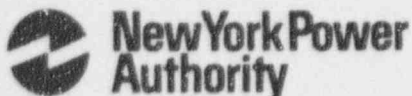


James A. FitzPatrick
Nuclear Power Plant
P.O. Box 41
Lycoming, New York 13093
315-342-3840



Michael J. Colomb
Site Executive Officer

February 21, 1997
JAFP-97-0061

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Mail Station P1-137
Washington, D.C. 20555

SUBJECT: James A. FitzPatrick Nuclear Power Plant
Docket No. 50-333
Revision to Reply to Notice of Violation
NRC Inspection Report 50-333/96-07

Reference: JAFP-97-0018, from M. J. Colomb to USNRC, Reply to Notice of Violation, NRC Inspection Report 50-333/96-07.

Gentlemen:

This letter is being submitted to revise corrective actions for Violation A and Violation C previously submitted in reply to Notice of Violation as referenced above.

In accordance with the provisions of 10 CFR 2.201, Notice of Violation, the Authority submits a response to the notice transmitted by your letter dated December 13, 1996. Your letter refers to the results of the integrated inspection conducted from September 29, 1996 through November 16, 1996 at the James A. FitzPatrick Nuclear Power Plant.

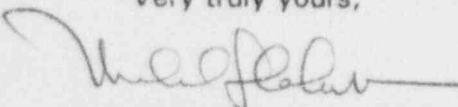
Attachment I provides the description of the violations, reason for the violations, the corrective actions that have been taken and the results achieved, corrective actions to be taken to avoid further violations, and the date of full compliance.

In addition to the corrective actions described in the attachment, in an effort to continue improvement in all aspects of operation at the James A. FitzPatrick Nuclear Power Plant, a team of line personnel was formed to evaluate human performance related events at the site. Corrective actions developed by the team will be implemented to ensure continued performance improvement. To address the lack of rigor and weaknesses in engineering activities, an improvement plan is being developed. Both of these efforts are part of the FitzPatrick Business Plan.

There are no commitments contained in this submittal.

If you have any question, please contact Mr. Arthur Zaremba at (315) 349-6365.


Very truly yours,


MICHAEL J. COLOMB
9702280118 970221
PDR ADOCK 05000333
Q PDR

MJC:GB:las
cc: next page

280011

STATE OF NEW YORK
COUNTY OF OSWEGO
Subscribed and sworn to before me
this 21 day of Feb., 1997


NOTARY PUBLIC NANCY B. CZEROW

Notary Public, State of New York
Qualified in Oswego County #4884611
Commission Expires 1-26-99

cc: Regional Administrator
U.S. Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, PA 19406

Office of the Resident Inspector
U.S. Nuclear Regulatory Commission
P.O. Box 136
Lycoming, NY 13093

Ms. K. Cotton, Acting Project Manager
Project Directorate I-1
Division of Reactor Projects-I/II
U.S. Nuclear Regulatory Commission
Mail Stop 14 B2
Washington, DC 20555

Attachments:

- I. Reply to Notice of Violation

Attachment I

Reply to Notice of Violation 96-07

Violation A

Technical Specification 6.8.(A) requires that written procedures and administrative policies shall be established, implemented and maintained that meet or exceed the requirements and recommendations of Section 5 of American National Standards Institute (ANSI) 18.7-1972 "Facility Administrative Policies and Procedures." Section 5.1.2 of ANSI 18.7-1972 states in part, that procedures shall be followed, and the requirements for use of procedures shall be prescribed in writing. MP-004.03, CRD Removal and Replacement, describes removal and replacement of control rod drives (CRDs). The procedure requires that all CRDs to be removed are accurately located and readily identified (marked) prior to removal.

Contrary to the above, on November 11, 1996, during the work preparation phase, CRDs to be removed were not accurately located prior to removal which resulted in the incorrect removal of three CRDs.

This is a Severity Level IV Violation (Supplement 1).

Admission or Denial of the Alleged Violation

The Authority agrees with this violation.

