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FLORIDA POWER & LIGHT COMPANY

March 5, 1984
L-84-58

Mr. James P. O'Reilly
Regional Administrator, Region II
U. S. Nuclear Regulatory Commission
101 Marietta Street, Suite 2900
Atlanta, Georgia 30303

Dear Mr. O'Reilly:

Re: Turkey Point Units 3 and 4
Docket Nos. 50-250 and 50-251
Proposed Civil Penalty: EA 83-138
Inspection Report 83-37

Florida Power and Light has reviewed the proposed civil penalty and associated inspection report and a response is attached.

Also attached are additional comments concerning information provided with the civil penalty letter.

Based on the additional comments we respectfully request a reevaluation of this finding for the purpose of rescinding or reducing the civil penalty.

Pursuant to this request we are not remitting payment of the civil penalty at this time.

There is no proprietary information in the report.

Very truly yours,

C. W. Williams
for J. W. Williams, Jr.
Vice President
Nuclear Energy

JWW/JLD/mvt

Attachment

cc: Harold F. Reis, Esquire

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PDR ADOCK 05000250
Q PDR

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FINDING:

- A. Technical Specification 6.12 requires that a radiation work permit be issued for entries into a high radiation area (an area where the dose rate exceeds 0.1 rem per hour), that workers entering into high radiation areas possess a radiation monitoring device which continuously indicates the radiation dose rate in the area, and that entries into locked high radiation areas be controlled by locks with their keys maintained under administrative control.

Technical Specification 6.11 requires that procedures for radiation protection be prepared consistent with the requirements of 10CFR20 and be approved, maintained and adhered to for all operations involving radiation exposure.

Plant Procedure 11550.2 (HP-2) prohibits entry by personnel into local radiation control areas until they comply with the precautions and limitations posted at the entry to the area.

Contrary to the above, on October 14, 1983,

1. A Radiation Protection Technician and a Shift Technical Advisor entered an area in Unit 3 where dose rates were in excess of 50 rems/hr and did not:
 - a. obtain a radiation work permit as required by Technical Specifications,
 - b. comply with precautions and instructions posted at the entry to a local radiation control area, and
 - c. possess a radiation monitoring device which continuously indicated the radiation dose rate in the area in that the instrument was incapable of measuring dose rates in excess of 5.0 rems/hr.
2. The licensee did not:
 - a. maintain the keys to a locked high radiation area under adequate administrative control to preclude unauthorized entry, and
 - b. implement by procedure the requirement of Technical Specification 6.12 that a radiation work permit be issued for entries into a high radiation area. Instead, the established procedure permitted substitution of a radiation protection technician for a radiation work permit.

RESPONSE

1. Florida Power and Light concurs with the finding, in part, subject to the following exceptions:
 - a. With respect to item 1c, the individuals did possess a radiation monitoring device which could continuously indicate the radiation dose rates for the area they were authorized to enter. The radiation dose rate inside the enclosure (14th elevation) was approximately 50 mrems/hr. Entry into the sump area (by descending down the ladder) was not authorized.

- b. With respect to item 2a, adequate key control was maintained in that the night shift containment supervisor knew exactly where his personally assigned key was at all times. Also, the entry into the locked high radiation area enclosure by the health physics technician and the Shift Technical Advisor was preplanned and authorized by the health physics containment supervisor under the cognizance of the health physics shift supervisor. The Plant Supervisor Nuclear was also aware of the STA going into containment to perform leak checks.
2. The finding occurred due to the following reasons:
- a. Poor judgment was exercised by the HP technician and the STA. The HP technician was briefed and authorized by HP supervision to enter the enclosure but not to go down the ladder to the sump. The HP technician was aware of the radiological significance of the condition in that; (1) he was aware of the thimbles being withdrawn, and (2) as acknowledged in the Notice of Violation the door was conspicuously marked with signs reading, "EXCLUSION AREA, HIGH RADIATION AREA, STAY-OUT, RWP REQUIRED FOR ENTRY". Yet the HP technician still failed to exercise proper control of this activity as required by his position, until the latter portion of the incident. The STA demonstrated poor judgment when he remained in the sump area knowing that his radiation survey instrument was reading off-scale.
 - b. The long standing practice of using health physics coverage in lieu of a radiation work permit has been determined to provide controls equivalent to those on an RWP. This practice had consistently been practiced at Turkey Point, had received previous NRC reviews, and is a common practice used in the industry.
3. Corrective steps which have been taken include:
- a. The individuals were immediately restricted from the Radiation Controlled Area.
 - b. Disciplinary action was taken against both individuals due to the poor judgment exercised by them in this event.
4. In order to prevent recurrence,
- a. New key core was installed in the enclosure door with the only key under the direct control of the Health Physics Supervisor. This interim action will remain in effect until corrective action based on the review of locked high radiation areas is completed.
 - b. The requirement to have an RWP prior to entering any high radiation area was incorporated into plant procedures.
- In addition, an engineering review of placing a grating over the entrance to the sump is in process and an indepth review of other locked high radiation areas was initiated.
5. Full compliance was achieved prior to December 1, 1983.

