

### UNITED STATES **NUCLEAR REGULATORY COMMISSION**

#### REGION II 101 MARIETTA STREET, N.W. ATLANTA, GEORGIA 30303

MAY 2 3 1984

Report Nos.: 50-321/84-15 and 50-366/84-15

Licensee: Georgia Power Company

P. O. Box 4545 Atlanta, GA 30302

Docket Nos.: 50-321 and 50-366

License Nos.: DPR-57 and NPF-5

Facility Name: Hatch 1 and 2

Inspection at Hatch site near Baxley, Georgia

Inspector:

Approved by:

R. Jenkins, Section Chief

Division of Radiation Safety and Safeguards

Date Signed

Date Signed

SUMMARY

Inspection on April 16 - 20

Areas Inspected

This routine unannounced inspection involved 32 insepctor-hours on site in the areas of organization and management; external exposure; control of radioactive materials, ALARA; solid wastes and transportation.

Results

Of the five areas inspected, no violations or deviations were identified.

### REPORT DETAILS

### 1. Persons Contacted

\*H. Nix, General Manager, Plant Hatch

\*C. Belflower, QA Site Manager

R. Rosanski, Radiological Health and Safety Representative

\*R. Zavadoski, Manager Health Physics/Chemistry

\*H. Rogers, Health Physics Superintendent

\*D. Smith, Supervisor, Health Physics

\*C. Belflower, QA Site Manager

\*S. Bethay, Acting Regulatory Compliance Supervisor

\*D. Elder, QA Field Representative

Other licensee employees contacted included two technicians.

NRC Resident Inspectors

\*R. Crlenjak, Senior Resident Inspector

\*P. Holmes-Ray, Resident Inspector

### 2. Exit Interview

The inspection scope and findings were summarized on April 19, 1984 with those persons indicated in paragraph 1 above.

3. Licensee Action on Previous Enforcement Matters

Not inspected.

4. Unresolved Items

Unresolved items were not identified during this inspection.

- Organization and Management
  - a. The licensee continues to provide Health Physics coverage for the recirculation piping project in Unit 2 through a well organized group dedicated solely to this purpose and described in Report No. 83-39. The preplanning and coverage given this project has apparently been effective as evidenced by limiting man-rem exposures well below ALARA projections which are discussed in paragraph 6 of this report.
  - b. Licensee Quality Assurance Report No. QA-84-143 was reviewed by the inspector. No violations or deviations were observed by the inspector during tours of the plant made prior to review of the content of the audit report. The inspector had no further questions.

## 6. External Exposures

The licensee organization formed to exclusively cover the recirculation piping project includes a strong ALARA components which is well staffed and equipped to perform the function. The external exposures are tracked on a current basis using an HP-1000 computer system. The original estimates of external exposures for the project was 1700 man-rem and this was adjusted downward on March 29, 1984, to 1300 man-rem. As of March 30, 1984, the predicted exposures were 881 man-rem and the actual exposures to date have been 500 man-rem or 57%. The licensee expects to see a further downward trend in external exposures since a major part of the work having higher exposure potential has been completed. The highest total exposure for any individual involved in the project has been 2616 mrem for the year 1984, as of April 18, 1984. No exposures have exceeded the applicable limits of 10 CFR 20. Exclusive of the recirculation piping project the highest exposure to date, April 18, 1984, for any other Georgia Power employee on site was 1829 mrem. The licensee plans to incorporate features of the project ALARA program into the overall Hatch ALARA program which is expected to significantly improve the existing plant program. Improvements include use of the HP-1000 computer system and more effective use of existing and added personnel in all phases of the ALARA program, including pre-planning.

# 7. Control of Radioactive Materials, Contamination, Surveys and Monitoring

During tours of the plant the inspector observed controls over radioactive materials and noted no instances of inadequate controls of these materials. The allegation was made that Anti-C clothing was being stored at Hatch outside the controlled area without posting. The inspector observed the licensee's storage areas for Anti-C clothing and found them to be adequately controlled and posted as required by 10 CFR 20. No violations or deviations were found. The licensee has an ongoing program for decontamination of areas. Records revealed that management is kept apprised of assigned decontamination efforts and the current status of decontamination work. Review of radiation survey records revealed that surveys are apparently made as required by 10 CFR 20. The inspector made numerous surveys and found reasonable agreement with licensee posted radiation levels.

# 8. Solid Waste and Transportation

The licensee has a separate solid waste handling facility devoted solely to this purpose. The facility was well designed and structured to handle solid waste. The facility has been staffed with personnel who do only this work. The facility was designed to segregate and compact solid waste. All wastes were observed to be handled in an orderly manner. Containers were observed to be strong, tight containers in good condition. No violations or deviations were observed.

