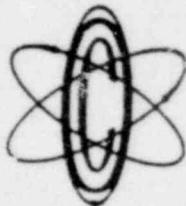


OYSTER CREEK



NUCLEAR GENERATING STATION

JCP&L GPU

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October 16, 1980

Mr. Eldon J. Brunner
Reactor Operations and Nuclear Support Branch
Office of Inspection and Enforcement
Region I
631 Park Avenue
King of Prussia, Pennsylvania 19406

Dear Mr. Brunner:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
I E Inspection 80-28

This is in reply to the letter from Mr. B. Grier dated September 29, 1980 regarding the inspection conducted by Mr. L. Briggs covering the period from August 4, 1980 to August 29, 1980 at the Oyster Creek Nuclear Generating Station. In Appendix A of the referenced letter there are noted three activities which apparently were not conducted in full compliance with the conditions of the Oyster Creek NRC Facility License. The infractions and our responses to them are presented below:

INFRACTIONS

Item A. Technical Specification 6.8.1 states in part, "Written procedures shall be established, implemented, and maintained that meet or exceed the requirements of ... Appendix 'A' of the Nuclear Regulatory Commission's Regulatory Guide 1.33-1972..."

Regulatory Guide 1.33-1972, Appendix A, Section G.5 lists procedures for protective clothing and for radiation work permits as procedures that should be prepared.

Procedure 915.4, "Contamination Control", Revision 0, states in part, "All personnel entering a contamination controlled area are required to wear protective clothing. ...Required protective clothing will be specified on the Radiation Work Permit..."

Radiation Work Permit No. 127980 required the user to wear protective clothing consisting of one set of coveralls, surgeon's cap, cotton glove liners, plastic gloves, disposable shoe covers, and rubber shoes while performing activities authorized by the permit.

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Contrary to the above, on August 6, 1980, four individuals were performing decontamination activities authorized by Radiation Work Permit No. 127980. The decontamination consisted of soap and water washing of equipment and piping in contamination controlled areas of the 51 foot elevation of the reactor building around the core spray booster pumps and the reactor building closed cooling water heat exchangers. The individuals were wearing protective clothing consisting only of cotton glove liners, plastic gloves, disposable shoe covers, and surgeon's caps. None of the individuals were wearing coveralls and one individual was bare chested.

RESPONSE

Immediate corrective actions taken by the Radiation Protection Technician who identified this deficiency consisted of a) stopping the work, b) surveying all involved personnel for radioactive contamination (none was detected), and c) documenting the incident on a Radiological Deficiency Form. In addition, a critique was held; the workers and their supervisor were given verbal reprimands; and the workers were reinstructed in the need for verbatim compliance with Radiation Work Permits.

Since the time of the deficiency listed above an augmented training program has been formulated which places added emphasis on the following items as minimum.

- a) Selection and proper use of protective clothing required by RWP's.
- b) Demonstration of proper conduct of operations within a Radiation Controlled Area.
- c) Demonstration of proper frisking techniques to insure that no contamination is present.

It is planned in the future that this program will be incorporated in the contractor indoctrination program.

It is felt that these actions are responsive to the deficiencies in Management Controls identified above and that future occurrences of these type events will be reduced.

It should be noted that this deficiency was identified by a Radiation Protection Technician independent of the NRC inspector's activities. His immediate corrective actions as described above were taken while the NRC inspector was reporting this problem to the Supervisor Radiation Protection and were completed before the NRC inspector and the Supervisor arrived on the scene.

The responsiveness of Health Physics personnel to this event is considered to be adequate and not part of the lack of Management Controls which led to the deficiency.

JCP&L considers classification of this item as an infraction to be inappropriate based upon the definitions contained in "Policy Session Item" SECY-80-139H. It is stated therein that failure to follow procedures is a

Category V classification which is a deficiency. Moreover, the deficiency was promptly identified by station personnel and appropriate corrective actions were taken independent of NRC inspection activities. This item should accordingly be reclassified as a deficiency.

- Item B. Technical Specification 6.8.1 states in part, "Written procedures shall be established, implemented, and maintained that meet or exceed the requirements of ... Appendix 'A' of the Nuclear Regulatory Commission's Regulatory Guide 1.33-1972..."

Regulatory Guide 1.33-1972, Appendix A, Section G.5 lists procedures for protective clothing as procedures that should be prepared.

Procedure 915.4, "Contamination Control", Revision 0, states in part, "All personnel entering a contamination controlled area are required to wear protective clothing. ...Protective clothing is not to be worn outside the controlled area. ...At exits from contaminated areas, an area is designated as the step off pad. This area...is considered part of the area outside the contaminated area. Nothing contaminated should be placed on this area".

