

GPU Nuclear Corporation

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August 30, 1984 5211-84-2223

Dr. T. E. Murley Region I, Regional Administrator U. S. Nuclear Regulatory Commission 631 Park Avenue King of Prussia, PA 19406

Dear Sir:

Three Mile Island Nuclear Station, Unit 1 (TMI-1) Operating License No. DPR-50 Docket No. 50-289 Notice of Violation for Inspection 84-16

Attached to this letter is the GPUN response to Appendix A of Inspection Report 50-289/84-16, "Notice of Violation".

Sincerely,

Director, TMI-1

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Enclosure

cc: R. Conte

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NOTICE OF VIOLATION

As a result of the inspection conducted on June 4-8, 1984, and in accordance with the revised NRC Enforcement Policy (10 CFR 2, Appendix C), published in the <u>Federal Register</u> on March 8, 1984, (49 FR 8583), the following violation was identified:

Technical Specification 6.8.1 specifies that written procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978 shall be established, implemented and maintained. RWP Procedure 1613, Revision 25, Section 5.2 developed pursuant to the above states, "A dose rate instrument or an alarming dosimeter is required for entry into an area that is entered under a standing RWP." Radiation Work Permit No. 25908, a standing RWP for the Nuclear Sampling Room requires a dose rate instrument or Xetex for entry into the area covered by this permit.

Contrary to the above, on June 7, 1984, at approximately 9:00 a.m. and again at approximately 9:30 a.m., a chemistry technician entered an area covered by Radiation Work Permit No. 25908 without a dose rate instrument or Xetex. While such instrument was in the room, it was not used by the technician.

RESPONSE TO NOTICE OF VIOLATION

The violation described in section 8.2 and Appendix A to Inspection Report 84-16 resulted from the improper use of a Xetex alarming dosimeter. Procedures require that a Xetex be worn by at least one person in a group when the Radiation Work Permit (RWP) specifies the use of a Xetex. The technician entering the Nuclear Sample Room was aware of the RWP requirement for a dose rate instrument or Xetex and considered the requirement to have been met with an operable Xetex present in the room. This technician and others were unaware of a March 9, 1984 memorandum of clarification from the Radiological Engineering Department explaining that whenever a Xetex alarming dosimeter is issued to an individual it must be worn by that individual. The cause of this incident was failure to communicate this clarification within the chemistry department.

The following is GPUN's response to the items required by 10 CFR 2.201 regarding this Notice of Violation.

- I. CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED
 - a. A critique was held on the day of the incident. Radiological Investigative Report No. 84-009 details the actions and conclusions of this critique.
 - b. A memorandum detailing the requirements for use of a Xetex instrument has been reissued to all TMI-1 departments.
 - c. All chemistry technicians have been instructed or otherwise informed as to the requirements for use of the Xetex dosimeter.

II. CORRECTIVE STEPS WHICH WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

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GPUN feels that the corrective actions which have been taken are sufficient to avoid further violations.

III. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

GPUN feels that full compliance has been achieved.