Reasons for the Violation

The cause for this violation was personnel error. The performance factors leading to these errors were:

- Inadequate training and qualification. The contract supervisor assigned the duties associated with Control Rod Drive (CRD) replacement at FitzPatrick during the plant's Refuel Outage 12 did not have the proper training or experience to accurately locate and identify the correct CRDs prior to removal.
- Ineffective worker practices. The contract supervisors overseeing the CRD removal/replacement activities did not effectively utilize self-checking or second verification techniques to ensure the CRDs were correctly labeled. Additionally, numerous opportunities arose during the CRD work evolution where work should have been stopped by both the contractor and the Power Authority because of abnormal or unexpected conditions.
- Poor supervisory oversight and methods. The Authority did not provide an appropriate level of management or supervisory oversight of the job.

Attachment I

Reply to Notice of Violation 96-07

- Poor written procedures and documents. The written procedure provided by the Authority to the contractor was inadequate and did not contain steps for verification of crucial work evolutions (i.e., selection of the correct CRD). Additionally, the core map was not part of the work procedure. The core map could have contained additional reference points such as nuclear instruments.

Corrective Actions That Have Been Taken

- The Authority revoked the contract supervisor's task qualification certification.
- The Authority assigned Senior Nuclear Managers to oversee the remainder of the CRD mechanism changeout once work was stopped.
- Immediately following this event, a memorandum titled "NYPA Responsibilities For Contractors" was issued by the Plant Manager to all departments re-emphasizing obligations when using contract personnel at FitzPatrick. The accountability and responsibility for the quality of work performed by contract personnel belongs to the Authority. Expectations including work oversight, quality, questioning attitude, and open communication was stressed.
- A case study was completed to review and identify opportunities during the CRD replacement evolution where personnel directly involved could have, but failed to take a questioning attitude and stop work. The case study was enhanced with management expectations at each opportunity. The case study was then presented to the appropriate plant staff.

Results Achieved

The Authority believes the corrective actions taken were effective in preventing recurrence. A heightened awareness of the issues relating to the causes for this violation has been achieved. The Authority will continue to reinforce the importance of maintaining a questioning attitude, performing self verification and applying the appropriate level of management oversight.

Corrective Actions To Be Taken

- Maintenance Procedure MP-004.03, "CRD Removal and Replacement" will be revised to incorporate a map with reference points and verification steps to ensure that the correct CRD unit is initially identified and assure the correct CRD unit is identified during ensuing steps when opportunities for selecting the wrong drive exists. (Scheduled Completion Date - 06/30/97)
- Guidelines will be proceduralized to give management expectations regarding oversight of contract personnel assigned duties at FitzPatrick. The procedure will also include obligations and responsibilities as outlined in "NYPA Responsibilities For Contractors". (Scheduled Completion Date - 06/30/97)

Date When Full Compliance Will Be Achieved

Full compliance was achieved on 11/15/96 following issuance of the Plant Manager's memorandum affirming the Authority's responsibility for the quality of all work performed at FitzPatrick.

Attachment I

Reply to Notice of Violation 96-07

Violation B

10 CFR Part 50, Appendix B, Criterion III, "Design Control," requires that the design basis shall be correctly translated into specifications, drawings, procedures, and instructions; that the adequacy of the design be verified; and that design changes be subject to design control measures.

Contrary to the above, on and before October 25, 1996, the design basis was not correctly translated into procedures, the adequacy of design was not verified, and design changes were not subjected to design control measures, as evidenced by the following examples:

- (1) Unverified engineering judgement regarding design calculations JAF-CALC-ELEC-00426 and JAF-CALC-ELEC-00427 erroneously equated spare battery capacity with voltage at safety-related components.
- (2) Electrical load added to safety-related station battery calculations JAF-CALC-ELEC-01417 and JAF-CALC-ELEC-01418 was not consistent with the load specified in Modification F1-89-158.
- (3) Unverified engineering judgement concerning calculation JAF-CALC-HPCI-00840 was used to conclude that air injection would not affect high pressure coolant injection pump operability.
- (4) An incorrect assumption was made in calculation JAF-CALC-DHR-03445 that a non-safety related component could be assumed as a limiting single failure.
- (5) An unverified assumption was made in calculation JAF-CAL-DHR-02380 that a plate heat exchanger could be modeled as a shell and tube heat exchanger.

