FLORIDA POWER & LIGHT COMPANY

December 8, 1977
L-77-365

Central File
50-335

Mr. James P. O'Reilly, Director, Region II
Office of Inspection and Enforcement
U.S. Nuclear Regulatory Commission
230 Peachtree Street, N.W., Suite 1217
Atlanta, GA 30303

Dear Mr. O'Reilly:

Re: RII:MVS
50-335/77-18

Florida Power & Light Company has reviewed the subject inspection report. There is no proprietary information in the report.

Very truly yours,

Robert E. Uhrig
Vice President

REU/MAS/lah

cc: Robert Lowenstein, Esquire

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UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
230 PEACHTREE STREET, N.W. SUITE 1217
ATLANTA, GEORGIA 30303

NOV 2 9 1977

In Reply Refer To:
RII:MVS
50-335/77-18

Florida Power and Light Company
Attn: Dr. R. E. Uhrig, Vice President
of Nuclear and General
Engineering
P. O. Box 013100
9250 West Flagler Street
Miami, Florida 33101

Gentlemen:

This refers to the special inspection conducted by Mr. M. V. Sinkule of this office on November 9-10, 1977, of activities authorized by NRC Operating License No. DPR-67 for the St. Lucie facility, involving the possible contamination and/or radiation exposure of an Florida Power and Light Company employee who was in the Community Hospital of the Palm Beaches at West Palm Beach, Florida. The findings of this inspection were discussed with Mr. K. N. Harris by telephone on November 16, 1977.

Areas examined during the inspection and our findings are discussed in the attached inspection report. Within these areas, the inspection consisted of interviews with personnel, and observations by the inspector.

Within the scope of this inspection, no items of noncompliance were disclosed.

In accordance with Section 2.790 of the NRC's "Rules of Practice", Part 2, Title 10, Code of Federal Regulations, a copy of this letter and the enclosed inspection report will be placed in the NRC's Public Document Room. If this report contains any information that you (or your contractor) believe to be proprietary, it is necessary that you make a written application within 20 days to this office to withhold such information from public disclosure. Any such application must include a full statement of the reasons on the basis of which it is claimed that the information is proprietary, and should be prepared so that proprietary information identified in the application is contained in a separate part of the document. If we do not hear from you in this regard within the specified period, the report will be placed in the Public Document Room.

Should you have any questions concerning this letter, we will be glad to discuss them with you.

Sincerely,

F. J. Long, Chief
Reactor Operations and Nuclear
Support Branch

Enclosure:
RII Inspection Report
No. 50-335/77-18

cc: Mr. K. N. Harris, Plant Manager
St. Lucie Plant
P. O. Box 128
Ft. Pierce, Florida 33450

Mr. Nat Weems, Assistant QA Manager
P. O. Box 128
Ft. Pierce, Florida 33450

UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
230 PEACHTREE STREET, N.W. SUITE 1217
ATLANTA, GEORGIA 30303

Report No.: 50-335/77-18

Docket No.: 50-335

License No.: DPR-67

Category: C

Licensee: Florida Power and Light Company
P. O. Box 013100
Miami, Florida 33101

Facility Name: St. Lucie 1

Inspection at: Community Hospital of the Palm Beaches,
West Palm Beach, Florida

Inspection conducted: November 9-10, 1977

Inspector: M. V. Sinkule

Reviewed by: R. C. Parker 11-23-77
for R. C. Lewis, Chief Date
Reactor Projects Section No. 2
Reactor Operations and Nuclear Support Branch

Inspection Summary
Inspection on November 9-10, 1977 (Report No. 50-335/77-18)
Areas Inspected: Special, unannounced inspection of event involving the alleged contamination and/or radiation exposure of a St. Lucie employee at the Community Hospital of the Palm Beaches at West Palm Beach, Florida. The inspection involved 5 inspector-hours at the hospital by one NRC inspector.
Results: Of the area inspected, no items of noncompliance or deviations were found.

DETAILS I

Prepared by: R.C. Lewis 11/28/77
for M. V. Sinkule, Reactor Inspector Date
Reactor Projects Section No. 2
Reactor Operations and Nuclear
Support Branch

Dates of Inspection: November 9-10, 1977

Reviewed by: R.C. Lewis 11/28/77
R. C. Lewis, Chief Date
Reactor Projects Section No. 2
Reactor Operations and Nuclear
Support Branch

1. Persons Contacted

J. Cogswell, Civil Defense Health Physicist
H. Buchanan, FP&L Health Physics Supervisor - St. Lucie
H. Mercer, FP&L, Plant Coordinator
C. Wells, FP&L, Operations Supervisor
Dr. Serafini, Radiation Emergency Evaluation Facility
Dr. Kenny, Radiation Emergency Evaluation Facility
C. G. Weird, Hospital Administrator, Community Hospital
Dr. Kiner, Attending Physician, Community Hospital
K. Harris, FP&L Plant Manager - St. Lucie (by telephone on November 9, 1977)

2. Licensee Action on Previous Inspection Findings

Not inspected.

