GPU Nuclear

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January 9, 1986

Mr. Thomas T. Martin, Director
Division of Radiation Safety and Safeguards
United States Nuclear Regulatory Commission
Region I
631 Park Avenue
King of Prussia, Pennsylvania 19406

Dear Mr. Martin:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
NRC Inspection Report No. 50-219/85-18
and Meeting Report No. 50-219/85-21

Your letter of December 13, 1985, transmitted the findings of a routine safety inspection by Region I on June 3-7, 1985; the discussion of findings by Region I staff with representatives of GPU Nuclear Corporation; and the meeting summary from an enforcement conference held June 13, 1985 at the Region I office. The letter identified one violation with regard to the GPUN Radiation Protection Program and in addition identified apparent false statements which were made to NRC inspectors by a Group Radiological Controls Supervisor and a Radiological Controls Technician.

GPU Nuclear Corporation policy was and continues to be honesty and integrity. Because of apparent false statements by a Radiological Controls Technician and Supervisor, two independent investigations were conducted by GPU Nuclear. Each investigation concluded that this was an isolated incident and not programatic. In accordance with 10CFR2.201 the following identifies the violation as stated in the inspection report and provides GPUN's response.

Violation:

Technical Specification 6.11 requires, in part, adherence to radiation protection procedures for all operations involving personnel radiation exposure. Licensee Procedure 915.12 requires, in part, compliance with any condition stated on the RWP by all personnel who sign in on the RWP. Licensee Procedure ADM-4241.05 requires, in part that a Dosimetry Investigative Report (DIR) be performed for a malfunctioning self-reading dosimeter (SRD) or for a violation of posting/RWP requirements without

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proper dosimetry. The RWP for entrance to the Condenser Bay while at power, RWP No. 33485, required, in part that a 0-200 mrem and 0-500 mrem self-reading dosimeter be worn. Contrary to the above,

A. a self-reading dosimeter (SRD) in the 0-500 mrem range was not issued to and therefore, nor worn by an individual who had signed in on RWP No. 33485 on June 6, 1985.

B. a DIR was not performed for an apparent violation of an RWP requirement concerning the failure to learn [sic] the proper dosimetry and also a suspect SRD value.

GPUN Response:

A. With regard to Item A of the violation:

1. Corrective steps which have been taken and the results achieved:

All Radiological Controls Technicians and their supervisors were reinstructed in the requirements of adherence to procedures, honesty, and integrity. The results of the investigation of this incident were reviewed. The Firewatch Technician was counselled in adherence to RWP requirements including specified dosimetry.

All Radiological Controls Technicians and their supervisors were instructed in the role of USNRC inspectors and the specifics of revised NRC enforcement policy (10CFR2, Appendix C).

The Radiological Controls Technician and the Supervisor involved in the incident had their employment terminated for dishonesty, not for failing to issue the specified dosimetry.

2. Corrective steps which will be taken to avoid further violations:

No further action is planned except to periodically issue memoranda reinforcing the Company's honesty and integrity policy.

3. The date when full compliance will be achieved:

Full compliance was achieved on June 7, 1985, when the Dose Investigation Report (DIR) was completed.

B. With regard to Item B of the violation:

1. Corrective steps which have been taken and the results achieved:

Because of false statements by the Radiological Controls Technician and Supervisor, it was not known for certain until approximately noon, June 7, 1985, that two SRD's were not issued. Prior to the NRC exit interview at approximately 2:00 P..M. on June 7, 1985, a DIR had been initiated and was completed by close of business on the same day (approximately five hours). The Manager, Radiological Controls Field Operations, did not consider a DIR was necessary until approximately noon on June 7, 1985, because of the false statement. The Radiological Controls Director ordered that a DIR be initiated shortly after noon when it was verified there had been a violation.

2. Corrective steps which will be taken to avoid further violations:

   The DIR procedure is being revised to clarify the requirements for initiation to prevent the possibility of future misinterpretation.

3. The date when full compliance will be achieved:

   Full compliance was achieved June 7, 1985.

If there are any questions or additional information is needed regarding this subject, please contact Mr. Michael W. Laggart at (201) 299-2341.

Very truly yours,

GPU NUCLEAR CORPORATION

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