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

Admission or Denial of the Alleged Violation

The Authority agrees with the violation. However, after review of pertinent data for cited example 2, the Authority determined that battery calculations JAF-CALC-ELEC-01417 and JAF-CALC-ELEC-01418 are consistent with the final calculations for modification F1-89-158 and that no deviation exists.

Attachment I

Reply to Notice of Violation 96-07

Reasons for the Violation

The cause for the violation was personnel error. The performance factors contributing to this were:

- Inadequate training. For example 1, personnel assigned responsibilities for preparation and review of the battery calculations (JAF-CALC-ELEC-00426 and JAF-CALC-ELEC-00427) did not exhibit rigor in verifying the assumption that equated spare battery capacity with voltage. For example 4, personnel assigned responsibilities for preparation and review of the flooding analysis (calculation JAF-CALC-DHR-03445) demonstrated inadequate understanding of the application of single failure criteria.
- Weak supervisor/managerial methods. For examples 3 and 5, the expectations for documenting engineering judgement and unverified assumptions had not been adequately communicated to the individuals responsible for preparing the calculations.

Corrective Actions That Have Been Taken

- An operability assessment was performed to review the adequacy of the unverified judgement against station batteries A and B. The assessment confirmed that A and B station batteries were operable. New calculations were prepared which properly documented the basis for the station battery modified performance test. As a conservative measure to assure adequate capacity exists for the long term, Modification M1-96-078, Revision 1, was implemented which added two cells to each station battery.
- Calculation JAF-CALC-HPCI-00840 was revised to state that NUREG-0897, Revision 1, "Containment Emergency Sump Performance" was used as a basis for vortex limit determination. The revised calculation also included the discussion with the pump vendor which confirmed the use of the NUREG-0897 vortex limit is appropriate.
- A review of calculation JAF-CALC-DHR-03445 was performed to confirm that no safety-related components were affected as a direct consequence of the postulated piping failure.
- Calculation JAF-RPT-DHR-02535, Revision 0, was developed and approved on 10/24/96. This calculation validated the use of the GOTHIC code used for the specific Decay Heat Removal System application. The use of the GOTHIC simulation of a shell and tube heat exchanger in place of a plate heat exchanger as evaluated in calculation JAF-CALC-DHR-02380 was found to be acceptable.
- This violation, its causes, lessons learned, and management expectations were discussed with Design Engineering personnel at a departmental tailgate meeting.

Attachment I

Reply to Notice of Violation 96-07

Results Achieved

The Authority believes the above corrective actions were successful in resolution of the conditions identified in the violation and will be effective in preventing recurrences.

Corrective Actions To Be Taken

- Design Engineering Action Plan JDED-APL-96-018 was developed to track additional improvements with the DC systems' design calculations and surveillance tests. (Scheduled Completion Date - 06/30/97)
- Engineering Procedure DCM-2, "Preparation and Control of Manual Calculations and Analysis" will be reviewed, and revised if necessary, to assure appropriate design controls and processes related to rigor, verification and engineering judgement are included. Training will be conducted with Design Engineering to reinforce and ensure management expectations regarding documentation of engineering judgement are clearly understood. (Scheduled Completion Date - 04/30/97)
- Training on the requirements of DCM-14, "Preparation and Control of Computer Generated Calculations" will be performed to increase staff sensitivity to the process for utilizing and controlling computer generated calculations and analysis. (Scheduled Completion Date - 03/31/97)
- This violation will be entered into the Engineering Support Personnel (ESP) Training Program to provide Technical Support staff with lessons learned from this event. (Scheduled Completion Date 03/01/97)
- Calculation JAF-CALC-DHR-03445 will be revised to correct the application of single failure criteria. (Scheduled Completion Date 03/01/97)

Date When Full Compliance Will Be Achieved

The Authority has been in compliance with 10 CFR 50, Appendix B, Criterion III since the identification, review and verification of the above conditions found no inadequacies in plant design. This conclusion is based on: for example 1, when the new calculation was prepared which properly documented the basis for the A and B station battery modified performance test; for example 3, the revision to the calculation and confirmation by the pump manufacturer that the vortex information in calculation JAF-CALC-HPCI-00840 is acceptable; for example 4, the review of calculation JAF-CALC-DHR-03445 confirmed that no safety-related components are affected by the postulated piping failure; and for example 5, calculation JAF-CALC-DHR-02380 being performed and validating that the GOTHIC code used was acceptable.

