





Pennsylvania Power & Light Company

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U. S. Nuclear Regulatory Commission
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**SUSQUEHANNA STEAM ELECTRIC STATION
RADIOLOGICAL CONTROLS RESPONSE
50-387/94-21; 50-388/94-22
PLA-4231**

FILE R41-2

**Docket Nos. 50-387
and 50-388**

Dear Sir:

This letter provides Pennsylvania Power & Light Company's response to your request identified in NRC Combined Inspection Report 50-387/94-21 and 50-388/94-22 dated October 26, 1994, concerning an operational evolution that changed the radiological conditions in an area of the station. The Inspection Report cover letter indicated a concern about possible procedural controls that may have contributed to the event. The cover letter requested a written reply to this concern that provides a summary of actions completed and planned, within 30 days of the date of the Report. However, as discussed with Dr. R. J. Bores of Region I on November 23, 1994, PP&L has been authorized to delay the response until November 28, 1994.

On August 30, 1994, a resin transfer evolution was started in the Unit 2 Condenser Demineralizer Resin Regeneration (CDRR) Room with several workers in the room. The operator performing the resin transfer, recognized the potential for those workers to receive an unplanned exposure if they remained in the room. The operator notified the workers. At the same time, the HP technician monitoring the workers alerted them to the change in radiological conditions and had instructed them to exit the room. The operator performing the evolution took prompt and effective corrective action; therefore, no significant personnel exposures were received. The Operations' Shift Supervisor was notified and reported the incident utilizing the Station's corrective action program which initiated a formal investigation and root cause analysis (RCA).

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During this RCA, the potential for generic implications was recognized and an event review team (ERT) was formed at the direction of the Health Physics Supervisor to perform a management assessment of the broader radiological issues in parallel with the event RCA. The ERT reviewed other operational evolutions that impact plant radiological conditions to determine if generic implications existed.

The ERT concluded that adequate procedural controls are in place for operational evolutions in areas that can receive significant dose transients (greater than 10R/hr). These areas are controlled by ALARA blocking and procedural notification to Health Physics. However, for operational evolutions which create a less significant change in radiological conditions (10 mR/hr to 10R/hr) the ERT concluded that additional procedural controls are warranted.

During the NRC inspection (September 12- 16, 1994) the inspector was briefed on the progress of our investigations and preliminary corrective actions. The corrective actions to prevent recurrence of this event were developed through our internal corrective action and self-assessment programs.

Based on our investigations, PP&L determined that procedures that control operational evolutions that may change the station's radiological conditions require review and revisions to enhance the ability to identify and adequately control these evolutions. Also, training to increase the awareness of these evolutions and associated responses to them is being developed for appropriate Operations and Health Physics personnel. These corrective actions are scheduled to be completed by March 31, 1995.

PP&L believes that the above actions will improve the identification of and response to operational evolutions affecting radiological conditions at Susquehanna.

Very truly yours,



R. G. Byram

cc: Regional Administrator - Region I
Ms. M. Banerjee, NRC Sr. Resident Inspector
Mr. C. Poslusny, Jr., NRC Sr. Project Manager