Pursuant to provisions of 10CFR2.205 we would like to provide additional clarification on the following statements appearing in the Notice Of Violation and Proposed Imposition Of Civil Penalty dated February 2, 1984, respectively:

- A. End of second paragraph on page one states, "When the shift personnel were changed, the on-coming technician received the key to the sump from the off-going technician, but he did not recall being told he was not to enter the sump." In fact shift turn-over between day and night shift included information on the potential leak inspection of the reactor sump. The on-coming technician obtained the key from the night shift health physics containment supervisor and was pre-briefed about the inspection, including; that the thimbles were withdrawn, not to go down the ladder to the sump and to anticipate an operator inspection of the sump area during his roving watch. Each relieving technician was also prebriefed in the same manner and obtained the key from his predecessor.
- B. Third paragraph on page one states the Shift Technical Advisor and the Health Physics Technician met by chance at the door to the reactor sump and that the two workers decided to open the door. In fact, it was preplanned and authorized by health physics management for entry into the enclosure to take place cognizant of the radiation dose rates on the 14' elevation and in the sump. The Plant Supervisor - Nuclear notified the Health Physics Shift Supervisor when the STA was about to enter the containment. As stated in item A above, the health physics technician was also aware of the inspection to take place prior to his entry into containment.
- C. First sentence, first paragraph on page one states, "The STA then read his self-indicating pocket dosimeter and found it to be off-scale (greater than 0.200 rems). In fact, the self-indicating pocket dosimeter worn by the S.T.A. was capable of monitoring up to 0.500 rems.
- D. The third sentence of the third paragraph of page 1 implies that the two individuals decided on their own to open the door to the sump. This is in error, in that the opening of the door was a preplanned and approved evolution. The decision made on their own was to enter the sump by descending the ladder.

Based on the above, we believe plant management involvement did take place in the decision to enter the enclosure and specific instructions were given not to descend the ladder and enter the reactor sump. The Health Physics Technician was cognizant of the reactor thimbles being pulled and the radiological significance of the condition in the sump. The Shift Technical Advisor stated that he was aware of the off-scale survey instrument reading while in the sump, thus demonstrating poor judgment. The decision to proceed with the inspection while in the sump was a deliberate action taken by the STA, being fully cognizant of the off-scale survey meter reading.

We believe management controls for this activity were adequate and the root cause was poor judgment on the part of both individuals. However, additional strengthening of controls as stated herein have been taken to preclude the reoccurrence of this event due to workers exercising poor judgment. Pursuant to the above additional information, the prompt identification and reporting, and the immediate corrective actions taken we respectfully request a reevaluation of this violation for the purpose of rescinding or reducing the civil penalty.

**RE: TURKEY POINT UNITS 3 AND 4
DOCKET MOS. 50-250, 50-251
CIVIL PENALTY EA 83-138
IE INSPECTION REPORT 83-37**

FINDING:

- B. Technical Specification 6.8 requires that written procedures be established, implemented and maintained that meet or exceed the requirements and recommendations of Appendix A of Regulatory Guide 1.33 and that each procedure be reviewed by the Plant Nuclear Safety Committee and approved by the Nuclear Plant Superintendent before implementation.

Regulatory Guide 1.33, Appendix A, states that plants should have procedures for the control of radioactivity, including procedures for spent resin and filter sludge handling and procedures for demineralizer resin replacement.

