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

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R. H. Smith, Acting Senior, Facilities Radiological Section
Directorate of Regulatory Operations, Region I

RO INSPECTION REPORT NO. 50-219/73-02
JERSEY CENTRAL POWER AND LIGHT COMPANY
OYSTER CREEK

An inspection was conducted on February 13-16, 1973 for purposes of following up on allegations relative to adverse radiological conditions at the facility. The allegations were received by the RO:I office in a letter, dated February 6, 1973, without a signature, and identified in the closing, as a "concerned employee". The allegations included, general housekeeping problems, high exposure use, high radiation and contamination levels, outside storage of waste drums, leaking drums, chromated water storage, and unsafe conditions in the radwaste facility. As evidenced by statements in the letter, management has failed to correct the conditions, even after constant complaints to the safety department.

In general, inspection findings verified that conditions were as described in the letter. The inspection was limited to those areas spoken to in the letter, with little effort given to review of records, radioactive releases, and other areas normally reviewed during an inspection. In spite of this limited review, approximately 27 violations in 10 different categories were identified. Additionally, one safety item relating to management control systems, and one relating to exposure controls were identified.

Inspection findings showed that management control systems were practically nonexistent relative to the radiation protection program. Responsibilities for implementation of the program were poorly defined. No audit system to determine program effectiveness was in evidence. Line organization supervisors are not required to formally (in writing) report on their activities, identify problems, or otherwise be accountable. In the inspectors opinion, those responsible for the program were negligent in their response to program needs.

Two cases in point to the above; (1) the radiation protection group is under-staffed and the supervisor (in his own words), had communicated this to higher management (verbally) but in no way had documented this need, or made issue of the need; (2) in general management was aware of the problems

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associated with the radwaste facility, in particular with the 600 to 800 drums of waste in inventory, but took little action to lower that inventory. In the words of management, "it took exposure to get rid of the waste". Little did they realize the exposure used in living with the problem. No ultimatums were given to anyone relative to resolving the problem. I don't think they could, "see the woods for the trees".

To illustrate the poor handle that the station manager had on things was demonstrated during the closeout meeting. The inspector asked him if he had knowledge of the condiitons in the plant, as evidenced by the numerous violations or as described by the inspector. He responded, "it's obvious that I don't, these people don't even know". The reference to "these people" was a motion towards the five supervisors in attendence at the meeting.

In the inspector's opinion, the violations noted and the general radiological conditions observed did not pose a threat to health and safety. Some of the problems noted can be corrected with little effort. The overall problem will take a concerted effort to resolve. Specifically, they will have to identify the various problems, establish direction, and implement needed changes.

I would recommend a reinspection of the program after a reasonable time period (2 months) for the licensee to adjust to the needs.

R. J. Meyer
Radiation Specialist

F. Cantrell
Reactor Inspector

for R. Friess
Environmental Specialist