GPU Nuclear

GPU Nuclear Corporation
Route 441 South
P.O. Box 480
Middletown, Pennsylvania 17057-0480
(717) 944-7621
Writer's Direct Dial Number:
(717) 948-8005

May 4, 1994
C311-94-2065

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

Subject: Three Mile Island Nuclear Station, Unit 1 (TMI-1)
Operating License No. DPR-50
Docket No. 50-289
Response to Notice of Violation 94-02-02

Dear Sirs:

Your letter of March 30, 1994, transmitted Inspection Report 94-02 which contained two Notice of Violations. This letter contains our response to Notice of Violation 94-02-02. The Notice of Violation states that records required by Commission regulations or license conditions were not complete and accurate in all material respects. Pursuant to the provisions of 10 CFR 2.201, Attachment 1 provides the GPU Nuclear response to the Notice of Violation.

Sincerely,

T. G. Broughton
Vice President and Director, TMI

JSS/emf

Attachment

cc: M. G. Evans - TMI Senior Resident Inspector
R. W. Hernan - Senior Project Manager
T. T. Martin - NRC Regional Administrator, Region I

9405090222 940504
PDR ADOCK 05000289
Q PDR

IE01

ATTACHMENT 1
C311-94-2065

NOTICE OF VIOLATION RESPONSE

During an NRC inspection conducted on January 18, 1994 - February 28, 1994, two violations of NRC requirements were identified.

Notice of Violation 94-02-02 states:

> 10 CFR 50.9(a) requires that information required by statute or by Commission's regulations shall be complete and accurate in all material respects. Technical Specification 6.8.1a states, in part, that written procedures shall be implemented covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Regulatory Guide 1.33, Revision 2, February 1978, Appendix A, identifies safety-related activities that should be covered by written procedures. Item 1.h. under Administrative procedures identifies log entries as an activity that should be covered by procedures.
>
> Contrary to the above, the licensee determined that records required to be maintained by commission regulations or license conditions were not complete and accurate in all material respects. On January 27, 1994, on the 7 a.m. to 3 p.m. shift, the auxiliary operator performing the Outbuildings Tour Log, recorded two readings for the River Water Fire Service Diesel Building without entering the building to perform the readings. This error was material in that it evidenced that checks had been made when they had not.

Response:

GPU Nuclear acknowledges that the violation occurred as stated in the notice of violation. At the time of discovery of the event by GPU Nuclear, GPU Nuclear informed the NRC and conducted an investigation. The investigation confirmed that an Auxiliary Operator (AO) had entered log readings on the 7-3 shift on January 27, 1994 for FS-P-3 (Fire Service Pump 3) without entering the FS-P-3 building. The AO entered the FS-P-3 readings on the Outbuildings Log while he was in the Screen house in anticipation of what the readings were going to be when he entered the FS-P-3 Building. When the AO exited the Screen House, he was told to pick up another operator immediately and turnover the truck to the operator. The Outbuildings operator then ate dinner and was given other duties for the rest of his shift. The Outbuildings operator could not finish the Outbuildings log readings and that task was turned over to another operator with no instructions to validate the FS-P-3 log entries.

The event was identified on January 28, 1994 by GPU Nuclear when during an investigation into a reported problem with the lock on the door of the FS-P-3 building that prevented taking of FS-P-3 readings on the 3-11 shift on January 27, 1994, the AO in question informed the daylight Shift Supervisor that he had entered the FS-P-3 log readings in the Outbuilding Log without entering the building on January 27, 1994. The AO repeated his statement during a subsequent interview on January 28, 1994, and acknowledged that he had received documented training on the proper way to take readings.

The cause of this event is personnel misconduct. The AO failed to perform his assigned job in accordance with specific procedural requirements and documented training.

GPU Nuclear took the following corrective actions in response to this event:

1. The AO involved received disciplinary action.

2. It was verified that the FS-P-3 readings had been taken for the 11-7 shift on January 26/27, 1994 and on the 11-7 shift on January 27/28, 1994.

3. The activity records for the AO that was disciplined were reviewed with respect to operator readings and vital door access for a three month period. No additional log keeping problems were identified.

4. All TMI Auxiliary Operators were personally informed by the Plant Operations Director of his expectations on the proper way of doing business which included Tours, Log Keeping and filling out the Operators Log sheets and a reading of step 4.1.2.1.a.5 of Administrative Procedure 1016, "Operations Surveillance Program ", which states "Information should be recorded on the log concurrently with when it is obtained. In no case shall information be entered prior to or in anticipation of the observation or event". At the completion of each discussion with each AO, the operators were asked if they knew of any logging problems. No additional logging problems were identified.

All actions have been completed as of the date of this response. GPU Nuclear believes the actions taken provide reasonable assurance that a similar event will not occur in the future.