Entergy

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November 6, 1996

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
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Washington, DC 20555-0001

Subject: Reply to a Notice of Violation 50-458/96-014
River Bend Station - Unit I
License No. NPF-47
Docket No. 50-458

File Nos.: G9.5, G15.4.1

RBG-43381
RBF1-96-0419

Gentlemen:

Pursuant to the provisions of 10CFR2.201, attached is the Entergy Operations Inc. response to the notice of violation described in NRC Inspection Report (IR) 96-014. The subject violation documents a violation of Technical Specification 5.4.1a and Appendix A of Regulatory Guide 1.33 when on September 5, 1996, a radiation protection procedure was not properly implemented, in that an individual entered the radiologically controlled area without a functional direct reading dosimeter.

Should you have any questions regarding the attached information, please contact Mr. David Lorfing of my staff at (504) 381-4157.

Sincerely,

RJK/CRM
attachment

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IE07

cc: U. S. Nuclear Regulatory Commission
Region IV
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NRC Sr. Resident Inspector
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ATTACHMENT A

REPLY TO NOTICE OF VIOLATION 50-458/9614-02

Violation:

Technical Specification 5.4.1.a states, in part, that written procedures shall be implemented covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, "Quality Assurance Program Requirements (Operations)," Revision 2, February 1978.

Appendix A of Regulatory Guide 1.33, Section 7.e recommends written procedures for radiation protection. Section 4.6.1 of Radiation Section Procedure RSP-0203, "Personnel Monitoring," Revision 13, stated, in part, that direct reading dosimeters were required for all entries into the radiologically controlled area.

Contrary to the above, on September 5, 1996, Procedure RSP-0203 was not properly implemented in that an individual entered the radiologically controlled area without a functional direct reading dosimeter.

Reasons for the Violation:

The primary cause for this violation was personnel error. The individual became distracted while in-processing into the RCA and was not alert to the potential impact. His inattention to detail and failure to self check culminated in this event.

An individual became distracted during the process of activating his dosimeter at the RCA access point when he dropped the bar-code scanner. While he was inspecting the scanner for damage, the reader station initiated an audible alarm to indicate that a dosimeter was left in the reader port. He silenced this audible alarm by partially removing the dosimeter from the port. The individual completed his inspection of the bar-code scanner. He then mistakenly picked up a "Paused" digital dosimeter from the storage area adjacent to the dosimeter reader station, and left his activated dosimeter in the reader port. The individual entered the RCA without self checking the dosimeter that he had in his possession to ensure that it was activated and actively indicating exposure. The activated dosimeter left in the reader port was discovered a few minutes later by a radiation protection technician.

Corrective Actions That Have Been Taken:

- The individual was escorted out of the RCA.
- The Radiation Protection (RP) Technician coached the individual who then properly processed into the RCA.
- RP performed a dose assessment to verify the individual's exposure.
- The RP Supervisor was informed.
- The individual's superintendent conducted an accountability session.
- A letter of reprimand was placed in the individual's personnel file.
- The dosimeter storage area was moved from the self access terminal area to a more remote location so that dosimeters would not inadvertently be exchanged.
- The access terminal area was modified so that dosimeters could not be inadvertently laid down.

Corrective Actions That Will Be Taken to Avoid Further Violations:

As part of River Bend's corrective action process, a Condition Report (CR) was previously initiated on March 11, 1996 to document a potential adverse trend in the area of Radiation Protection work practices. The disposition to this CR identified generic corrective actions to improve radworker work practices and minimize performance errors for ingress and egress to the RCA. These corrective actions fall into the following areas:

- Minimizing distractions during the ingress / egress process.
- Increasing worker awareness to be more attentive during the ingress / egress process.
- Reviewing the software controls for the access stations.
- Assuring that RP technicians are aware of the expectations for ingress / egress controls.
- Evaluating and implementing as appropriate, the findings of the natural work team which is evaluating the trend in procedure non-compliance.

An additional action item was added to the corrective actions for this CR.

- Evaluate the RCA entrance process from the human factors perspective to identify needed improvements. Provide recommendations for implementing each of the identified improvement suggestions. Include evaluation of the use of a hard barrier interface, such as turnstiles linked to an activated electronic dosimeter.

Date When Full Compliance Will Be Achieved:

EOI was in full compliance on September 5, 1996, when the individual was escorted out of the RCA and a dose assessment was performed.