Contrary to the above, the procedure used to transfer radioactive resin from the spent fuel pool demineralizer to a temporary collection facility in the cask washdown area on October 18, 1983, had not been reviewed by the Plant Nuclear Safety Committee, nor approved by the Nuclear Plant Superintendent.

RESPONSE:

1. FPL concurs with the finding.
2. During the troubleshooting process of a possibly clogged SFP demineralizer, the departments involved failed to obtain an approved procedure to remove the remaining six cubic feet of resin.
3. The evolution of resin removal was terminated and the Operations Supervisor - Nuclear discussed the problem with the Auxiliary Building Supervisor, emphasizing the need for approved procedures.
4. All further evolutions to clear the SFP demineralizers were performed by approved procedures.
5. Full compliance was achieved on February 29, 1984, when the resin transfer line was flushed.



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W.
ATLANTA, GEORGIA 30303

FEB 02 1984

Florida Power and Light Company
ATTN: Mr. J. W. Williams, Jr.
Vice President, Nuclear
Energy Department
P. O. Box 14000
Juno Beach, FL 33408

Gentlemen:

SUBJECT: PROPOSED IMPOSITION OF CIVIL PENALTY: EA 83-138
UNAUTHORIZED ENTRY INTO A LOCKED HIGH RADIATION AREA
REFERENCE: INSPECTION REPORT NO. 50-250/83-37

A routine safety inspection was conducted by this office during the period of October 18-21, 1983, of activities authorized by NRC Operating License Nos. DPR-31 and DPR-41 for Turkey Point Units 3 and 4. The inspection included a review of the circumstances surrounding the entry into the Unit 3 reactor sump by an experienced Florida Power and Light (FP&L) technical employee and a contractor employee. As a result of this inspection, significant failures to comply with NRC regulatory requirements were identified and, accordingly, an Enforcement Conference to discuss this matter was held in the Region II office on November 9, 1983.

The violation identified as Item A in the enclosed Notice of Violation and Proposed Imposition of Civil Penalty involves a failure to have procedures which adequately implement Turkey Point's Technical Specifications for entry into a locked high radiation area - an area where dose rates are in excess of 1 rem per hour. As a result of this failure, two workers entered the reactor sump area (reactor cavity) at a time when the retractable incore detector thimbles were withdrawn and the sump was classified as a locked high radiation area. One worker received 1.3 rems and the other worker received 0.20 rems during their stay in the area (about one minute). The licensee subsequently measured the radiation fields present in the sump under similar conditions and found dose rates greater than 50 rems/hr in the area occupied by one of the workers. Under your Technical Specifications, the workers should not have been permitted entry into that high radiation area without having received a specific radiation work permit (RWP). Your procedures did not satisfactorily implement the Technical Specifications because they did not require the workers to obtain such a permit.

The NRC is concerned that this violation of regulatory requirements could have resulted in the workers exceeding the dose limits for exposure to ionizing

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

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DESIGNATED ORIGINAL

Certified By

Roy L. Lee

FEB 02 1984

Florida Power and Light Company

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radiation set forth in 10 CFR 20.101. It is fortuitous that neither worker remained in the area for a longer period of time. FP&L stated, during the Enforcement Conference on November 9, 1983, that the cause of this event was a momentary failure on the part of the radiation protection technician to exercise good radiological control practices. A more basic cause of this event was the failure of FP&L to establish appropriate controls, including both administrative control of keys and a no-exception procedural requirement for the issuance of a specific RWP to control workers entering into a locked high radiation area under non-emergency conditions as required by Technical Specifications. These controls would have ensured plant management involvement in the decision to enter a potentially hazardous area. Had the workers been required to obtain a specific RWP prior to entry, a review of circumstances of the entry would have been performed by at least two additional levels of plant supervision. Such a review could have provided the additional control necessary to have prevented entry into the reactor sump while the thimbles were withdrawn.

To emphasize the seriousness of this violation, I have been authorized, after consultation with the Director, Office of Inspection and Enforcement, to issue the enclosed Notice of Violation and Proposed Imposition of Civil Penalty in the amount of Forty Thousand Dollars (\$40,000) for the Violation described in the enclosed Notice. The violation has been categorized at Severity Level III in accordance with the NRC Enforcement Policy, 10 CFR Part 2, Appendix C.

