

GPU Nuclear Corporation

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December 21, 1990 C321-90-2040

U.S. Nuclear Regulatory Commission Attn: Document Control Desk Washington, D.C. 20555

Dear Sir:

Subject: Oyster Creek Nuclear Generating Station

Docket No. 50-219

Inspection Report 90-19

Reply to a Notice of Violation

In accordance with 10CFR2.201, the enclosed provides GPU Nuclear's response to the violations identified in NRC's Inspection Report 50-219/90-19.

If further information is required, please contact Brenda DeMerchant, Oyster Creek Licensing Engineer at (609) 971-4642.

Very truly yours,

E) Yitzpatrick

Vice President and Lirector Oyster Creek

EEF/BDeM/jc Enclosure

cc: Mr. Thomas T. Martin, Administrator

Region 1

U.S. Nuclear Regulatory Commission

475 Allendale Road

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NRC Resident Inspector

Oyster Creek Nuclear Generating Station

Mr. Alexander Dromerick

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GPU Nuclear Corporation is a subsidiary of General Public Utilities Corporation

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VIOLATION A

A. Technical Specification 6.8.1 requires that written procedures be established, implemented and maintained that meet or exceed the requirements of NRC Regulatory Guide 1.33.

Regulatory Guide 1.33, Revision 2, specifies that equipment control activities be covered by written procedures and endorses ANSI N18.7~1976, Section 5.2.2, which requires that procedures be followed.

Station Procedure 108, "Equipment Control", Revision 48, specifies the required review and documentation for the installation of temporary piping when it is not shown on approved system drawings.

Contrary to the above, procedures were not followed in that an air hose routed from the reactor building 23 ft elevation to the 119 ft elevation and a hose and valves in a reactor building penetration were installed without the required review and documentation until September 27, 1990, when the installations were reviewed and documented. This equipment was not shown on approved system drawings.

This is a Severity Level IV Violation (Supplement 1).

RESPONSE:

- 1. GPU Nuclear concurs with the violation as stated.
- 2. The reason for this violation was weaknesses in the maintenance and construction work control processes.
- 3. Corrective Actions taken are as follows:
 - a. Walkdowns were conducted by Technical Functions and Operations personnel to determine if other configurations existed in the plant which were not properly controlled or shown on plant drawings. An action plan was established to properly document and control the differences in configuration and all known configuration differences have either been properly documented or controlled in accordance with Procedure 108.
 - b. This violation is based on configuration changes made some time in the past. It is felt that considerable changes have been made in our work control process to reduce the probability of non-documented or non-controlled configuration changes to the plant in the future. These changes include: 1) Establishing a Work Authorization and new Long-Term Planning organization in Plant Maintenance to screen incoming Plant Maintenance work requests for configuration control concerns. 2) Strengthening the job planning function in both Plant Maintenance and Site Services Departments, including the issuance of job planning guidelines which specifically address the area of temporary variations. 3) Procedure 108 is now covered by our craft Maintenance Training Program.

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violations.

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- 4. Corrective Actions that will be taken to avoid further violations.
 - a. Additional emphasis on configuration control responsibilities of the maintenance and construction staffs will be accomplished through training, required reading programs, or crew meetings as necessary.
 - b. A further assessment of how failures in configuration control may be occurring will be conducted and the needed corrective measures will be identified. This effort is expected to be a more comprehensive determination of the root cause for the loss of configuration control for those events already identified and determination of other potential mechanisms not already addressed.
- 5. Full compliance was achieved on September 27, 1990 when temporary variations were issued documenting the configuration.

VIOLATION B

B. Technical Specification 6.11 requires that procedures for personnel radiation protection shall be adhered to for all operations involving personnel radiation exposure.

Procedure 9300-ADM-4000.11, Revision O, Rules for Conduct of Radiological Work, Section 7.2, requires that all personnel who enter the Radiological Controls area shall obey the posted, oral, and written radiological controls instructions, procedures and Radiation Work Permits.

Contrary to the above, on October 16, 1990, procedures for personnel radiation protection were not adhered to in that a worker entered an area posted as a High Radiation Area without the high range self reading dosimeter and the dose rate meter or alarming dosimeter required by Radiation Work Permit No. 90-990 for high radiation areas.

This violation is Severity Level V (Supplement IV).

RESPONSE:

- 1. GPU Nuclear concurs with the violation as stated.
- 2. The reason for this violation was personnel error on the part of the individual who entered the posted high radiation area.
- 3. The following corrective actions have been taken:
 - a. Upon discovery of the individual in the posted high radiation area, the Radiological Controls Technician directed him to exit and a Radiological Investigation was initiated in accordance with procedure 9300-ADM-1201.01, "Investigation of Radiological Incidents (RIR)".

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- b. The individual's authorization to enter the radiologically controlled area was lifted pending the outcome of a critique which was held on the day following the event.
- c. The individual received special counseling on the requirements for entry into posted high radiation areas.
- 4. The corrective steps which have been taken to avoid further violations are:

This violation is considered to be an isolated incident in that it is not a symptom of a programmatic problem. However, particular attention to this type of event is being given in the Radiological Controls Technician training and qualification program. Efforts by Radiological Controls personnel at screening persons entering the controlled area have been increased

5. Full compliance was achieved on October 18, 1990.