Attachment I

Reply to Notice of Violation 96-07

Violation C

10 CFR Part 50, Appendix B, Criterion XI, "Test Control," requires written test procedures which incorporate acceptance limits contained in applicable design documents.

Contrary to the above, on and before October 25, 1996, surveillance procedures did not incorporate the acceptance limits contained in applicable design documents, as exemplified by the following:

- (1) Instructions in Work Request 94-02935-00, dated April 21, 1994, did not contain sufficient guidance to ensure that volt meters of appropriate accuracy and precision were used to measure voltage between the reactor protection system electrical protection assemblies and their respective power panels.*
- (2) Acceptance criteria in surveillance procedure ST-2X, "RHR Service Water Flow Rate," did not incorporate acceptance limits contained in applicable design documents by not accounting for instrument error associated with measuring required flow to the residual heat removal system heat exchangers.*
- (3) Acceptance criteria in station battery service test procedures MST-071.24, Revision 2 and MST-071.26, Revision 0, "Modified Station Battery Performance/Service Test," did not reflect the minimum battery terminal voltages for acceptable operation of safety-related equipment specified in design calculations JAF-CALC-ELEC-00426, Revision 1, dated October 16, 1992 and JAF-CALC-ELEC-00427, Revision 0, dated June 4, 1992, respectively.*

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

Admission or Denial of the Alleged Violation

The Authority agrees with the violation.

Attachment I

Reply to Notice of Violation 96-07

Reasons for the Violation

The cause for this violation was personnel error. The performance factors leading to the three cited examples of design document acceptance limits not incorporated into written test procedures were:

- Inadequate training. The individual responsible for preparing the work instructions for Work Request 94-02935-00 did not have an adequate knowledge of the test equipment requirements to assure the correct volt meters were identified in the work package and that their accuracy was properly considered. The individuals responsible for preparing the calculations used to establish the acceptance criteria used in station battery service test procedures MST-071.24 and MST-071.26 did not assure that the results of their calculations were accurately translated to the test procedure. Contributing to this was the lack of written guidance for translation of the calculation to the test procedure and a lack of a questioning attitude by the preparer of the test procedure in establishing the basis for the acceptance criteria.
- Ineffective worker practices. The individuals assigned responsibility for the preparation and inclusion of acceptance criteria into surveillance test procedure "RHR Service Water Flow Rate" did not maintain a questioning attitude. The procedure reflected an acceptance limit value contained in the Technical Specifications (T.S.). He assumed the T.S. value accounted for instrument error. The basis for this assumption had not been documented. Contributing to this error was the ineffective corrective actions taken in 1994 when this condition was first identified.

Corrective Actions That Have Been Taken

- An operability review was completed for the Reactor Protection System (RPS) electrical protection assembly (EPA) calibration period. The review determined that RPS was operable. In addition, new voltage measurements between the RPS electrical protection assemblies and their respective power panels have been completed.
- Calculations were prepared and surveillance test procedures ST-2R, "RHR Service Water Pump and MOV Operability Test" and ST-2X, "RHR Service Water Flow Rate" were revised to accurately account for instrument error during test measurement evolutions. Additionally, a review was completed of other similar T.S. surveillance procedures which utilize installed instrumentation to measure test data. The review determined that these surveillance test procedures did not require change.
- New calculations were prepared to determine the acceptance criteria for the station battery service tests. Test procedures MST-071.24 and MST-071.26 were revised to include the acceptance criteria.

Attachment I

Reply to Notice of Violation 96-07

- An evaluation of other Technical Specifications was performed to confirm that an adequate basis existed for the Technical Specification requirements.
- This violation, its causes, lessons learned, and expectations were discussed with Design Engineering personnel at a departmental tailgate meeting.

