10 CFR 2.201

# PHILADELPHIA ELECTRIC COMPANY

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GRAHAM M. LEITCH
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June 11, 1992

Docket No. 50-352
License No. NPF-39

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

SUBJECT: Limerick Generating Station, Unit 1
Reply to a Notice of Violation
NRC Combined Inspection Report Nos. 50-352/92-13 and 50-353/92-13, and Combined Inspection Report Nos. 50-352/92-14 and 50-353/92-14

Attached is Philadelphia Electric Company's reply to a Notice of Violation for Limerick Generating Station (LGS) Unit 1, which was contained in a NRC letter dated May 12, 1992 that transmitted Combined Inspection Report Nos. 50-352/92-14 and 50-353/92-14. The subject of the violation was discussed in NRC Combined Inspection Report Nos. 50-352/92-13 and 50-353/92-13. NRC Enforcement Conference Nos. 50-352/92-13 and 50-353/92-13 was held at the NRC Region I office on April 10, 1992, to discuss the violation, its cause, and corrective actions taken. A follow-up meeting was held at the NRC Region I office on June 9, 1992, to resolve questions about the bioassay results that suggested a substantial intake of alpha-emitting radionuclides occurred following this violation. The Notice of Violation identifies the failure to follow the requirements and limitations specified in a Radiation Work Permit.

The attachment to this letter provides a restatement of the violation identified during an NRC special inspection conducted at LGS, Units 1 and 2, on March 26-27, 1992, and a follow-up inspection on April 20-24, 1992, followed by our response.

If you have any questions or require additional information, please contact us.

Very truly yours,

J. Doering for GAL

JLP:cah

Attachment

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PDR ADOCK 05000352
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cc: T. T. Martin, Administrator, Region I, USNRC
T. J. Kenny, USNRC Senior Resident Inspector, LGS

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# Reply to a Notice of Violation

## Restatement of the Violation

As a result of the inspection conducted on March 26-27, 1992, and in accordance with the NRC Enforcement Policy (10 CFR 2, Appendix C), the following violation was identified:

Technical Specifications, Section 6.8, Procedures, require that written procedures be established, implemented, and maintained.

Procedure A-C-107, Radiation Work Permit Program and Radiological Controlled Area Access Requirements, specifies that a worker's signature on a radiation work permit (RWP) means that the worker understood the requirements and limitations specified in the RWP and will comply with these requirements and limitations.

Contrary to the above, on March 25, 1992, workers on RWP 920704 entered the Unit 1 fuel transfer canal in violation of the RWP prohibition on entering this area.

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

## RESPONSE

## Admission of Violation

Philadelphia Electric Company (PECo) acknowledges the violation.

## Reason for the Violation

The cause of the violation is personnel error resulting in procedural non-compliance due to failure to follow administrative controls and a failure to communicate changes in planned work activities.

Radiation Work Permit (RWP) 9207074 for the reactor cavity area included a special instruction that stated, "Entry into the Transfer Canal prohibited on this RWP."

While waiting for the Reactor Services Section (RSS) Superintendent to inspect the reactor pressure vessel flange, the Job Leader decided to proceed with the planned work activities which included removal of Stop Log #15. During the course of the

cavity cleaning the rope barrier was removed by the Job Leader from across the Transfer Canal Entrance. The Job Leader knew that the rope barrier should not be removed without the authorization of Health Physics (HP). Based upon a discussion of the planned work activities with HP personnel earlier in the day, the Job Leader's perception was that he received authorization to remove the rope barrier along with the other equipment from the reactor cavity. Removal of the rope barrier removed a barrier in place to assist personnel to comply with RWP 9207074.

When the Stop Log was lifted, sealant material broke off and fell to the floor of the Transfer Canal. Gouges were identified in the side of the Stop Log after it was lifted approximately five feet. At that point the lift was halted and the Job Leader and an Engineer exited the reactor cavity to inspect the gouging from the Fuel Floor. Stop Log removal was completed after it was determined that the gouging was caused during Stop Log insertion during a previous outage.

The RSS Superintendent entered the reactor cavity and inspected the reactor pressure vessel flange. Once the RSS Superintendent completed his inspection, the Job Leader and the Engineer discussed the Stop Log gouging problem with him. All three individuals then entered the Transfer Canal to inspect the Stop Log Keyway for damage because the extent of the damage could not be determined from the cavity area or Fuel Floor. These individuals failed to follow administrative controls established by Common Nuclear Procedure A-C-107," Radiation Work Permit Program and Radiological Controlled Area Access Requirements," when they made their unauthorized entry into the Transfer Canal and failed to comply with RWP 9207074.

Corrective Action and Results Achieved

An outage stand down was conducted on March 26, 1992. The outage work stoppage was initiated to provide time to inform all outage workers of several recent events that could have been avoided. The focus was on the cause of the event and the lessons to be learned so that similar problems could be avoided. This event was one of five that was discussed. Management conveyed the following expectations to all plant workers based upon the lessons learned from these events:

1. Adhere to procedures.

2. Think before acting. When in doubt, stop and ask.

3. Follow proper Radiation Worker practices at all times.

Corrective Actions Taken to Avoid Future Non-Compliance

The following actions were taken or are planned to be taken to avoid future non-compliance:

1. On March 26, 1992, an HP supervisor was assigned to assess the fuel floor HP operations to determine where improvements in communication and HP coverage can be made. The improvements identified have been completed.

2. Group meetings were held with RSS and HP personnel to discuss the event and to reinforce management's expectations regarding communication, pre-job briefings, radiation worker practices, and adherence to procedures.

3. Appropriate RSS personnel were disciplined in accordance with the disciplinary guideline for their failure to follow the requirements of the RWP.

Date When Full Compliance was Achieved

Full Compliance was achieved on March 26, 1992, when the outage stand down was conducted and all outage workers were informed of management expectations of their conduct to avoid similar problems.