Exelon Generation Company, LLC
LaSalle County Station
2601 North 21st Road
Marseilles, IL 61341-9757

www.exeloncorp.com

Exelon Nuclear

December 17, 2004

United States Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, D.C. 20555

LaSalle County Station, Units 1 and 2
Facility Operating License Nos. NPF-11 and NPF-18
NRC Docket Nos. 50-373 and 50-374

Subject: Response to Apparent Violation EA-04-170

Enclosed is the Exelon Generation Company (EGC), LLC, response to apparent violation EA-04-170. EGC acknowledges that three craft workers and their foreman entered a posted high radiation area without signing the required radiation work permit or receiving the required high radiation area briefing. The enclosure contains our response, including the reason for the apparent violation, the corrective steps that have been taken and the results achieved, the corrective steps taken to avoid further violations, and the date when full compliance will be achieved. The enclosure also contains the reasons EGC considers that this apparent violation should be characterized as Severity Level IV.

Should you have any questions concerning this letter, please contact Mr. Terrence W. Simpkin at (815) 415-2800.

Respectfully,

George P. Barnes

George P. Barnes
Site Vice President
LaSalle County Station

Enclosure

cc: Regional Administrator - NRC Region III
NRC Senior Resident Inspector - LaSalle County Station

IE14

ENCLOSURE

RESPONSE TO AN APPARENT VIOLATION, EA-04-170

APPARENT VIOLATION:

On January 25, 2004, at LaSalle County Station Unit 1, three employees of The Venture (Venture) and their foreman, contractors to EGC, entered a high radiation area (HRA) in the Unit 1 reactor building raceway to conduct preparations for valve replacement and did not sign onto the required HRA radiation work permit (RWP) or receive the required briefing for work in an HRA. This resulted in a violation of LaSalle County Station's Technical Specification 5.7.1.b, which requires that an appropriate RWP be utilized by radiation workers, and Technical Specification 5.7.1.e, which requires that a pre-job brief be provided prior to entry into an HRA. The NRC's Office of Investigation (OI) determined that two of the three craft workers and the foreman willfully violated the station radiation protection procedures implementing the Technical Specifications.

REASON FOR APPARENT VIOLATION:

The reason for the apparent violation was the commission of rule-based errors regarding basic radiation work practices by three Venture craft workers and a foreman. There was inadequate personal accountability for complying with radiation protection (RP) requirements prior to entering a HRA.

CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED:

The craft workers and the foreman were removed from the radiologically controlled area. Following an investigation of the circumstances, their employment was terminated.

CORRECTIVE ACTIONS TAKEN TO AVOID FURTHER VIOLATIONS:

Venture management discussed the seriousness of the event during the subsequent pre-shift briefing with craft personnel, emphasizing that radiological safety is the same as personnel safety. They reinforced expectations to walk down new work and understand the job, know the radiological conditions, and know the correct RWP. Venture management also assigned rovers to remain in the plant to monitor preparedness of workers entering HRAs.

LaSalle County Station management has implemented a requirement for all workers to stop at the RP desks located in the south or north service building at the beginning of each shift, or when conditions have changed, to receive a briefing from RP prior to attempting to log on to any RWP allowing access to an HRA.

LaSalle County Station has also implemented additional administrative requirements for radiation worker awareness of HRA controls. These actions included additional RP control points at the south and north service building radiologically controlled area (RCA) entrances to challenge workers on RWP understanding, HRA compliance, work area understanding and response to dosimetry alarms.

In preparation for upcoming outages, LaSalle County Station management has

implemented the following additional actions.

Initial radiation worker training material has been revised to highlight HRA entry requirements and consequences for the radiation worker if requirements are not met. RWP instructions that allow HRA entry have been revised to state "high radiation area entry brief required." The Radiation Protection department also added worker-acknowledged warnings on the computer screen during the access control electronic dosimetry log in process.

A radiation protection aid for conducting HRA briefings in accordance with requirements of EGC procedure RP-AA-460, "Controls For High and Very High Radiation Areas" has been developed and implemented. The aid prompts formal communication of permission to enter an HRA using three-way communication techniques.