Results Achieved

The above listed corrective actions were successful in resolving the deficiencies identified in the violation. The Authority believes the corrective actions taken will provide increased awareness of the issues and the causes identified in this violation.

Corrective Actions To Be Taken

- This violation will be entered into the Engineering Support Personnel (ESP) Training Program to provide Technical Support staff lessons learned from this event. (Scheduled Completion Date - 03/01/97)
- Test standards are being developed to assist engineers in selecting proper test methods. These standards will contain guidance on the proper consideration of measurement instrument accuracy. (Scheduled Completion Date - 08/01/97)
- The Authority is currently engaged in an Improved Technical Specifications Project. The project will ensure that instrument accuracy is considered when specifying the requirements of the Technical Specifications. (Scheduled Completion Date - 12/31/97)
- The calculation for the RPS/EPA calibration period will be revised using new measured voltages. (Scheduled Completion Date - 03/01/97)

Date When Full Compliance Will Be Achieved

Full compliance was achieved on 01/16/97 following: (1) the operability assessment and completion of new RPS/EPA voltage measurements; (2) the revision to surveillance procedure ST-2X; and (3) the revisions to the modified Battery Performance/Service Tests.

Attachment I

Reply to Notice of Violation 96-07

Violation D

10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," requires conditions adverse to quality such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and non-conformance be promptly identified and corrected.

Contrary to the above, on and before October 25, 1996, conditions adverse to quality were not promptly identified and corrected, in that:

- (1) Approximately 54 deviations and deficiencies associated with the Final Safety Analysis Report, calculations, and procedures pertaining to the residual heat removal system, identified in the design basis documentation verification program (DBD-10) in 1994 were not evaluated for corrective action.*
- (2) Appropriate corrective action related to the calibration frequency was not taken to correct recurring APRM flow bias flow transmitter calibration failures.*

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

Admission or Denial of the Alleged Violation

The Authority agrees with this violation.

Reasons for the Violation

The cause for this violation was personnel error. The performance factor leading to these errors was:

- Poor supervisory methods. Following compilation of the 54 Residual Heat Removal (RHR) System DBD identified deviations/deficiencies, adequate controls and oversight were not in place to assure that the deviations were reviewed and resolved in a timely manner.
- Programs and/or processes did not require prompt resolution to questions involving transmitter performance history and instrument calibration failures that had been identified during instrument calibration in 1994.

Attachment I

Reply to Notice of Violation 96-07

Corrective Actions That Have Been Taken

- The Authority has completed evaluations and system operability reviews of the 54 identified conditions found during the RHR System DBD review. No operability concerns were identified. The evaluation determined that 24 issues had been corrected and subsequently closed. The remaining issues have been prioritized and entered into management's corrective action tracking system for resolution.
- Responsible design engineers have been assigned to DBDs, as owners, to ensure accountability for proper maintenance and validity of DBDs.
- I&C engineering has reviewed the performance history of the Flow Bias Transmitter. The instrument calibration frequency for the transmitter has been reduced to 12 month intervals.
- This violation, its causes, lessons learned, and management expectations were discussed with Design Engineering personnel at a departmental tailgate meeting.

Results Achieved

The completed corrective actions were effective in resolving the conditions identified in the violation. The Authority believes the corrective actions being taken will be an enhancement to the corrective action program.

Corrective Actions To Be Taken

- A Nuclear Engineering Administrative Procedure NEAP-38, "Design Basis Document Validation Procedure" has been developed and is in the review and approval process. This NEAP defines responsibilities and interfaces for the conduct of DBD validations. These responsibilities include closure of open items.
(Scheduled Completion Date - 04/04/97)
- The flow bias transmitter parameters will be reviewed to determine the cause(s) for and corrective action(s) to be taken to resolve instrument drift.
(Scheduled Completion Date - 04/01/97)
- Administrative Procedure AP-19.01, "Surveillance Testing Program" will be reviewed to determine the adequacy of the guidance contained in Corrective Action section of the program. (Scheduled Completion Date - 03/17/97)
- This violation will be entered into the Engineering Support Personnel (ESP) Training Program to provide Technical Support staff with lessons learned from this event.
(Scheduled Completion Date - 03/01/97)

Attachment I

Reply to Notice of Violation 96-07

Date When Full Compliance Will Be Achieved

Full compliance was achieved 10/18/96 following completion of the operability determination for the open DDD items and following calibration frequency change to the flow bias transmitters to a 12 month cycle to assure instrument reliability.

