE on March 31, 1998. Enclosed is a list of prior occurrences that were individually addressed in four NTS reports and two additional occurrence reports.

LMITCO initiated this NTS report as a direct result of its follow-up actions to the earlier DOE Preliminary Notice of Violation of September 19, 1997, regarding certain work process deficiencies. The LMITCO letter of October 23, 1997, to DOE committed to two broad corrective actions. In addition, the LMITCO letter of February 26, 1998, from C. York, vice president for Nuclear Operations, to R. Stallman, DOE, made further recommendations, including an evaluation of management controls for radiation instruments. This evaluation is required by your nuclear facilities Safety Analysis Reports. The evaluation identified a potential deficiency of not maintaining the operability of radiation monitoring instrumentation and systems which would be a violation of your Operation Safety Requirements (OSR) and Technical Safety Requirements (TSR).

After evaluating the deficiencies identified in this NTS report and the corrective actions taken to date, we have concluded these deficiencies likely did not impact the safety of workers or the environment; however, they constitute repetitive noncompliance with the requirements of 10 CFR 830.120 (c)(2)(i), "Work Processes." We recognize that this repetitive problem was identified as one outcome of currently ongoing corrective

actions.

The results of the corrective actions are included in a LMITCO interdepartmental communication report of April 7, 1998. It was concluded by LMITCO that no single common cause was evident for the occurrences evaluated, although most dealt with various aspects of Conduct of Operations. Based on our evaluation of the six occurrences as a group, it appears that these occurrences describe an attitude of indifference toward and a lack of awareness of OSR/TSR requirements, their importance, implementation, and associated procedures. This attitude is not only apparent for workers at the operating level but also for facility managers and other management staff.

We have also evaluated the safety significance of the noncompliances. The safety hazard associated with each of the six events was low; however, personnel exposure could have resulted in the case of an accident. While it is essential that radiation monitoring instruments and systems are operable, the overall nuclear safety significance of this noncompliance was determined to be low. Your self-identification of the noncompliances, including the repetitive problem, and timely and comprehensive corrective actions, coupled with the low nuclear safety significance of this problem, meet the discretionary criteria described in DOE's nuclear safety enforcement policy. Therefore, I have decided to defer any enforcement action at this time. Ineffective implementation of the corrective actions or subsequent similar repetitive breakdowns in radiation monitoring instruments and systems that have the potential to adversely affect nuclear safety, however, will be evaluated for appropriate enforcement action.

If you would like to discuss these matters further, please contact Steven Zobel of my staff at (301) 903-0100.

Sincerely,

R. Keith Christopher
Director
Office of Enforcement and Investigation

Enclosure:
Non-operability Occurrences of Radiation
Monitoring Instruments and Systems List

cc: P. Brush, EH-1
M. Zacchero, EH-1
S. Zobel, EH-10

G. Podonsky, EH-2
O. Pearson, EH-3
J. Fitzgerald, EH-5
W. Magwood, NE-1
L. Miller, NE-40
J. Wilcynski, DOE-ID
W. Bergholz, DOE-ID
S. Somers, DOE-ID
K. Whithan, DOE-ID
S. Forcey, LMITCO PAAA Coordinator
Docket Clerk, EH-10

Non-operability Occurrences of Radiation Monitoring Instruments and Systems

1. NTS-ID--LITC-WASTEMNGT-1997-0002, Idaho Chemical Processing Plant (ICPP), June 19, 1997: Flow instrument for online stack monitor was removed from service without verification that other system was on line.
2. NTS-ID--LITC-ATR-1997-0002, Nuclear Material Inspection and Storage (NMIS) Facility, July 22, 1997: Operational checks of [nuclear safety] alarm system were performed with inappropriate QA level, and inadequate procedures (preparation, control and use).
3. Occurrence Report ID--LITC-ATR-1997-0016, Nuclear Material Inspection and Storage (NMIS) Facility, July 28, 1997: Alarm set point of [Nuclear Safety] Alarm System [] was set above the set point in the associated Safety Analysis Report (SAR).
4. NTS-ID--LITC-1997-0004, Test Reactor Area (TRA), November 1997: One of two required stack monitors was taken out of service without notification of operations management and without verification that alternate monitoring had been established.
5. NTS-ID--LITC-SMC-1997-0002, Material Development Facility (MDF), December 2, 1997: Filter change out for radiation monitoring system was performed monthly instead of weekly as specified in the associated Technical Specification Requirement (TSR).
6. Occurrence Report ID--LITC-ATR-1997-0027, Digital Radiation Monitoring System (DRMS), December 4, 1997: Nineteen radiation alarm monitors (RAMs) did not actuate the local or remote alarm when tested but were otherwise operable.