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May 10, 1991
JAFP-91-0289

William Fernandez II
Resident Manager

U.S. Nuclear Regulatory Commission
Mail Station Pl-137
Washington, DC 20555

ATTENTION: DOCUMENT CONTROL DESK

SUBJECT: RESPONSE TO NOTICE OF VIOLATION -
INSPECTION NO. 91-06 (DOCKET 50-333)

Reference: 1. USNRC Letter Dated April 26, 1991
Subject: Inspection Report 50-333/91-06

Enclosure: Response to Notice of Violation

Gentlemen:

In accordance with the provisions of 10 CFR 2.201, the Authority is submitting our response to Appendix A Notice of Violation transmitted by your letter (Reference 1), dated April 26, 1991. This refers to the inspection conducted by Mr. Peter V. O'Connell March 11 through 15, 1991 at the James A. FitzPatrick Nuclear Power Plant.

Very truly yours,


WILLIAM FERNANDEZ

WF/GJV

enclosure

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ENCLOSURE 1

NOTICE OF VIOLATION

During an NRC inspection conducted on March 11 - 15, 1991 a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C (1990), the violation is listed below:

- A. Technical Specification 6.11.A.1, states, that locked doors shall be provided to prevent unauthorized entry into such areas (i.e., each high radiation area in which the intensity of radiation is greater than 1000 mrem/hr).

Contrary to the above, on March 9, 1991, an individual taped over the lock on the personnel access gate to the drywell, thereby defeating the locking mechanism, and then left the area. The personnel access gate was unlocked and positive access control was not maintained into containment for approximately two hours before an operator discovered the defeated lock and secured the personnel access gate. There were areas inside the personnel access gate in which the intensity of radiation was greater than 1000 mrem/hr as noted on radiological surveys of the drywell.

RESPONSE

A. The Authority agrees with the violation.

The reason for this violation was personnel error.

On March 9, 1991 at approximately 2035 hours a Radiological Technician (RT) was attempting to install a hose for a High Efficiency Particulate Air (HEPA) filter unit which was to be used in the drywell (DW). The hose was located at the DW entrance area outside gate 272-11. At the time of this incident there were two entrance points available to the DW. The DW equipment hatch area was the normal entry point and was open and guarded 24 hours per day. The second entry point, gate 272-11, is normally shut and locked during this time. The RT entered the DW through the DW equipment hatch area and proceeded to the DW personnel entrance area (gate 272-11) from inside the DW. While attempting to move the hose into the DW through gate 272-11 he taped the latch mechanism over to facilitate this work evolution so that the gate would not swing closed and lock him out of the DW. Once the hose was in place he exited the DW through the equipment hatch area instead of the now taped open DW entrance gate. In doing so he forgot to untape the latch to gate 272-11. This provided possible access to a high radiation area with dose rates greater than 1000 mrem/hr general area for a period of approximately four hours at which time the gate was discovered unlocked and immediately secured.

The corrective steps that have been taken and results achieved include specific training on this event for all radiation workers. Appropriate disciplinary action was taken.

The corrective steps that have been taken to avoid further violations include a prohibition on the use of tape to defeat or block open high radiation area gates or barricades. In the event that a high radiation area gate or barricade is permitted to be defeated, the gate or door will be blocked open conspicuously and posted with a sign indicating the authorized status of the gate or door.

Full compliance was achieved when the high radiation area gate was secured on March 10, 1991.