### 9. Inquiry Into Worker Concerns

On March 19, 1984 the NRC Senior Resident Inspector at Hatch was contacted by two former contractor employees. The workers expressed a concern that they may have been permitted access to areas and exposed to conditions that were not commensurate with their training and were terminated for following plant procedures. They stated they received whole body counts when they arrived on site and were issued security badges. On March 13, 1984 they were allegedly taken by escort into the Reactor Building where they observed pipes covered with lead blankets, warning signs and workers wearing protective clothing. The workers and the escort were not wearing protective clothing. They stated that their foreman then obtained a radiation work permit (RWP) and asked then to sign the form, but they were prevented from doing so by plant health physics when they told the health physics technician they didn't know what an RWP was. They were instructed to report to the health physics office where they were told they could not enter an RWP area without training. They stated that after spending three to four days in the Fabrication Shop, they were shown a 55 minute training film and received a 30 minute class on the use of protective clothing. They then stated that when they reported to the site the next work day they were informed they were being terminated for failure to work and follow instructions.

Information was obtained by telephone on March 21, 1984, from a licensee representative at Hatch as to the findings of an ongoing investigation into this matter. The source furnished information as follows:

The two individuals did not enter an RWP area. Their TLD's read zero and pocket dosimeters totaled 10 mrem (considered drift primarily). They were in fact given the 55 minute training film. It was planned that they be used on a job with an escort. They were scheduled for dress out training on March 16, 1984; however, they left the plant site early and did not attend the training. This was said to be the reason they were ultimately terminated. Records showed that they were scheduled for full training on Monday, March 19, 1984, but were not available for this training since they had been terminated. The source stated that the two individuals did enter the Reactor Building with an escort. The source stated that the investigation was continuing and reviews of Security records and an interview with the escort were in progress or upcoming. Source stated that information obtained indicated that the two individuals approached their management and requested that they be terminated on a Reduction In Force (RIF) so that they would be eligible for Workman's Compensation. They were alleged to have stated that if this was not done, they would report to the NRC.

Later on March 21, 1984, the licensee representative source furnished additional information developed in the investigation. On March 13, 1984, the two individuals were escorted into the Reactor building, but only as far as the Health Physics control point for work in the Torus area. The two individuals could have observed other personnel in protective clothing from this location.

The escort talked with Health Physics personnel and was told that the two individuals could not work without a Radiation Work Permit (RWP) and they would need additional required training. The source stated that the control system was apparently effective and the two individuals were not allowed to enter the area without an RWP and without required training.

During this inspection the inspector confirmed that the above information was essentially correct through discussions, record reviews and observations. The individual who escorted the two contactor employees in the reactor building retraced the route with the inspector that he had taken with the two individuals and he pointed out each location occupied by them and the sequence of events as they occurred. It was evident that the two individuals could have observed posted radiation signs, lead blankets in use and other personnel in anti-c clothing, however, the escort stated that they were not permitted to enter a radiation work permit area. No violations or deviations were found.

LER 50-321/1983-113 (Closed) Reactor Building Exhaust Monitor

On December 20, 1983, the Reactor Building exhaust vent radiation monitors 1D11-K609 A, B and C were declared inoperable due to being out of calibration. The instruments were immediately recalibrated and returned to service on December 20, 1983. The instruments are calibrated at three month intervals in accordance with licensee procedure HNP-1-5114. A licensee representative stated that this event is not expected to be repetitive in the future and if the need is indicated, surveillance of the instruments will be increased to assure proper operation. This event report is considered closed.

11. IFI 50-321/366/84-09-01 (Open) Reporting Whole Body Counting Results to Terminated Employees

Inspection revealed that the licensee reports to a terminating employee for his exit whole body count the isotope and quantity in nanocuries for results greater than 1% derived organ burden (DOB). Activities greater than the lower limit of detection (LLD) of the counter, but less than 1% of DOB, are reported as less than 1% detectable activity. The licensee was informed that consideration should be given to reporting actual valves to the employee rather than less than 1% detectable activity. A licensee representative stated that a decision has been reached to report to terminating employees actual values even for the lower activities. The change to the reporting method had not been fully effected at the time of this inspection. This item will be reviewed on a subsequent inspection.

# 12. Unresolved Item 50-321/366/84-09-02 (Open)

The licensee has been reporting only the exit whole body counts to terminating employees. The inspector informed the licensee that failure to report all whole body count results, in addition to the exit count, could constitute a violation of 10 CFR 20.409 and 10 CFR 19.13(a). This matter was being carried as unresolved pending clarification of the requirements by the Region. At the time of this inspection a licensee representative stated that a decision has been made to report all whole body count results to terminating employees but the system for accomplishing this had not been fully effected. This item will be reviewed at the time of the next inspection.

### 13. NUREG 0737 Items

IIB3, Post Accident Sampling System items which were being carried as unresolved are as follows:

321/83-32-01 83-32-02 83-32-03 83-32-04 83-32-05

These items are still deemed to be open and will be reviewed on subsequent inspections.