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

New York Power Authority

William Fernandez II
Resident Manager

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JAFP-90-0455

United States Nuclear Regulatory Commission
Mail Station P1-137
Washington, DC 20555

ATTENTION: Document Control Desk

SUBJECT: RESPONSE TO NOTICE OF VIOLATION -
INSPECTION NO. 90-02 (DOCKET 50-333)

Reference: 1) USNRC Letter Dates May 9, 1990
Subject: Inspection Report No. 50-333/90-02

Enclosures: 1) Response to Notice of Violation (3 pages)

Gentlemen:

This letter provides the Authority's response (Enclosure 1) to the Notice of Violation transmitted by Reference (1). This refers to the inspection conducted by Messrs. Wayne Schmidt and Richard Plasse of your office between March 12, 1990 and April 25, 1990 at the James A. Fitzpatrick Nuclear Power Plant.

Very truly yours,

WILLIAM FERNANDEZ
WF/JAS/:aml

Enclosure

CC: R. Beedle, WPO
J. Brons, WPO
R. Liseno, JAF
G. Vargo, JAF
NRC Resident Inspector, JAF
S. Toth, WPO
M. Knapp, NRC Region I,DRSS
Document Control Center
WPO Records Management

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Enclosure 1

NOTICE OF VIOLATION

As a result of the inspection conducted on March 12 to April 25, 1990, and in accordance with NRC Enforcement Policy (10 CFR 2, Appendix C) the following violations were identified.

10 CFR 20.201 requires that surveys be taken to ensure the measurement and evaluation of the concentration of radioactive material present at a job site, to ensure adequate respiratory protective measures. NYPA Radiological Work Permit Procedure (RPP-4) requires that respiratory protective measures be used in an area where surface contamination is above 50,000 dpm.

Contrary to the above, on April 3, 1990, NYPA did not perform a survey and thus did not evaluate the concentration of radioactive material present at the edge of the reactor vessel cavity, to ensure adequate respiratory protective measures. Respiratory protective measures where not used when surface contamination was above 50,000 dpm (600,000 dpm). This led to the internal contamination of two maintenance workers.

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

NYPA RESPONSE TO NOTICE OF VIOLATION

The Authority agrees with the violation.

1. Reasons for the Violation

On April 3, 1990 there were several tasks in progress on the refuel floor that required Radiation Protection coverage. The mechanics were moving the ladder in the equipment storage pit to another location and were about to install some ball valves and connections in the cavity weirs for the Operations Department. The decontamination crew was also on the refuel floor performing cavity cleaning. The Chief Radiation Protection Technician on the refuel floor became preoccupied with the mechanics moving the ladder in the equipment storage pit due to very high contamination levels. He consequently directed less attention to loosening the plates on the weirs.

The loosening of the plates on the weirs was described by the mechanics as a short and simple task. The Chief Radiation Protection Technician did not perform or direct that a contamination survey on the weir plates be performed because

he assumed that the contamination levels on the weirs were the same as the cavity walls (approximately 60,000 dpm/100 cm^2), and the heads of the mechanics would be 18-20 inches from the work area.

Radiation Protection Procedures provide guidelines that normally require respiratory protection for contamination levels greater than 50,000 dpm/100 cm^2 unless supervisory concurrence is granted otherwise. In this instance the technician allowed them to perform their task without respiratory protection and without supervisory concurrence.

This event resulted from the Chief Radiation Protection Technician failing to maintain a questioning attitude and incorrectly assuming that the contamination levels on the weirs were the same as the general reactor cavity surfaces. The Chief Technician should have exercised his authority to not allow work to proceed, until a survey had been performed.

2. Corrective Action Taken and Results Achieved

The Superintendent of Power directed that work be stopped on the refuel floor until a survey of the weir plates was performed and a critique of the event was completed. In addition, both mechanics received whole body counts and exposures in MPC-hours were calculated (3.2 and 11.6 MPC-hours).

3. Corrective Action Which Will be Taken to Avoid Future Violations

The Chief Radiation Protection Technician was disciplined. The importance of following procedural guidelines and the significance of controlling radiologically sensitive work was strongly reinforced.

In addition, the need for supervisors (especially refuel floor supervisors) to be sensitive to the radiological issues continues to be stressed by management.

The details of this event will be added to the Radiation Protection Technician continuing training program and the importance of following procedural guidelines for radiologically sensitive work will continue to be emphasized by management.

4. The Date When Full Compliance Will Be Achieved

All items were completed April 3, 1990 with the exception of continuing training. The continuing training will be resumed at the the conclusion of the current refuel outage.