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September 5, 1986

Mr. Harry B. Kister, Chief
Projects Branch No. 1
U.S. Nuclear Regulatory Commission
Region I
631 Park Avenue
King of Prussia, PA 19406

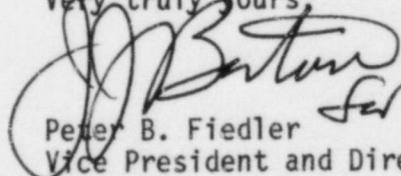
Dear Mr. Kister:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
IE Inspection Report 50-219/86-17

In accordance with 10 CFR 2.201, the attached response is provided to the Notice of Violation contained in Appendix A of your letter dated August 8, 1986.

If you should have any questions, please contact Mr. George W. Busch at (609)971-4909.

Very truly yours,


Peter B. Fiedler
Vice President and Director
Oyster Creek

PBF/GB/dam
Attachment

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

Mr. Jack N. Donohew, Jr.
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NRC Resident Inspector
Oyster Creek Nuclear Generating Station

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ATTACHMENT 1

Violation

Technical Specification 6.13 and Oyster Creek Station Procedure 9300-ADM-4110.06 require, in part, that each entrance or access point to a high radiation area shall be maintained locked except during periods when access to the area is required, with positive control over each individual entry. Procedure 9300-ADM-4110.06 further requires a key control responsibility briefing prior to an individual receiving custody of a high radiation area key.

Contrary to the above, on June 25, 1986, the licensee failed to:

- (1) conduct a high radiation area key control responsibility briefing and to verify with the radiological controls shift technician that a person assuming custody of a locked high radiation area key had been properly briefed; and
- (2) Lock the entrance to the cleanup room on elevation 51' which is a normally locked high radiation area.

Response

GPUN concurs in the violation.

Immediate corrective action was taken to re-establish control of the high radiation area and the incident was documented. A critique was held, discipline was administered, and the incident was reviewed with all Rad Con technicians.

Full compliance was achieved on June 25, 1986.

In relation to item (1) in the violation, the briefing referred to is posted on a large sign at the issue window and is written on the back of the signature sheet which acknowledges the briefing. Procedure 9300-ADM-4110.06 paragraph 7.1 note 2 states:

"The briefing referred to in this procedure is defined as follows: The RCT is to verify the person signing out his locked high radiation area key has read the posted instructions (identical to form 9300-ADM-4110.06-1, side 2 of 2). The signature of the person signing out the locked High Radiation Area key on form 9300-ADM-4110.06-1 signifies he has read, understands, and will comply with posted instructions."

In accordance with the procedure, the individual's signature is the verification referred to in the procedure. In this case, the form was signed prior to issuing the key, therefore, the Radiological Control Technician complied with the procedural requirements. However, as a result of reviewing the circumstances leading to this violation, the following actions will be taken to avoid further violations of this nature:

- (1) An inspection of each locked high radiation area will be conducted to identify whether or not a mechanical modification may reduce the probability of human error when locking high radiation area doors.
- (2) Although classroom instruction during General Employee Training is deemed adequate, lesson plans and handouts will be revised to further emphasize high radiation area key control; where the briefing is located and what it contains; high radiation area custodial responsibilities; and disciplinary actions that may occur upon failure to comply with procedures.

The inspection report also requested that GPUN respond to the following specific areas of concern:

Concern:

Adequacy of Rad Con staffing to support ongoing work activities.

Response:

Rad Con staffing for the outage was forecast based on area coverage. As the work scope and schedules were released, the forecast was cross-referenced and verified. The adequacy of Rad Con staffing during the outage has been confirmed by (1) no significant work stoppages have occurred due to a lack of Rad Con staffing; (2) overtime has been within NRC guidelines; (3) rescheduling of vacations has not been necessary; and (4) attendance at training and safety meetings has been maintained.

Concern:

Apparent ignorance or poor attitude of contract workers that led to this noncompliance.

Response:

During the first two months of the outage, contractor supervisors were given two days of additional training, which emphasized working in a radiation environment and procedural adherence. Contractor work rules are being reviewed and revised as necessary to parallel GPUN work rules. A summary of this incident will be circulated to contractor supervisors emphasizing not only the specific incident but, in addition, the worker's responsibility to ask questions if he (or she) does not understand a procedure.