All transient refueling outage workers will be required to attend and pass a dynamic learning activity on proper HRA entry. A signature will be required from transient refueling outage workers prior to the issuance of dosimetry that acknowledges their understanding of HRA entry requirements and the consequences for violating them.

Additionally, transient refueling outage workers will be given radiation worker pocket RWP data sheets that include critical RWP information, including HRA entry requirements.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

Full compliance was achieved on January 25, 2004, when the craft workers and their foreman were removed from the RCA and barred from further entry.

SEVERITY LEVEL OF APPARENT VIOLATION:

EGC does not dispute that a violation occurred and that it could be characterized as willful. EGC recognizes that willful violations are, by definition, of particular concern to the NRC. They are of particular concern to EGC as well. Accordingly, EGC took significant remedial action in responding to the violation and implemented a number of corrective actions in an effort to prevent violations of RP procedures, including actions to prevent willful violations. Those actions are described above.

This apparent violation of LaSalle County Station's Technical Specifications (willfulness aside) is appropriately characterized under the NRC's Reactor Oversight Process as being of very low safety significance (green) under the Significance Determination Process (SDP). The characterization of the apparent violation as green is consistent with the NRC's characterization of a similar violation documented in LaSalle County Station, Units 1 and 2 NRC Integrated Inspection Report 05000373/20004002; 05000374/2004002. As documented in that inspection report, two technicians entered an HRA inside the 1B Residual Heat Removal (RHR) room without signing onto a RWP that authorized entry into the HRA and without receiving a briefing prior to entry into the HRA. As was the situation with the apparent violation on January 25, 2004, the individuals entering the HRA were wearing electronic dosimeters. The NRC determined that the violation was green.

The NRC's Enforcement Policy, Section IV.A, states that Severity Level IV (SL IV) violations and violations associated with green SDP findings are normally dispositioned as NCVs. Accordingly, had the January 25, 2004, apparent violation not been characterized as willful, it would have been dispositioned as an NCV. Since the apparent violation is characterized as willful, additional factors must be addressed prior to determining that the apparent violation should still be dispositioned as an NCV.

Under Section IV.A, willful SL IV violations and willful violations associated with green SDP findings may still be appropriately characterized as an NCV if:

(1) The licensee identified the violation and the information concerning the violation, if not required to be reported, was promptly provided to appropriate NRC personnel, such as a resident inspector or regional branch chief;
(2) The violation involved the acts of a low-level individual (and not a licensee official as defined in Section IV.A).
(3) The violation appears to be the isolated action of the employee without management involvement and the violation was not caused by lack of management oversight as evidenced by either a history of isolated willful violations or a lack of adequate audits or supervision of employees; and
(4) Significant remedial action commensurate with the circumstances was taken by the licensee such that it demonstrated the seriousness of the violation to other employees and contractors, thereby creating a deterrent effect within the licensees organization.

For the reasons described below, the apparent violation should be dispositioned as an NCV.

First, LaSalle County Station personnel identified the apparent violation and promptly reported the event to the NRC resident staff. As stated in the NRC letter, the LaSalle County Station Radiation Protection Manager notified the NRC Senior Resident Inspector when the facts of the event were understood.

Second, the violation involved acts of low-level individuals, and not "licensee officials". Two of the individuals involved were non-supervisory craft workers, employed by an EGC contractor (i.e., The Venture). There should be no dispute that they are "low-level" and not "licensee officials." The other individual involved was their foreman. A Venture craft foreman does not meet the definition of "licensee official."

The NRC Enforcement Policy, Section IV.A.4, contains the following guidance on determining when someone is acting as a "licensee official."

> The term "licensee official" as used in this policy statement means a first-line supervisor or above, a licensed individual, a radiation safety officer, or an authorized user of licensed material whether or not listed on a license. Notwithstanding an individual's job title, severity level categorization for willful acts involving individuals who can be considered licensee officials will consider several factors, including the position of the individual relative to the licensee's organizational structure and the individual's responsibilities relative to the oversight of licensed activities and to the use of licensed activities.

