NMP-19742

NIAGARA MOHAWK POWER CORPORATION

NIAGARA MOHAWK

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THOMAS E. LEMPGES
VICE PRESIDENT—NUCLEAR GENERATION

August 14, 1986

Dr. Thomas E. Murley
Regional Administrator
United States Nuclear Regulatory Commission
631 Park Avenue
King Of Prussia, PA 19406

Subject: Response to Inspection Report No. 50-220/86-08

Dear Sir:

Niagara Mohawk herein submits responses to each of two violations described in NRC Inspection 86-08 conducted at the Nine Mile Point Unit I Facility on May 19-24, 1986.

Notice Of Violation Item 1 (50-220/86-04-03)

The Inspection Report states:

> "10 CFR 20.201 requires, in part, that each licensee make or cause to be made such surveys that are necessary and reasonable to comply with 10 CFR 20. 10 CFR 20.201 defines a survey as, among other items, an evaluation of the radiation hazards incident to the presence of radioactive materials and, when appropriate, includes a physical survey of materials and measurements of concentrations of radioactive material present. 10 CFR 20.103 requires among other items, that respiratory protection equipment be used as specified therein. 10 CFR 20.103 also requires the use of engineering controls to minimize airborne radioactivity concentrations.
>
> Contrary to the above, at about 4:30 p.m. on March 28, 1986 necessary and reasonable surveys to ensure compliance with 10 CFR 20.103 were not made during lapping operations on #15 discharge bypass valve. As a result appropriate respiratory protection equipment was not selected and used consistent with 10 CFR 20.103 (c)(1) requirements. The two workers lapping the valve generated airborne radioactivity with a peak concentration of about 420 times the applicable concentration specified in 10 CFR 20 Appendix B exceeding the protection factor (50) of respirators used by the workers. In addition, appropriate engineering controls, as required by 10 CFR 20.103(b)(1), were not used."

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Niagara Mohawk response:

In our review of this violation, we concur that the cause was the inadequate contamination survey performed prior to permitting flapping operations on #15 Recirculation Loop Bypass valve, though Radiation Protection Procedure S-RP-3 provides adequate instructions.

As a result of this, the following actions have been taken to prevent recurrence of an incident of this nature:

1. A formal memorandum was issued to all Unit I Radiation Protection Technicians on 5/21/86 describing the survey requirements contained in S-RP-3 relative to insuring adequate evaluation of contaminated surfaces prior to permitting flapping or similar operations. In addition, the memorandum provided instructions related to decontamination activities, fixed contamination assessment methods, criteria for requiring respirators, and the proper use of engineering controls. This memo has been read and understood by all of the above indicated technicians in accordance with Radiation Protection Instruction RPI-1.

2. On 5/21/86, a Radiological Incident Report (RIR-21) was issued to summarize the investigation of this incident including appropriate measures to prevent recurrence. This RIR was completed on 5/23/86.

3. On 5/23/86, Radiation Protection Instruction RPI-1, "In House Radiation Protection Technician Reading Assignments and Training", was revised to require Chief and Backshift Radiation Protection Technicians to read, understand and initial the "RP Supervisor Log Book" prior to beginning activities on a tour of duty.

4. The contractor technician responsible for the radiological control of this flapping operation failed to follow approved procedures that specify survey requirements and conditions requiring the use of each type of respirator. As a corrective measure, the technician was dismissed from the site and placed on 2 year probation by his employer.

Notice of Violation Item 2 (50-220/86-08-01)

The Inspection Report staes:

"10 CFR 19.12 requires in part, that all individuals working in or frequenting any portion of a restricted area be instructed in precautions and procedures to minimize exposure and the purpose and function of protective devices employed.

Contrary to the above, on April 28, 1986, two workers, performing grinding and lapping operations in preparation for replacing reactor water clean-up suction valve 33-02 (highly radioactively contaminated), were provided inadequate instructions for the installation and use of a glove bag. As a result, air tools were used within the bag. Air exhausting into the bag caused the bag to lose its integrity thereby subjecting the workers to airborne radioactivity concentrations of about 800 times the applicable 10 CFR 20 concentration values. In addition, and as a result, one of the workers sustained a limited unplanned intake of airborne radioactive material."

Niagara Mohawk response:

We have reviewed the details of this violation and concur with your general finding that the cause can be attributed to the insufficiency of oversight and control of contractors. As a result of this, the following corrective actions have been completed to prevent recurrence of this incident:

1. Site Radiation Protection Procedure S-RP-2, "Radiation Work Permit Procedure", and S-RP-7, "Incorporating ALARA Requirements into Work Planning and Instruction", have been revised to require that essential job radiological controls specified by the ALARA Review are incorporated into the RWP as a condition for performing the specified work. These procedure revisions also included requirements to insure uniform ALARA radiological controls were incorporated into RWP's as well as requirements strengthening the oversight and control of all station radiological control activities.

2. A review has been performed to insure that all Radiation Protection Chief Technicians are cognizant of the memorandum issued to them on 4/30/86 concerning the incorporation of essential job radiological controls into applicable RWP's. This review has concluded that these personnel have read, and understand, the memorandum.

3. All active RWP's issued prior to this incident were reviewed and revised, as applicable, to insure essential job radiological controls were incorporated into the RWP as a condition for the specified work.

In addition to the above completed actions, additional actions are being taken or evaluated to further reduce the potential for incident recurrence. Each of these items will be completed by December 31, 1986.

1. Glove bags will not be used without proper ventilation and exhaust. Procedures for use have been drafted.

2. The contractor's Health Physics liason position will be evaluated to determine whether it aids, or interferes with, the communication link between NMPC Radiation Protection and the contractor.

3. This construction contractor's performance is being reviewed relative to continued use in nuclear station activities.

In summary, we believe we have taken all practicable corrective actions to insure these violations will not recur. If there are additional concerns relative to these actions, please notify my office or Mr. Ed Leach at 315-349-2439.

Very truly yours,

Thomas E. Lempges

Thomas E. Lempges
Vice President
Nuclear Generation

TEL/tb