UNITED STATES
ATOMIC ENERGY COMMISSION
DIRECTORATE OF REGULATORY OPERATIONS
REGION 1
970 BROAD STREET
NEWARK, NEW JERSEY 07102

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J. G. Keppler, Chief, Reactor Testing & Operations Br.
Directorate of Regulatory Operations, HQ

SPECIAL INSPECTION REGARDING ALLEGATION OF POOR RADIOLOGICAL CONTROL PRACTICES AT OYSTER CREEK, DOCKET NO. 50-219*

RO:I inspectors completed a special inspection at the Oyster Creek BWR facility during February 13 - 16, 1973. Although up to 30 violations and/or safety items were identified, the inspectors' preliminary conclusions at the facility on February 16, 1973 were that no immediate threat to the health and safety of the public appeared to exist.

The Director of Region I personnally contacted the cognizant Jersey Central Power & Light Company Vice President regarding our concerns in this matter on February 14, 1973. RO:I is currently completing an evaluation of the violations and plan to meet with the licensee's corporate management on or about March 1, 1973 to discuss these matters.

The licensee at the facility began completing some corrective actions during the time of the RO:I inspection. This was visually observed by our inspectors.

The licensee's corporate level management reported via telephone on February 23, 1973 that approximately 70% of the violations had been corrected. We intend to verify the licensee's telephone report during planned RO:I followup inspections at the site.

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*Reference to letter, J. P. O'Reilly to R. H. Engelken, dated February 14, 1973 regarding "Anonymous Allegations - Jersey Central Power & Light Co., Oyster Creek Nuclear Generating Station".

Types of violations identified by RO:I inspectors included:

a. Failure to properly post (approximately 8) low radiation and (approximately 7) high radiation areas,

b. Failure to properly label (approximately 8) radioactive material containers and/or locations,

c. Excessive radiation levels in unrestricted areas,

d. Failure to make adequate surveys,

e. Failure to provide personnel monitoring,

f. Failure to inform personnel of the occurrence of radioactive materials or radiation levels in a restricted area,

g. Failure to report, within 30 days, exposure to personnel to excessive air concentrations,

h. Violation of Technical Specification requirement 6.2.B.2 relating to radiation control procedures,

i. Failure to control radiation exposure to one individual within the limits specified by plant procedures.

Types of safety items include:

a. Failure to establish a radiological protection retraining program for plant personnel,

b. Failure to make dose rate surveys prior to capping high level waste drums,

c. Failure of extended radiation work procedures to reflect the existing conditions, covering routine work in the reactor building,

d. Poor radiological housekeeping practices relative to storage and control of radioactive materials.

An inspection report is being prepared covering these matters. The report is being given Regional priority.

D. L. Caphton

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Senior Reactor Inspector
Facility Operations Branch

Issued by facsimile on 2/26/73