

April 30, 2004

MEMORANDUM TO: James Heller (JKH@nrc.gov)  
Senior Region III Office Allegation Coordinator

FROM: Kenneth Riemer  
Chief, Plant Support Branch  
Division of Reactor Safety

SUBJECT: REVIEW OF LICENSEE IDENTIFIED WRONGDOING ISSUES;  
ALLEGATION NO. RIII-04-A-0047 (POINT BEACH)  
[AITS NO. S04-0170]

This responds to K. Lambert's memorandum dated April 14, 2004, which forwarded a copy of the subject document and requested our review to (1) identify any new safety concerns and/or enforceable items and (2) provide a recommendation for follow-up actions (including coordination with the Office of Investigations (OI) if an investigation is potentially warranted).

PSB's Evaluation and Recommendation(s):

As a member of the Plant Support Branch (PSB) staff assisted the Resident Inspectors in drafting the initial allegation receipt form while onsite on February 12<sup>th</sup>, PSB concurs with the characterization of the two concerns documented in the original submittal (as noted below):

Concern No. 1

*The NRC is concerned that three contract ISI/NDE workers knowingly entered Containment to conduct work while signed in on a Radiation Work Permit (RWP) only for activities in the Auxiliary Building.*

Concern No. 2

*The NRC is concerned that while the three contract ISI/NDE workers were conducting work in Containment on the incorrect RWP, at least one worker knowingly worked up to his dosimetry dose alarm limit (50 mrem), and subsequently received dose in excess of the allowed amount by the RWP (the individual received 51 mrem).*

As noted in Section 7 of the Allegation Receipt Form, the workers violated the RWP requirements as required by NP 4.2.19 "General Rules for Work in Radiologically Controlled Areas" (Section 4.3) in entering containment on the incorrect RWP (as related to Concern 1). Additionally, one worker (Mr. Auer) violated NP 4.2.27 "Personnel Exposure Monitoring Device Minimum Requirements and Use," in that Step 3.7.1 states that workers are to ensure that they do not exceed their RWP approved dose limits. However, Point Beach does not have the "Regulatory Guide 1.33, Appendix A" Technical Specification, and as such the procedures identified as being violated are not required by NRC regulations.

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Also as noted in Section 7, a PSB inspector was onsite for a baseline radiological access control inspection and "pulled the string" on these issues by obtaining radiological surveys for the area the workers were in at the time of the event (attached). In reviewing the surveys, the inspector initially determined that at the time of the incident Containment was posted as Radiation and Contaminated Areas (it was down posted from a High Radiation Area (HRA) early on April 4, 2004). However, the area where the individuals were working in Containment on April 5, was a posted HRA. Therefore, it appeared that this was a violation of Technical Specification 5.7.1 which establishes controls for HRAs including the requirement for the establishment of and adherence to an RWP for entry into such an area. As such, the inspector initially believed that a regulatory tie to 10 CFR 50.5 "Deliberate Misconduct" could be established.

However, upon review of the survey map of the area, the PSB inspector determined that the maximum dose rate at 30 cm was 80 mrem/hour. The licensee had conservatively posted the area as an HRA (>100 mrem/hour at 30 cm) to account for possible operational changes as allowed by its procedures. Since the area did not meet the definition of an HRA (>100 mrem/hour at 30 cm), Technical Specification 5.7.1 is not required to be met and thus the regulatory tie to 10 CFR 50.5 can not be established.

The PSB inspector reviewed several additional licensee procedures and documents while onsite the week of April 19, 2004, to assess if any additional regulatory ties existed between the RWP requirements, RWP procedure, Technical Specifications, and 10 CFR Parts 20 and 50. The inspector was unable to identify any viable regulatory ties during his review.

As such, PSB determined that:

- (1) **These occurrences represent human performance deficiencies and non-compliances with Point Beach Station procedures.**
- (2) **No regulatory requirement exists requiring the licensee to follow these procedures, as the area the individuals entered did not meet the definition of a High Radiation Area (>100 mrem/hr at 30 cm).**
- (3) **Because compliance with these station procedures is not required by Technical Specifications or other NRC rule, regulation, or order, the requirements of 10 CFR 50.5 "Deliberate Misconduct" do not appear to apply.**
- (4) **Utilizing the current versions of MC 0612, Appendix B, and MC 0609, Appendix C, based on the dose consequences realized in this occurrence (1 mrem in excess of the RWP limit), and not considering willfulness, the performance deficiencies would at the most be characterized as Green (and a case can be made that they are not more than minor).**

Therefore, due to a lack of a regulatory basis and the low level nature of the performance deficiencies, PSB recommends that the concerns be closed with respect to a potential Office of Investigations activities. However, PSB intends to address the performance issues with the licensee during upcoming routine radiation protection inspections.

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Attachments: ARB Sheets for Concerns 1 & 2  
Supporting information (CAP, Licensee Investigation Report, Surveys, etc.)

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