

August 12, 1997

Mr. Michael J. Colomb
Site Executive Officer
New York Power Authority
James A. FitzPatrick Nuclear Power Plant
Post Office Box 41
Lycoming, NY 13093

Dear Mr. Colomb:

Subject: **NRC Inspection Report No. 50-333/97-04 and Notice of Violation**

This letter refers to your July 17, 1997 correspondence, in response to our June 13, 1997 letter.

Thank you for informing us of the corrective and preventive actions documented in your letters. These actions will be examined during a future inspection of your licensed program.

Your cooperation with us is appreciated.

Sincerely,

Original Signed by:

John F. Rogge, Chief
Projects Branch 2
Division of Reactor Projects

Docket No. 50-333

cc:

C. Rappleyea, Chairman and Chief Executive Officer
R. Schoenberger, President and Chief Operating Officer
J. Knubel, Chief Nuclear Officer and Senior Vice President
H. P. Salmon, Jr., Vice President of Nuclear Operations
W. Josiger, Vice President - Engineering and Project Management
J. Kelly, Director - Regulatory Affairs and Special Projects
T. Dougherty, Vice President - Nuclear Engineering
R. Deasy, Vice President - Appraisal and Compliance Services
R. Patch, Director - Quality Assurance
G. Goldstein, Assistant General Counsel
C. Faison, Director, Nuclear Licensing
K. Peters, Licensing Manager
T. Morra, Executive Chair, Four County Nuclear Safety Committee



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cc w/copy of Licensee's Response Letter:

Supervisor, Town of Scriba

C. Donaldson, Esquire, Assistant Attorney General, New York Department of Law

P. Eddy, Director, Electric Division, Department of Public Service, State
of New York

G. T. Goering, Consultant, New York Power Authority

J. E. Gagliardo, Consultant, New York Power Authority

E. S. Beckjord, Consultant, New York Power Authority

F. William Valentino, President, New York State Energy Research
and Development Authority

J. Spath, Program Director, New York State Energy Research
and Development Authority

Distribution w/copy of Licensee's Response Letter:

RI EDO Coordinator

A. Dromerick, NRR

K. Cotton, NRR

D. Hood, NRR

M. Campion, RI

R. Correia, NRR

F. Talbot, NRR

Nuclear Safety Information Center (NSIC)

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Region I Docket Room (with concurrences)

Inspection Program Branch, NRR (IPAS)

J. Rogge, DRP

R. Barkley, DRP

R. Junod, DRP

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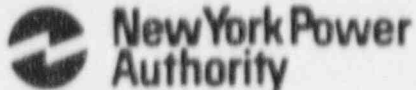
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James A. FitzPatrick
Nuclear Power Plant
268 Lake Road
P.O. Box 41
Lycoming, New York 13093
315-342-3840



Michael J. Colomb
Site Executive Officer

July 17, 1997
JAAP-97-0251

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Mail Station P1-137
Washington, D.C. 20555

Subject: James A. FitzPatrick Nuclear Power Plant
Docket No. 50-333
Reply to Notice of Violation
NRC Inspection Report 50-333/97-04

Dear Sir:

In accordance with the provisions of 10 CFR 2.201, Notice of Violation, the Authority submits a response to the notice transmitted by your letter dated June 13, 1997. Your letter refers to the results of an inspection completed at the James A. FitzPatrick Nuclear Power Plant on May 25, 1997.

This violation concerns failure of radiation workers to follow radiation protection requirements. Poor human performance was the cause of workers failing to follow requirements. The JAF plant leadership team has recognized several incidents attributed to personnel error. We have completed an evaluation of human performance documented in the Human Performance Team Report. The report identifies causes of personnel errors and recommendations to prevent future events. We have also developed a Radiation Work Excellence Plan that is focused on improving human performance consistent with the recommendations of the Human Performance Team Report. We understand the broad implications of this violation and have long-term corrective action plans underway.

Attachment 1 provides the description of the violation, reason for the violation, the corrective actions that have been taken and the results achieved, corrective actions to be taken to understand the broader implications of the violation and avoid further violations, and the date of full compliance.

There are no commitments contained in this report.

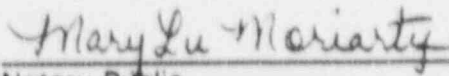
If you have any questions, please contact Mr. Arthur Zaremba at (315) 349-6365.

Very truly yours,


MICHAEL J. COLOMB

MJC:RAP:las
cc: next page

STATE OF NEW YORK
COUNTY OF OSWEGO
Subscribed and sworn to before me
this 17th day of July, 1997.


Notary Public
MARY LU MORIARTY #4965820
Notary Public, State of New York
Qualified in Oswego County

9.707230328 6AP

cc: Regional Administrator
U.S. Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, PA 19406

Office of the Resident Inspector
U. S. Nuclear Regulatory Commission
P.O. Box 136
Lycoming, NY 13093

Ms. K. Cotton, Acting Project Manager
Project Directorate I-1
Division of Reactor Projects I/II
U. S. Nuclear Regulatory Commission
Mail Stop 14B2
Washington, D.C. 20555

REPLY TO NOTICE OF VIOLATION
NRC Inspection Report 97-04

Violation

During an NRC inspection conducted from April 13 to May 25, 1997, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600, the violation is listed below:

Technical Specification 6.11 requires, in part, that procedures for personnel radiation protection shall be prepared and adhered to for all plant operations. Administrative Procedure (AP)-07.00 (Rev. 0), Radiation Protection Program, Section 6.1.5, states that radiation workers shall comply with radiation protection instructions.