The base civil penalty for a Severity Level III violation is \$40,000. Prior notice of similar events had been provided to FP&L by NRC Information Notice 82-51, issued in December 1982, and entitled "Overexposure in Reactor Cavities." Because FP&L failed to take effective preventive steps suggested by this Notice, the base civil penalty amount could be increased 25 percent. However, FP&L did report this event upon its discovery, even though this event was not required to be reported. In recognition of this, I have decided not to escalate the penalty for prior notice.

No penalty was assigned to Item B in the enclosed Notice because it was categorized as a Severity Level IV Violation and did not meet the criterion for a civil penalty under the enforcement policy.

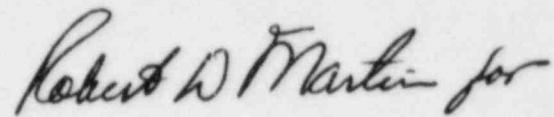
You are required to respond to the enclosed Notice and you should follow the instructions specified therein when preparing your response. Your response should specifically address the corrective actions planned with regard to ensuring that plant procedures, particularly in the area of radiation protection, provide proper implementation of the requirements of the facility Technical Specifications. In your response, appropriate reference to previous submittals is acceptable.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," Part 2, Title 10, Code of Federal Regulations, a copy of this letter and the enclosure will be placed in the NRC's Public Document Room.

FEB 02 1984

The responses directed by this letter and accompanying Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, PL 96-511.

Sincerely,



James P. O'Reilly
Regional Administrator

Enclosure:
Notice of Violation and Proposed
Imposition of Civil Penalty

NOTICE OF VIOLATION
AND
PROPOSED IMPOSITION OF CIVIL PENALTY

Florida Power and Light Company
Turkey Point Units 3 and 4

Docket Nos. 50-250 and 50-251
License Nos. DRP-31 and DRP-41
EA 83-138

As a result of the inspection conducted on October 18-21, 1983, and in accordance with NRC Enforcement Policy, 10 CFR Part 2, Appendix C, violations of NRC requirements were identified.

On October 14, 1983, during the evening shift, work was being performed in the Unit 3 reactor containment in preparation for refueling activities. The reactor cavity was being filled with water as a prerequisite for the anticipated movement of fuel. Earlier, during the day shift, radiation protection supervision had anticipated the need to examine the reactor sump area when the cavity was filled because leaks in the seal between the reactor vessel and the cavity had been found in this location when this operation had previously been performed. The roving radiation protection technician in the containment had been provided with a key to the sump area by his supervisor, and had been admonished to only look in the door and not to enter the sump. This precaution was believed to be necessary because the retractable thimbles of the incore detection system were exposed in the sump and this resulted in high radiation levels being present, exceeding 50 rems/hr. However, the filling of the cavity did not take place on the day shift. When the shift personnel were changed, the on-coming technician received the key to the sump from the off-going technician, but he did not recall being told he was not to enter the sump.

When the cavity filling process began, another worker, a Shift Technical Advisor (STA), was sent into the containment to determine if there were leaks. By chance, he met the technician at the door to the reactor sump. The door was conspicuously marked with signs reading "EXCLUSION AREA, HIGH RADIATION AREA, STAY-OUT, RWP REQUIRED FOR ENTRY," but the two workers decided to open the door to determine if there was any leakage into the sump. Each worker had in his possession a dose-rate indicating instrument, which could detect radiation levels of up to 5 rems/hr.

The STA could not determine if leakage was occurring, so he decided to enter the sump. The technician descended the ladder approximately halfway and performed a radiation survey. The radiation levels measured were approximately 0.03 rems/hr. The technician allowed the STA to descend after setting the STA's instrument on the 0.5 rems/hr scale. The STA proceeded down the ladder into the sump and was followed by the technician. When the technician reached the bottom of the ladder, the STA was 6-8 feet toward the area under the reactor vessel. At that time the technician asked the STA what his instrument was reading. The STA replied that it was off-scale. The technician immediately told the STA to get out of the sump and both exited promptly.