A foreman is a low-level position in The Venture and should not be considered a "licensee official" for purposes of NRC enforcement. The Venture foreman in this case reported to a Venture general foreman, who reported to the Venture piping superintendent, who reported to the Venture project supervisor, who reported to the Venture site manager. The site manager reported to the corporate Mid-West operations manager. The foreman has no direct responsibilities relative to the oversight of licensed activities other than the expectation of complying with all appropriate procedures. In addition, the position of foreman is not permanent for any particular individual. For example, an individual selected by the Venture to serve as a foreman on one particular project, such as the LaSalle outage, may not be selected to serve as a foreman for the next job and would serve as a craft-worker. Therefore, it would be much more consistent with the roles and responsibilities of a foremen to characterize the position as "low-level relative to the oversight of licensed activities," and not as a "licensee official."

Third, this violation was the isolated action of the two craft workers and their foreman. The violation was not caused by a lack of management oversight. It is likely the Office of Investigations (OI) concluded that the apparent violation was willful because of the enormous amount of management oversight and emphasis at LaSalle County Station on compliance with radiation protection requirements. Prior to the violations that are the subject of this response, due to similar previous non-willful violations, LaSalle County Station implemented multiple actions to ensure compliance with RP procedures. These actions included a Venture stand down and a LaSalle County Station-wide stand down to emphasize procedural compliance. In addition, as acknowledged by the NRC in its November 19, 2004, letter, the HRA was properly posted and equipped with a turnstile to preclude inadvertent entry.

Fourth, both EGC and Venture implemented significant remedial action commensurate with the circumstances to demonstrate the seriousness of the violation to other employees and contractors, thereby creating a deterrent effect within both organizations. The workers were disciplined in accordance with the Venture discipline policy and were not retained for the remainder of the refueling outage work. Additional corrective actions are described in detail above.

LaSalle County Station RP also implemented additional administrative requirements for radiation worker awareness of HRA controls. These actions included additional RP control points at south and north service building RCA entrances to challenge workers on RWP understanding, HRA compliance, work area understanding and response to dosimetry alarms. RP also added worker acknowledged warnings on the computer screen during the access control log in process.

Accordingly, even though the apparent violation is characterized as willful, consistent with Section IV.A of the NRC Enforcement Policy, it should be characterized as an NCV.

Even if the NRC determines that the Venture foreman was a "licensee official," this matter should be characterized no higher than a SL IV violation. As discussed above, an identical underlying violation was characterized as being of very low safety significance ("Green" under the SDP). The LaSalle County Station example is bounded by similar situations where there have been willful acts of "licensee officials" and the NRC has characterized the violation as SL IV. For example, a SL IV violation was

issued to the Duane Arnold Energy Center (EA-00-57, April 2000) when a fuel handling supervisor directed the transfer of two new fuel bundles from the spent fuel pool prep machine to spent fuel pool fuel rack locations without a reactor engineer present as part of the fuel moving crew in willful violation of refueling procedures causing a Technical Specification violation.

Additional examples of willful violations by supervisors that the NRC has determined are appropriately characterized as SL IV include a violation issued to Braidwood Station (OI-1999-26, April 2000) and another violation issued to Beaver Valley (OI 1-2002-47, October 2003). In the Braidwood Station case, a nurse (considered a supervisor by the NRC) detected the odor of alcohol on an individual and did not direct the individual to FFD testing in willful violation of licensee procedures. In the Beaver Valley case, a senior reactor operator willfully failed to follow procedures when he did not initiate a required condition report in a timely manner.

The above cases represent examples of willful violations that bound those engaged in by the Venture employees at LaSalle County Station when they went into an HRA without a RP briefing and without obtaining the correct RWP. In addition, the apparent violation does not appear to be as significant as any of the examples found in the NRC Enforcement Policy, Supplement I – Reactor Operations or Supplement IV – Health Physics. Therefore, even if the NRC views the Venture foreman as a supervisor, the violations should be characterized no higher than SV IV.

In conclusion, while EGC has taken this matter seriously and has taken significant and lasting steps to ensure that there is no recurrence, this apparent violation should not be categorized any higher than SL IV.