GPU Nuclear

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

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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
Inspection Report 95-13 - Notice of Violation Response

Dear Sirs:

Attached is the GPU Nuclear reply to the Notice of Violation transmitted as an enclosure to Inspection Report 95-13.

Sincerely,

J. Knubel
Vice President and Director, TMI

AWM

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

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NOTICE OF VIOLATION - 95-13-02

Technical Specification (TS) 6.8.1 states, in part, that written procedures shall be established, implemented, and maintained covering certain activities, including the applicable procedures recommended in Appendix "A" of Regulatory Guide 1.33, Revision 2, February 1978, which includes radiation protection procedures. The licensee's Radiation Protection Procedure Number 6610-ADM-4110.07, entitled, "Radiography Operations," states, "entry into a radiography area can only be authorized by the radiographer, the Operations Shift Supervisor, and Group Radiological Controls Supervisor concurrence, and only if the source is in its stored position."

Contrary to the above, on September 6, 1995, an unauthorized individual entered a radiography area that was posted and barricaded to prevent unauthorized entry.

This is a Severity level IV violation (Supplement IV).

GPU NUCLEAR RESPONSE TO NOTICE OF VIOLATION 95-13-02

This Notice of Violation (NOV) is related to a violation of licensee procedures that involved an unauthorized entry into a radiography area. The inspection report stated that:" the immediate and long-term corrective actions for this violation were not considered sufficiently comprehensive to prevent recurrence of similar events. The licensee's problem identification and correction process was considered inadequate, in this instance, because: (1) the shift supervisor or other responsible licensee management was not provided an opportunity to exercise management oversight and review of the occurrence prior to the resumption of radiography operations, and (2) the originally determined long-term corrective actions were limited only to review of use of postings for improvements. Consequently, the violation is cited."

The inspection report further states: "In your response, you should document the specific actions taken and any additional actions you plan to prevent similar occurrences with adherence to radiological controls procedures."

I. Reason for the Violation

The root cause of this event was the individual's failure to read a radiological posting prior to entering the roped off area. The Event Capture Form initiated immediately after Rad Con Supervision was informed of the incident identified the individual's accountability as less than adequate because the Be SURE concept (a self checking process) was not used.

The Radiography Operations procedure was implemented and all postings were in accordance with procedures and regulations. The Shift briefing at the beginning of the shift included a discussion of the radiography operation to be performed. There was also a page announcement by the control room prior to starting radiography and approximately every 30 minutes while radiography was in progress. The page announcements identified the radiography location and informed personnel to stay clear of the area. The page announcements were required by and were in accordance with the Radiography Operations procedure.

All personnel qualified as Radiation Workers are taught in General Employee Training(GET) that it is their responsibility to read radiological postings prior to entering a radiologically controlled area. In the GET Lesson on Radiological Postings there is a specific portion on Radiography Postings and the requirement to KEEP OUT. It further states "the violation, movement, or removal of any radiological posting or boundaries will not be tolerated."

II. Corrective Steps That Have Been Taken and the Results Achieved

The Auxiliary Operator was counseled and disciplined for his failure to read and adhere to radiological postings. The severity of the discipline administered to this individual was mitigated due to the individual's good work performance and forthrightness during the investigatory process. The disciplinary remarks also state "any further violations of this or any other Company rules/regulations may result in more severe disciplinary action, including suspension and/or termination."

In addition, Operations management issued a memo concerning "Violation of Posted Boundaries During Radiography" on 10/24/95 and the Operations Director discussed the incident with each shift. The event was included in the monthly events report that is placed in the "Crew Required Reading" book.

Also, an article was put in the TMI "Power Points" newsletter on September 8, 1995 to heighten the awareness of all employees about the incident. It also reminded personnel of their responsibility to observe "Radiography In Progress" postings and other radiological postings for their safety.

Subsequent to this incident there were two additional radiography operations performed during the 11R outage. The subsequent radiography operations were reviewed in detail by radiological controls management and a radiological controls checklist was developed for each radiography operation which included all the necessary controls for the specific radiography task. The checklist detailed areas to be posted and areas which would be locked or guarded to prevent access. A copy of the checklist was provided to the radiography group to ensure all parties involved were aware of the required controls. These two subsequent radiography operations were performed without incident.

III. Corrective Steps That Will Be Taken to Avoid Further Violations

The radiological controls checklist mentioned above was an effective tool, so as an enhancement the procedure will be changed to incorporate this requirement. In addition, there will be a sign-off by both the Radiography Group and Rad Controls to ensure all parties have read and agree to the controls prior to starting radiography. This procedure change requires Rad Con Supervision and the Shift Supervisor to be advised of the controls and of any abnormal occurrences. The procedure change will also incorporate details on what to do and who to contact when problems arise. This revision will require management oversight and review of any abnormal occurrences prior to resumption of radiography operations. These procedure changes will be completed by April 15, 1996.

A review of the signs used for radiography operations determined that unique signs would improve controls for future radiography operations. The new sign is unique in color and size compared to other radiological postings. The new sign will be incorporated into the procedure by April 15, 1996.

The Training Department will cover this event during upcoming Auxiliary Operator Training classes. The training will be completed by June 30, 1996.

Finally, with respect to preventing similar occurrences with adherence to radiological controls procedures, TMI Management has initiated plans to improve the use of self-checking, observation, and coaching practices. A memo is planned to be issued in January 1996 entitled, "Site Management Expectations in Pursuit of Excellence." The purpose of this memo is to clearly communicate management's expectations in the areas of self-checking and to emphasize the Be SURE concept and to assure it is put into practice in all activities related to the operation, maintenance, and support of TMI. All maintenance, operation, and key support personnel will receive Self-Checking training to improve human performance by December 31, 1996.