ROCHESTER GAS AND ELECTRIC CORPORATION • 89 EAST AVENUE, ROCHESTER, N.Y. 14649-0001 AREA CODE 716 546-2700

ROBERT C. MECREDY
Vice President
Nuclear Operations

April 29, 1997

U.S. Nuclear Regulatory Commission
Document Control Desk
Attn: Guy S. Vissing
Project Directorate I-1
Washington, D.C. 20555

Subject: Reply to a Notice of Violation
NRC Inspection Report 50-244/97-01, dated March 25, 1997
R.E. Ginna Nuclear Power Plant
Docket No. 50-244

Dear Mr. Vissing:

Rochester Gas and Electric (RG&E) provides this reply to the Notice of Violation (VIO 50-244/97-01-02) submitted as an enclosure to a letter from Lawrence T. Doerflein, USNRC, to Robert C. Mecredy, RG&E, dated March 25, 1997. As a result of an inspection conducted from January 5 to February 23, 1997, the following violation of NRC requirements was identified. In accordance with the Enforcement Policy (NUREG-1600), the violation is listed below:

"10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," requires in part that measures be established to assure that conditions adverse to quality, such as deficiencies and deviations are promptly identified and corrected.

Contrary to the above, the licensee failed to correct problems regarding contamination boundary control and poor radiological work practices noted in NRC Inspection Report Nos. 50-244/94-29 and 50-244/96-11, and RG&E ACTION Report No. 96-0902 dated September 27, 1996, as evidenced by the following:

1) February 9, 1997, maintenance tools were removed from a designated contamination area on the A-Safety Injection pump. Several rags and a wire brush that had been used inside an area with loose smearable surface contamination were allowed to straddle across the boundary marker line and extend into an uncontaminated area. These items were not surveyed prior to being removed from the contaminated area. Other wrenches and tools that had been used inside a contaminated area were removed and placed on a clean surface without having been bagged or surveyed for contamination beforehand.

2) February 17, 1997, a leak from a fitting on the transmitter of a flow instrument (FI-116) was dripping from inside a contaminated area onto a clean floor surface that was designated as uncontaminated. A towel had been placed on the floor was collecting the leakage (sic), but the towel was saturated with the radioactive fluid. Water was flowing away from the towel to a low point in the floor, forming a puddle, and contaminating previously clean floor areas up to 2700 dpm/100cm^2. No collection device was in place that could prevent the spread of contaminated water to uncontaminated areas. The radiological protection technician on duty at the time was not aware of this condition.

BACKGROUND

1. Inspection Report 94-29

NRC Inspection Report 94-29 dealt with review of accessible areas of the plant to verify that high radiation doors were locked, and radiological postings were posted as required. Some variability in the use of contamination boundary demarcation tape (rad tape) was noted. In some areas, rad tape was used on the floor to define the contamination area boundary marker line, and in other areas this was not used. For example, for one area a contamination rope barricade and posting were used without a floor rad tape boundary marker line.

The inspector also noted an extension cord and a hose running from a clean area into a contaminated area without a clear definition of the clean or contaminated portion of the cord and hose. Both the cord and hose had been pulled loose during the work evolution and the original position of the cord and hose could not be determined. RG&E reestablished a clear contamination boundary marker line and stated that the use of rad tape would be reevaluated.

2. NRC Inspection Report 96-11

As reported in NRC Inspection Report 96-11, NRC inspectors observed a work area with some work partially conducted inside a roped-off contamination area. The inspector noted that several equipment service lines and power cords were not secured within the contamination area. Significant amounts of tape, grinding dust, and miscellaneous debris generated from welding and grinding work had fallen to the floor and were accumulating outside the contamination area boundary. The step-off pad for exiting the contamination area was not securely attached to the floor. Several buckets that

were used to collect contaminated fluids were not labeled properly. NRC inspector also noted additional contamination boundary control concerns, where loose bags and papers within the contamination area were allowed to collect on the floor and extend across the boundary marker line. Cords and test leads were not secured to the floor to prevent them from carrying contamination out of the area.

When notified by the NRC inspector of this condition, RG&E personnel immediately cleaned up the debris in and outside of the contamination area and secured the service lines to the floor to prevent them from being moved across the boundary marker line. Radiological surveys were taken and no spread of contamination was detected. However, RG&E agreed that management expectations for proper contamination boundary controls had not been met. Site personnel working in these areas were subsequently counseled.

3. ACTION Report 96-0902

ACTION Report 96-0902 dealt with contaminated tools/equipment found in unrestricted area tool storage areas. These tools were found as a result of the annual Radiation Protection (RP) surveys of these areas.

(1) The reasons for the violation, or, if contested, the basis for disputing the violation:

RG&E accepts the violation. We agree that problems regarding contamination boundary control and poor radiological work practices have not been programmatically corrected.

(a) Safety Injection Pump

The area around the safety injections pumps is very congested. Contaminated surface area boundaries are denoted by rad tape. The initial work planned for the area was to inspect and, if necessary, tighten some leaking Swagelok fittings. Typically, the small contamination control area established for this work scope is adequate.

Based on inspection of the leaking fittings, the work scope was expanded to include tubing replacement. Discussions occurred between the workers and Radiation Protection (RP) technician relative to the expanded work scope, but there was no decision to enlarge the contamination control area boundary to better optimize the work environment. Enlarging the work area would have better accommodated the expanded work scope and eliminated the need to

transfer hand tools and other items in and out of the contaminated area that had previously been established. There was a lack of alertness on the part of the workers and RP technician that the contamination area boundary should have been enlarged for more effective contamination control.

