



Georgia Institute of Technology

SCHOOL OF NUCLEAR ENGINEERING AND HEALTH PHYSICS

ATLANTA, GEORGIA 30332

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NEELY NUCLEAR RESEARCH
CENTER

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October 4, 1982

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Dr. D. M. Verrelli, Chief
Reactor Projects Branch 1
Division of Project and
Resident Programs
Nuclear Regulatory Commission
101 Marietta St., N.W., Suite 3100
Atlanta, Georgia 30303

Dear Dr. Verrelli:

This letter is in response to yours of September 8, 1982 to Georgia Institute of Technology. So that you may bring your records up-to-date, enclosed is a copy of a letter of March 28, 1980 notifying the NRC of a change of director for the GTRR. Also, the appropriate title for the operating unit through which the reactor management reports is the School of Nuclear Engineering and Health Physics.

As indicated by our records, and duly reported by your inspection, two incidents involving violations of our procedures and hence NRC requirements occurred during the period of the Radiation Protection review, September 15, 1978 to August 26, 1982. Following is a response as to circumstances, action and current status. For reference, each citation is reproduced with its appropriate response.

1. 10 CFR 20.203(c)(2)(iii) requires 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.

Contrary to the above, a high radiation area was not maintained locked or entrance positively controlled. On May 5, 1980, the doors to the process equipment room, a high radiation area, were left open and positive control over each entry was not exercised.

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RESPONSE

The location of this incident was the Process Equipment Room, a room immediately beneath the reactor shield which houses the primary and secondary pumps and heat exchangers which deal with reactor heat. During high power reactor operations and for a few minutes following shutdown, the radiation levels at certain locations in the room are above 100 mr/hr which requires it to be classified as a "High Radiation Area." The two doors to the area are normally closed and locked, and in addition are instrumented to produce an alarm in the reactor control room when opened.

At the time of the incident, the reactor had not been operated for eleven days because a gasket on the personnel air lock was being replaced - an activity unrelated to the Process Equipment Room either as to location or function. On the day of the incident, several management, health physics, and operating personnel had access to the Process Equipment Room area prior to discovery of the open, unguarded door. On investigating a few days later no one recalled deliberately leaving the door open. The importance of the procedure was discussed at a staff meeting the following week. To management's knowledge the incident has not been repeated.

2. Technical Specification 6.4 requires that procedures for radiation and radioactive contamination control shall be provided and utilized. Licensee procedures state that a Health Physics survey is required during the removal of any material from a penetration of the biological shield of the reactor.

Contrary to the above, the requirement that a Health Physics survey be made when removing material from the reactor was not met in that on May 13, 1982 an individual removed irradiated material from biological shield penetration H-12 without a Health Physics survey.

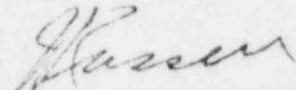
RESPONSE

The incident involved a routine measurement of flux in a phantom located in a shielded cavity at a beam port position

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outside the reactor shield. Investigation at the time of the incident pointed to a breakdown of communication. The seriousness of the matter was discussed with all parties involved, and personnel were reassigned. The matter appears to be resolved.

Yours truly,


John L. Russell, Jr.
Director

JR/jwh

Enclosures

cc: Dr. Walter Carlson
Dr. Thomas Stelson
Mr. John Wilson
Nuclear Safeguards Committee