Attachment I

Reply to Notice of Violation 96-07

Violation E

10 CFR 50.59, "Changes, tests, and experiments," permits licensees to make changes to the facility, as described in the Safety Analysis Report, without prior Commission approval, provided that the proposed changes do not involve a change in the technical specifications or involve an unreviewed safety question. Records of these changes must include a written safety evaluation which provides the bases for the determination that the change does not involve an unreviewed safety question.

Section 4.10.3 of the FitzPatrick Final Safety Analysis Report (FSAR) describes the utilization of the equipment area temperature monitoring system to detect reactor coolant pressure boundary leakage outside of the primary containment. Area temperature sensors are calibrated with the station in operation with normal ventilation patterns and ambient temperature levels to detect a seven gallon per minute leak. The residual heat removal (RHR) system equipment area temperature detector is shown in FSAR Table 4.10-1, "Summary of Isolation/Alarm of System Monitored and the Leak Detection Methods Used."

Contrary to the above, on or about August 12, 1996, a temporary high efficiency particulate air (HEPA) filter and blower, which could have altered the accuracy of the area temperature monitoring system, were installed in the "A" RHR heat exchanger room, and no safety evaluation was performed and documented to provide the bases for the determination that the change did not involve an unreviewed safety question.

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

Admission or Denial of the Alleged Violation

The Authority agrees with the violation.

Reasons for the Violation

The cause for this violation was personnel error. The performance factor leading to this error was:

- Inadequate implementation of a change process. The individual assigned the task of reviewing the temporary HEPA filter/blower installation for inclusion into the Temporary Modification process, failed to consider all parameters impacted by the temporary HEPA exhaust installation in the "A" Residual Heat Removal (RHR) System Heat Exchanger Room, specifically, the potential effect on the design of the Steam Leak Detection System (SLDS). This error led to the decision of not categorizing the HEPA installation as a Temporary Modification. Subsequently, the 10 CFR 50.59 safety evaluation review process was not invoked.

Attachment I

Reply to Notice of Violation 96-07

Corrective Actions That Have Been Taken

- The Technical Services Department Manager reviewed this event with the responsible engineer and the engineer's supervisor. Discussed were factors leading to the determination that a Temporary Modification was not required, and potential program weaknesses which may have lead to this conclusion.
- A Procedure Change Request was initiated to revise Administrative Procedure AP-05.02, "Control of Temporary Modifications", Section 2.0, APPLICABILITY, to include changes which could add or remove heat, or affect the air exchange rate to plant areas with a potential effect on area equipment design requirements.
- An abstract of this violation was included in the weekly Department Tailgate meetings to provided personnel a summary of the event and to increase their sensitivity on the use of portable ventilation and its potential effects on plant design.
- RES Department Procedure RP-RESP-02.15, "Portable Ventilation Systems" has been revised to include a prerequisite that all portable ventilation systems installed in SLDS areas will require initiation of a Temporary Modification and a precaution statement that removing air from areas monitored by SLDS may render the SLDS inoperable.

Results Achieved

Actions taken have increased awareness, sensitivity and understanding of the potential affects that temporary ventilation may have on plant design.

Corrective Actions To Be Taken

None

Date When Full Compliance Will Be Achieved

Full compliance was achieved immediately following removal of the temporary HEPA filter/blower from the "A" RHR System Heat Exchanger Room.

Attachment I

Reply to Notice of Violation 96-07

Violation F

Technical Specification 6.11 requires, in part, that each entry into a posted locked high radiation area shall be under the control of a radiation work permit (RWP) and that a radiation monitoring device which continuously integrates the radiation dose rate in the area and alarms when a preset integrated dose is received be utilized. RWP 96-0411 issued for work in the drywell requires that each worker wear an alarm dosimeter.