Contrary to the above, on August 6, 1980, an individual dressed in protective clothing was observed in an area outside a contaminated area. He had exited a contaminated area, crossed the step off pad and commenced to remove potentially contaminated protective clothing in a clean area creating the potential for the spread of radioactive contamination.

RESPONSE

Immediate corrective action consisted of isolating the area where the individual undressed and surveying it for radioactive contamination. No contamination was detected. The individual had left the site before he could be stopped; his dosimetry and security badge were removed to preclude his reentering the station while an investigation proceeded.

Follow up action involved permanently restricting the involved individual from entry to JCP&L nuclear plants. The individual is a general office engineer and has been reassigned to work solely on non-nuclear projects.

The augmented training program discussed in the response to Item A will similarly minimize recurrence of this type event.

The responsiveness of Health Physics Personnel to this event is considered to be adequate and not part of the lack of Management Controls which led to the deficiency.

JCP&L considers classification of this item as an infraction to be inappropriate. based upon the definitions contained in "Policy Session Item" SECY-80-139H. It is stated therein that failure to follow procedures is a Category V classification which is a deficiency. Moreover, the deficiency was promptly identified by station personnel and appropriate corrective actions were taken independent of NRC inspection activities. This item should accordingly be reclassified as a deficiency.

Item C. 10 CFR 50 Appendix "B" states in part, "The quality assurance program shall provide control over activities affecting the quality of the identified structures, systems, and components. Activities affecting quality shall be accomplished under suitably controlled conditions. Controlled conditions include the use of appropriate equipment... The program shall take into account the need for special controls..."

The Jersey Central Power and Light Company Generation Division Operational Quality Assurance Plan, Revision 3, Appendix A, Quality Assurance Systems List, lists "Liquid, Solid, and Gaseous Radwaste" (old plant). Note: The structural elements of the building and those portions of the systems necessary to contain radioactive material and isolate it from the environment are included".

Contrary to the above, a temporary waste water processing demineralizer was installed in the "old radwaste building" without adequate process controls or monitoring devices to safeguard against the release of radioactive materials to the environment. Subsequently, during system operation, the demineralizer overflowed spilling approximately 20 gallons of radioactively contaminated water, about two gallons of which flowed outside the confines of the building.

RESPONSE

The temporary waste water processing demineralizer was installed in the Old Radwaste Building in an effort to assist our present chemical waste system in producing good quality effluent. As stated, the system was intended to be used on a temporary basis until such time as the problems with the chemical waste evaporator were resolved and it was performing as intended and good quality water was being produced. Prior to placing the system into operation, a procedure detailing the operation, valve lineups, safety evaluation and applicable prerequisites and precautions were developed and reviewed by the Plant Operations Review Committee (PORC) and approved by the Station Manager. It was felt that adequate controls were applied to the temporary process in that an operator would be stationed for continuous monitoring and the system would be located in a selected area of old radwaste such that all leakage or spills would be collected in the floor drain system and contained within the building. As a result of the incident it appeared our process controls and monitoring was not adequate. Subsequently prior to restarting the temporary process additional controls were implemented as follows:

1. A cover was installed on top of the liner.
2. An overflow was installed in the liner and routed to collecting tank.
3. Level indication reading in inches of level was installed.
4. The area adjacent to the Demineralizer was covered to preclude any spillage from flowing outside of the confines of the building.

These additional controls were effective in guarding against overflow as evidenced by successful operation of the system. However, on September 29, 1980, one of the hoses used in the process ruptured and water was spilled outside the confines of the building. Investigation revealed that the cover designed to protect spillage from reaching the environs (item 4) had been removed.

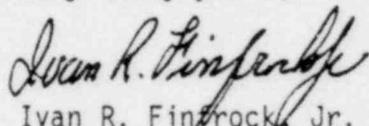
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This last incident resulted in correspondence between the Region and the Station requiring an evaluation be performed to determine the continued need for this system and, if it is required, to design and install a hard piping system and controls and instrumentation to provide automatic level control and isolation of the demineralizer. The water being processed through the clean waste system remains of a quality that requires additional processing prior to routing to the High Purity System. Without the temporary demineralizer the processing capability is severely limited and the amount of water released to the environ is increased. It is for these reasons that we plan to redesign the system with the additional criteria as stated.

The system will be modified with the appropriate controls and will be resubmitted to the PORC and Station Manager for approval prior to future operation.

Presently the system is shutdown with the valves tagged shut to the Radwaste Operation Manager. Full compliance is being achieved.

Very truly yours,



Ivan R. Finrock, Jr.
Vice President Generation

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