3. Unresolved Items

No new unresolved items were identified.

4. Exit Interview

The scope and findings of this inspection were discussed with Mr. K. N. Harris, Plant Manager, by telephone on November 16, 1977.

5. Summary of Event

The inspector was contacted by the Region II office in Atlanta, Georgia, at the Turkey Point site at approximately 5:30 p.m. on November 9, 1977, and directed to proceed to the Community Hospital of the Palm Beaches where a Florida Power and Light (FP&L) employee was alleged to be contaminated and/or irradiated. The inspector was to determine if the event was associated with control of contamination or irradiation at the St. Lucie site. FP&L personnel had contacted Region II at approximately 4:30 p.m. on November 9, 1977, and described the situation.

The inspector arrived at the hospital at approximately 9:30 p.m. on November 9, 1977. Upon entry into the hospital the inspector submitted to a brief interview from a reporter for the Miami Herald Newspaper.

When the inspector arrived at the hospital, he conducted an interview with Community Hospital officials, FP&L plant personnel, Radiation Emergency Evaluation officials, and a representative from the County Civil Defense office. The personnel present had conducted radiation surveys and reviewed hospital records of the individual involved and had concluded that the radiation levels were due to a prescribed diagnostic intake of radioactive technesium-99, prescribed by a physician and administered at the hospital.

The Civil Defense official stated that he had been contacted by Hospital officials on November 9, 1977, after they became alarmed with the radiation levels of an individual who had been admitted to the hospital to undergo treatment for a gastrointestinal disorder and high fever on November 5, 1977. The inspector was informed that the survey taken by the Civil Defense official ranged from 10 to 50 mrem per hour on different parts of the patients body. The Civil Defense official stated that he ordered the man isolated and scrubbed. He subsequently contacted FP&L personnel who responded to the scene.

FP&L personnel stated that they had arrived on the scene at approximately 6:00 p.m. on November 9, 1977, but were not permitted to conduct surveys until approximately 7:00 p.m. The survey, which was conducted with RM-14 radiation monitors, showed that there was no contamination on the patient's skin, clothing, or in his room; however, direct radiation readings indicated the presence of radioactivity inside of his body.

FP&L personnel also stated that a radiation survey of the patient's home, personal effects, and family did not reveal the presence of radioactive contamination.

The personnel from the Radiation Emergency Evaluation Facility (REEF) in Miami arrived at the hospital and conducted an independent radiation survey and their readings agreed with those taken by FP&L personnel. They reviewed the medical records of the patient and found that the patient had been given 10 millicuries of technesium-99 on the evening of November 8, to aid in the diagnosis of the patient. REEF personnel concluded that the technesium-99 was the source of the radiation and that this incident was not related to a radioactive source that had originated at the St. Lucie site.

Further discussions with the Civil Defense official indicated that the instrument used by him to conduct his survey was not reliable in the low radiation ranges. It appeared to the inspector that all parties were in agreement that the radiation readings of the patient were due to the diagnostic intake, which had been prescribed by a physician.

REEF officials stated that they had taken smears of the patient and the room which did not show evidence of contamination; however, the smears would be recounted on stationary equipment at the REEF at Miami. REEF representatives also stated that the patient would be transferred to REEF on November 10, for the conduction of confirmatory tests.

The inspector revisited the hospital on the morning of November 10, and conducted an interview with the patients' doctor and the hospital administrator to confirm the amount of the diagnostic intake and to determine additional circumstances surrounding the event. The patients' doctor had ordered the diagnostic intake of technesium-99 which was administered on November 8 and also ordered gieger counter readings to be taken when he was informed, by the patient, that he was employed at a nuclear power plant and had been involved in radiation type work. The doctor also stated that he was concerned with the slow recovery of the patient. The inspector could not determine why the hospital officials became alarmed at the radiation levels of the patient unless the hospital personnel making the radiation survey were not aware of the diagnostic intake. During this interview, the inspector was informed that hospital officials had contacted REEF on November 10 and were informed that the results of a blood sample taken from patient on November 9 indicated only the presence of technesium-99.

On November 11 Region II contacted the director of the REEF by telephone and was informed that the results of tests conducted on the facility conclusively proved that the only source of radiation was technesium-99.