Contrary to the above, on October 30, 1996, a contractor entered and worked in the drywell under RWP 96-0411, a posted locked high radiation area, for three hours with his alarming dosimeter turned off.

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

Admission or Denial of the Alleged Violation

The Authority agrees with the violation.

Reasons for the Violation

The cause for the violation was personnel error. The performance factor leading to this error was ineffective worker practices. The contracted maintenance worker did not follow procedures, did not utilize protective equipment properly, and did not utilize self-checking to verify that the equipment was operating correctly.

Corrective Actions That Have Been Taken

- Immediately following the event, a critique was conducted by the Radiological and Environmental Services (RES) Department with the responsible individual and Maintenance Department supervisors to review the circumstances surrounding this event. The individual's employment was subsequently terminated.
- Lessons learned from this event were included in all department tailgate meetings. Personnel were provided a summary of the circumstances surrounding this event including the necessity to spend sufficient time to assure compliance with procedures, maintaining a questioning attitude, take the time needed to perform Radiation Worker practices properly, and reaffirming that self verification practices also include frequent checks of personal dosimetry.

Attachment I

Reply to Notice of Violation 96-07

- Additional changes to the Radiation Protection program included: (1) an enhancement to the Radiological Controlled Area (RCA) access control computer program which eliminated the need to turn alarming dosimeters off at satellite control points when individuals change from one Radiation Work Permit to another; (2) during the recently completed Refuel Outage, Radiation Protection technicians verified that each individuals dosimetry was on prior to entry into the Drywell; and (3) RCA entry briefing rooms were limited to one crew at a time to reduce noise and confusion, and provide a better atmosphere for technician/radiation worker interface.

Results Achieved

The Authority believes the corrective actions taken were effective in preventing recurrence. A review of Radiation Worker events following FitzPatrick's recently completed Refuel Outage provided assurance that the causes for this event were satisfactorily addressed and resolved.

Corrective Actions To Be Taken

None.

Date When Full Compliance Will Be Achieved

Full compliance was achieved on October 30, 1996 when the maintenance worker exited the Drywell.

Attachment I

Reply to Notice of Violation 96-07

Violation G

Title 10, Code of Federal Regulations, Part 71.12 (10 CFR 71.12) states, in part, that shippers of licensed materials are generally licensed for shipment utilizing packages for which the Commission has issued a certificate of compliance, provided that the licensee have in place a quality assurance program meeting the requirements contained in sections 71.101 through 71.137. 10 CFR 71.133 requires, in part, that the licensee establish means to assure that conditions adverse to quality, such as deviations, are promptly identified and corrected.

Contrary to the above, on October 22, 1996, the licensee shipped licensed radioactive material in an NRC-approved package (Certificate of Compliance No. USA/9094/A) without promptly implementing corrective actions for a prior violation of an applicable shipping procedure (involving the lack of current certification of technicians relative to the applicable computer code used to classify the shipment) as previously identified by the licensee's deviation event report (DER 96-1188).

This is a severity level IV violation (Supplement V).

Admission or Denial of the Alleged Violation

The Authority agrees with the violation.

Reasons for the Violation

The cause for this violation was poor managerial methods. The RES Department management failed to be rigorous in its implementation of corrective actions to an identified problem. RES procedure RW-SHP-104, "Radioactive Waste Data Base Control Program" had been revised and was in the approval cycle. RES Department management did not ensure the changes were approved before the waste shipment was made.

Corrective Actions That Have Been Taken

- RES management has been counseled by the General Manager of Support Services on the importance of thoroughness of corrective actions, and stringent procedure compliance.
- RES Department procedure RW-SHP-104, was revised and approved for use on 10/24/96.

Results Achieved

The Power Authority believes the correction actions taken have been and will continue to be effective in preventing recurrence.

Attachment I

Reply to Notice of Violation 96-07

Corrective Actions To Be Taken

None.

Date When Full Compliance Will Be Achieved

Full compliance was achieved on 10/25/96 following revision to procedure RW-SHP-104.