Contrary to the above, radiation workers did not comply with radiation protection instructions as identified in the following examples:

- (1) On December 7, 1996, two radiation workers did not adhere to the radiation work permit, disregarded radiological posting requirements and one worker improperly used the portal monitor. These practices resulted in an individual becoming contaminated; and*
- (2) On April 16, 1997, in two separate incidents, radiation workers escorted three visitors into the plant cable tunnel which is a radiologically controlled area (RCA). The entrance to the cable tunnel was posted with a yellow and magenta sign which stated "Caution Radioactive Material" that the area was an RCA, that only authorized personnel were to enter, and that a thermoluminescent dosimeter (TLD) was required for entry. The visitors were not authorized or monitored for radiation exposure as required by procedure.*

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

Admission or Denial of the Alleged Violation

The Authority agrees with this violation.

Reasons for the Violation

The cause for the violation was personnel error. The performance factors leading to these errors were:

- Personnel failed to accept personal responsibility to adhere to written and posted instructions resulting in unauthorized access to radiological areas. In the first example, workers failed to obtain a radiation protection briefing prior to entry into a contaminated area. In the second example, the workers failed to adhere to postings in that they entered a radiological area without required dosimetry for their escorted visitors.
- Personnel failed to use available resources, the technical assistance of the radiation protection staff, to perform the tasks appropriately.

REPLY TO NOTICE OF VIOLATION
NRC Inspection Report 97-04

- In both cases the radiological postings were evaluated and determined to be adequate. The conclusion was made that the individuals, in both cases, were not attentive to posted instructions.
- Individuals performed tasks without proper preparation, including failing to obtain radiological briefings and work permits.
- Corrective actions for previous similar radiological control boundary incidents were inadequate in that extent of condition was not effectively addressed. Although an adverse trend DER was issued, earlier recognition of the adverse trend could have prevented the second incident.

Corrective Actions That Have Been Taken

Immediately following the event in example 1:

The individual who alarmed the security portal monitor:

- The individual was decontaminated and interviewed.
- Follow-up contamination surveys were performed to ensure there was no further spread of contamination.
- This individual was placed on radiological hold temporarily rescinding his authorization to access the RCA. Following investigation of the improper use of the portal monitor, the individual's employment was ended.

The second individual who did not adhere to the radiation work permit was provided job performance counseling.

Additional corrective actions taken for example 1:

- Operating shift workers were presented radiological briefing expectations to assure utilization of radiation protection resources.
- Plant staff was informed of the event, the cause of the event, and the requirement to follow written and posted instructions.

Immediately following the event in example 2:

- Technicians were posted at RCA access/egress points to ensure no further unauthorized entries occurred.
- The cable tunnel was toured by security personnel to ensure no unauthorized personnel were in the area.

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- The escorts were placed on radiological hold temporarily rescinding their authorization for access into the RCA.
- The escorts were counseled by radiation protection personnel and their supervisors.
- Second physical barriers were placed at RCA entrances to prevent recurrence of this type of event.. Second barriers currently include radiation ropes or swing gates with signs, in addition to normal radiological postings.
- An evaluation was performed to determine if other similar events had occurred. A listing of all visitors was compiled and compared to security access records. No additional deviations were identified.

Additional corrective actions taken for example 2:

- The individuals who inappropriately escorted visitors into the RCA were disciplined in accordance with Human Resources policies.
- Plant personnel were immediately notified by memorandum of this particular incident description and radiological consequences.

Results Achieved

The Authority believes the corrective actions taken were effective in preventing recurrence. The FitzPatrick staff awareness of the issues relating to these events has been heightened. The Authority is continuing to reinforce the importance of compliance with radiation protection performance standards by increasing radiation worker involvement through our Radiological Work Excellence Plan.

Corrective Actions to Be Taken to Understand the Broader Implications of These Violations

As previously stated in our 2/21/97 (JAFP-97-0061) correspondence to the NRC, in an effort to improve all aspects of operation at the James A. FitzPatrick Nuclear Power Plant, a team of line personnel was formed and has evaluated human performance related events at the site. The corrective actions developed by the team are being implemented to ensure continued performance improvement.

In addition, The Radiological Work Excellence Plan was developed and issued May 21, 1997. This plan is also focused on improving human performance. The actions are carried out by teams and involve radiation workers in many departments at FitzPatrick. The strategy of this plan is similar to the strategy used in the radiation protection improvement program. The Excellence Plan uses recent successes in radiation work practices as a guide for plant workers in all departments. Worker involvement, program ownership and personal integrity will help achieve high standards of performance and eliminate personnel errors that lead to events.

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Guidelines have been prepared to improve control over groups of visitors. These guidelines will be used in the future to ensure better control and monitoring of visitor activities. Visitors not on official business, are now required to receive Site Executive Officer approval prior to site restricted area access.

Extent of condition evaluations will be considered for all Deviation and Event Reports (DERs). Documentation of the evaluation will be included in the appropriate DER closure packages.

Date When Full Compliance Will Be Achieved

Management expectations for improving human performance have been and continue to be reinforced. Full compliance was achieved on April 16, 1997 when the visitors exited the RCA.