



GPU Nuclear Corporation
Post Office Box 388
Route 9 South
Forked River, New Jersey 08731-0388
609 971-4000
Writer's Direct Dial Number:

C321-91-2308
November 7, 1991

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

Dear Sir:

Subject: Oyster Creek Nuclear Generating Station
Docket 50-219
Reply to Notice of Violation
Inspection 91-20

In accordance with 10 CFR 2.201, Attachment 1 provides GPUN's response to the violations identified in the subject Inspection Report. GPUN wishes to note that these incidents were self-identified as stated in the report.

With regard to Violation B, the Unlocked High Radiation Area, we consider this to be entirely a personnel failure to abide by the GPUN Radiation Protection Plan. We found no evidence of programmatic weakness in our programs for control of Locked High Radiation Areas, and no programmatic changes are contemplated. This was the only violation of its kind in two years - a period in which over 6000 entries were made into Locked High Radiation Areas.

In the letter transmitting the Notice of Violation, you noted particular concern regarding falsification of records as being an offense that cannot and will not be tolerated by the NRC. We wish to most emphatically point out that GPUN has a well established record that clearly indicates that we do not in any way tolerate willful non-compliance with procedures, technical specifications, regulations and any other Commission requirements. We trust, furthermore, that our position on such matters is well known to the NRC and that your statement was in no way an expression of concern that we have in the past, did at the time in question, or would in the future condone falsification of records.

9111140073 911107
PDR ADOCK 05000219
PDR

120192


GPU Nuclear Corporation is a subsidiary of General Public Utilities Corporation

IE01
111

C321-91-2308
Page 2

Should you require additional information, please contact Thomas Blount,
Oyster Creek Licensing Engineer at (609)971-4007.

Sincerely,



for John J. Barton
Vice President and Director

JJB/T3:jc
cc: Administrator, Region 1
Senior NRC Resident Inspector
Oyster Creek NRC Project Manager

Attachment 1

VIOLATION A

Technical Specification Section 6.11 "Radiation Protection Program", requires that "Procedures for personnel radiation protection shall be prepared consistent with the requirements of 10 CFR 20 and shall be approved, maintained, and adhered to for all operations involving personnel radiation exposure."

Radiation protection procedure 9300-ADM-4000.11, "Rules for Conduct of Radiological Work", specifies, in part, in Section 7.2, that all personnel who enter the radiologically controlled area shall obey posted, oral, and written Radiological Control instructions, procedures, and Radiation Work Permits (RWP).

RWP 911086, "Radwaste Operations", required either an alarming dosimeter or a dose rate meter for entry into posted High Radiation Areas. RWP 911086 also required the wearing of a full set of protective clothing when entering posted contaminated areas, unless otherwise authorized by the Group Radcon Supervisor or Radcon Technician.

Contrary to the above, on July 5, 1991, an individual working under RWP 911086 entered an area of the New Radwaste Building, which was posted as a High Radiation Area/Contaminated Area, without an alarming dosimeter or a dose rate meter as specified on the RWP, and the individual, who was not otherwise authorized by the Group Radcon Supervisor or Radcon Technician, did not wear the protective clothing specified on the RWP.

This is a Severity Level IV violation. (Supplement IV).

RESPONSE:

GPUN concurs with the violation as stated and notes that it was self-identified.

The reason for this violation of Radiation Work Permit (RWP) number 911086 was personnel error in that the Radioactive Waste Operator believed that entry beyond a posted high radiation area boundary, but outside of an actual high radiation area (defined as an area in which dose rates exceed 100 millirem per hour) did not require use of a survey instrument or electronic alarming dosimeter.

The following corrective steps were taken to mitigate and avoid further violations:

Upon detection of the violation by a Radiological Controls Technician, the worker in the posted high radiation area was directed to halt work and exit the area. Senior management was promptly notified of the occurrence, and a fact finding investigation and critique was conducted. Upon completion, the event critique was issued as required reading for the Radwaste Operations staff.