The tool removed from the contaminated area was used to tighten a Swagelok nut that had been previously smeared and was free of loose contamination. Athough full compliance to contaminated area boundary control was lacking, smearing the nut was a positive step which is representative of ongoing efforts at the work area to help minimize the spread of contamination. The rags, wire brush, and wrench should have been bagged prior to removal from the contaminated area.

A contributing factor was the small contaminated area boundary. An enlarged boundary would have eliminated the need to transfer these items in and out of the contaminated area. Thus, bagging prior to final removal would have been accomplished as a standard, acceptable work practice, if the contaminated area had been properly enlarged.

(b) Leak from Flow Transmitter FI-116

It is not known who placed the absorbent towel under the transmitter, nor how long the towel had been there before the NRC inspector identified the problem. RG&E acknowledges that an absorbent towel is not an appropriate method for containing contaminated liquid. This is an unacceptable work practice. A catch containment or bucket should have been used.

As background for how this situation developed, a Maintenance Work Order had previously identified a boron buildup on a Swagelok fitting to FI-116. This prompted RP to provide contamination boundary controls to the immediate area adjacent to FI-116. Initially described as a dry boron buildup, the leak progressed to the point of a steady drip. It could not be ascertained at what stage in leak development the absorbent towel was placed under the transmitter.

(c) Contaminated Area Boundary Control

RG&E acknowledges that corrective actions for previously identified poor radiological work practices and inadequate contamination boundary controls were not effective. There have been additional incidents in these areas. The programmatic requirements need to be strongly reinforced. These incidents are the result of lapses in performance and failure to adhere to the established management expectations and standards.

Therefore, as discussed in detail under corrective actions, the focus will be on clear and unambiguous expectations for boundary demarcations and control, additional management coaching and counseling, heightened awareness of these expectations, enhanced training, enforcing consistency in application of standards, reinforcement of individual accountability and responsibility, and monitoring to ensure continuing compliance.

(2) The corrective steps that have been taken and the results achieved:

(a) On February 11/12, 1997, meetings were held with all available members of the Nuclear Operations Group. These meetings provided an opportunity for the Plant Manager to discuss radiological work practices and contamination boundary control. The importance of adherence to procedures and the seriousness of lapses in acceptable practices concerning contamination boundary control was personally conveyed by plant management.

(b) At the request of Maintenance Supervision, the Ginna Station Principal Health Physicist met with members of appropriate shops to outline concerns with improper contamination boundary control and to review station requirements and management expectations. Separate meetings were held with each of the following shops:

Mechanical Maintenance
Electrical Maintenance
Instrument and Control (I&C)
I&C Special Projects.

(c) A letter was issued by the Plant Manager and Superintendents to all plant personnel, dated March 20, 1997, regarding management expectations for contamination boundary control. This letter emphasized that all personnel are accountable for obeying established radiological boundaries when entering the restricted area. It further emphasized that if instructions are not clear or fully understood, then the planned work should not be initiated, and that it is the worker's responsibility to ensure that all instructions are understood. The letter further stated that any incident of unacceptable radiological work practice will result in a meeting with supervision, and further disciplinary action may be necessary.

(3) The corrective steps that will be taken to avoid further violations:

The Radiation Protection (RP) Group has been assigned responsibility to coordinate implemention of all corrective actions discussed below.

(a) Procedures will be reviewed, and revised as appropriate, to provide clear and unambiguous management direction. Any changes will clearly state acceptable practices for contamination boundary control. In addition, any changes will include clear definitions of the various types of acceptable contamination boundary markers.

(b) Contamination boundary control issues will be discussed at regularly scheduled shop meetings by Maintenance Supervision, to reinforce its importance. Periodically, RP personnel will be requested to attend these meetings to provide clarification and foster increased communications between groups.

(c) RP Supervision has directed the RP staff and RP technicians to provide strong coaching to radiological workers. This is being done to ensure RP personnel are effective in assisting workers in maintaining effective contamination boundary control. When practicable, assigned RP personnel are expected to be in the work area when work activites are occurring within contaminated areas, to ensure management expectations are being met.

(d) Training Work Requests have been initiated to provide enhanced training in contaminated area situations.

(e) A Root Cause Analysis is being performed to identify other factors that have contributed to poor radiological work practices in the past. Corrective actions, if needed, will address these factors, to assist in developing other appropriate means to strengthen the programmatic requirements and to increase compliance with these requirements.

(f) As a joint effort between Maintenance, RP, and Nuclear Training, "Project Boundary" has been established. Major attributes of this project include:

- Communication of management expectations
- Boundary Control policies that are easy to use
- Training for ALL groups on revisions to boundary control policies

- Reinforcing and rewarding good behaviors
- Revising Training programs
- Train contractors (who work during outages) to the same level as RG&E workers
- Verify adequacy of these actions against predetermined indicators

(g) An independent Effectiveness Review will be conducted to verify the adequacy of the above listed corrective actions. This review will be completed by October, 1997.

(4) The date when full compliance will be achieved:

Full compliance has been achieved as of March 20, 1997, when short term corrective actions, including heightened awareness and restatement of management expectations, were completed. Further long term enhancements, as discussed in corrective actions (a) through (g) above, will result in a more effective program.

Very truly yours,

Robert C. Mecredy

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Ginna Senior Resident Inspector

CATEGORY 1

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MECREDY,R.C. Rochester Gas & Electric Corp.
RECIP.NAME RECIPIENT AFFILIATION
VISSING,G.

SUBJECT: Responds to NRC 970325 ltr re violations noted in insp rept 50-244/97-01 on 970105-970223.Corrective actions:held meetings on 970211-12 w/available members of Nuclear Operations Group to discuss radiological work practices.

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