The Plant Operations Director issued written orders requiring that all Radioactive Waste Supervisors and Operators read and certify understanding of high radiation area requirements. Additionally, the Plant Operations Director conducted discussions with each subordinate section to insure that high radiation area requirements were understood.

As a follow up effort, the Lead Radwaste Engineer met with and interviewed each Operator to insure understanding of RWP requirements. Disciplinary actions were taken for personnel who violated the above referenced RWP.

In an effort to reduce the radiological challenges to the operators, procedures involving resin transfers in the subject high radiation area were revised to have Operators advise Radiological Controls Department when such transfers and water flushes are completed so as to allow surveys to be performed with the objective of reducing the size of the posted high radiation area. In addition, the Radiological Controls Department reviewed RWPs to insure that there were no ambiguities regarding entries into high radiation areas. No ambiguities were identified.

This event was discussed by the Station Director during "all hands" meetings. Full compliance in this matter was achieved on September 30, 1991.

VIOLATION B:

Technical Specification Section 6.11 "Radiation Protection Program", requires that "Procedures for personnel radiation protection shall be prepared consistent with the requirements of 10 CFR 20 and shall be approved, maintained and adhered to for all operations involving personnel radiation exposure."

Radiation protection procedure 9300-ADM-4110.06, "Control of Locked High Radiation Areas", requires, in part, that:

1. when issuing keys to Locked High Radiation Areas, the Radcon Technician is to conduct a High Radiation Area key control responsibility briefing;
2. immediately after restoring a Locked High Radiation Area to a locked condition, the responsible person shall physically challenge the latching mechanism (push pull, twist, etc.);

3. the responsible person shall ensure that a second person, known as a Verifier, ensures the locked condition in the manner stated above; and
4. the Radiological Controls Department shall daily verify the integrity of all Locked High Radiation Areas for which keys have been issued.

Contrary to the above, on June 13, 1991, a contractor Radcon Technician signed out a Locked High Radiation Area key to the Reactor Water Clean Up (RWCU) Heat Exchanger area and:

1. the Radcon Technician who issued the key to the RWCU, a Locked High Radiation Area, failed to conduct a High Radiation Area key control responsibility briefing;
2. after work was completed in the RWCU Heat Exchanger area, a contractor Radcon Technician, the responsible person, failed to physically challenge the latching mechanism to verify that the gate to the RWCU Heat Exchanger area was locked, yet signed off a procedure step to indicate it was completed;
3. another individual acted as a Verifier and failed to physically challenge the latching mechanism to verify that the gate to the RWCU Heat Exchanger area was locked, yet signed off a procedure step to indicate it was completed; and,
4. while performing midshift rounds, A Radcon Technician conducted the daily verification of the integrity of all Locked High Radiation Areas for which keys had been issued, yet failed to physically challenge the latching mechanism to verify that the gate to the RWCU Heat Exchanger area was locked.

This is a Severity Level IV violation. (Supplement IV).

RESPONSE:

GPUN concurs with the violation as stated and notes that it was self-identified.

This violation occurred as a result of one contractor Radiological Controls Technician (RCT) who failed to follow procedures although fully knowledgeable regarding those procedures. Other personnel including a second contractor Radiological Controls Technician, a temporary Firewatch, and a Company Radiological Controls Technician were involved although peripherally.

The following corrective steps and preventative actions were taken to deal with this violation and prevent further recurrence:

Upon discovery of a door to a Locked High Radiation Area being open, the area was searched and the door properly secured and tested.

Immediate disciplinary action was taken for the principle party involved. This action was taken within one hour of the conclusion of the event investigation. Subsequent disciplinary actions of appropriate severity were meted out to other culpable parties.

The Station Director has reviewed the importance of proper Locked High Radiation Area control during "all hands" meetings conducted in September and October 1991.

Full compliance in this matter was achieved on October 1, 1991.