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The STA then read his self-indicating pocket dosimeter and found it to be off-scale (greater than 0.200 rems). The workers reported this event to Florida Power and Light radiation protection supervision. Subsequent evaluation of the STA's thermoluminescent dosimeter indicated that he had received 1.3 rems as a result of his entry into the reactor sump. The workers estimated that the time spent in the sump was less than one minute. A radiation worker with an appropriately established exposure history is permitted by 10 CFR 20.101 to receive up to 3 rems in a calendar quarter.

In accordance with the NRC Enforcement Policy, 10 CFR Part 2, Appendix C, and pursuant to Section 234 of the Atomic Energy Act of 1954, as amended, 42 U.S.C. 7282, PL 96-295, and 10 CFR 2.205, the particular violations and associated civil penalty are set forth below:

- A. Technical Specification 6.12 requires that a radiation work permit be issued for entries into a high radiation area (an area where the dose rate exceeds 0.1 rem per hour), that workers entering into high radiation areas possess a radiation monitoring device which continuously indicates the radiation dose rate in the area, and that entries into locked high radiation areas be controlled by locks with their keys maintained under administrative control.

Technical Specification 6.11 requires that procedures for radiation protection be prepared consistent with the requirements of 10 CFR 20 and be approved, maintained, and adhered to for all operations involving radiation exposure.

Plant Procedure 11550.2 (HP-2) prohibits entry by personnel into local radiation control areas until they comply with the precautions and limitations posted at the entry to the area.

Contrary to the above, on October 14, 1983,

1. a radiation protection technician and a Shift Technical Advisor entered an area in Unit 3 where dose rates were in excess of 50 rems/hr and did not:
 - a. obtain a radiation work permit as required by Technical Specifications,
 - b. comply with precautions and instructions posted at the entry to a local radiation control area, and
 - c. possess a radiation monitoring device which continuously indicated the radiation dose rate in the area in that the instrument was incapable of measuring dose rates in excess of 5.0 rems/hr.

2. the licensee did not:

- a. maintain the keys to a locked high radiation area under adequate administrative control to preclude unauthorized entry, and
- b. implement by procedure the requirement of Technical Specification 6.12 that a radiation work permit be issued for entries into a high radiation area. Instead, the established procedure permitted substitution of a radiation protection technician for a radiation work permit.

This is a Severity Level III violation (Supplement IV).
(Civil Penalty - \$40,000).

B. Technical Specification 6.8 requires that written procedures be established, implemented and maintained that meet or exceed the requirements and recommendations of Appendix A of Regulatory Guide 1.33 and that each procedure be reviewed by the Plant Nuclear Safety Committee and approved by the Nuclear Plant Superintendent before implementation.

Regulatory Guide 1.33, Appendix A, states that plants should have procedures for the control of radioactivity, including procedures for spent resin and filter sludge handling and procedures for demineralizer resin replacement.

Contrary to the above, the procedure used to transfer radioactive resin from the spent fuel pool demineralizer to a temporary collection facility in the cask washdown area on October 18, 1983 had not been reviewed by the Plant Nuclear Safety Committee, nor approved by the Nuclear Plant Superintendent.

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

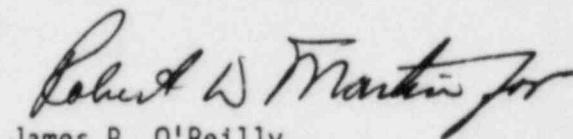
Pursuant to 10 CFR 2.201, Florida Power and Light Company is hereby required to submit to the Director, Office of Inspection and Enforcement, USNRC, Washington, D.C. 20555, with a copy to this office within 30 days of the date of this Notice a written statement or explanation, including for each alleged violation: (1) admission or denial of the alleged violation; (2) the reasons for the violation if admitted; (3) the corrective steps which have been taken and the results achieved; (4) the corrective steps which will be taken to avoid further violations; and (5) the date when full compliance will be achieved. Consideration may be given to extending the response time for good cause shown. Under the authority of Section 182 of the Act, 42 U.S.C. 2232, the response shall be submitted under oath or affirmation.

Within the same time as provided for the response required above under 10 CFR 2.201, Florida Power and Light Company may pay the civil penalty in the amount of Forty Thousand Dollars (\$40,000) for the violation, or may protest imposition of the civil penalty in whole or in part by a written answer. Should Florida Power and Light Company fail to answer within the time specified, the Director, Office of Inspection and Enforcement, will issue an order imposing the civil penalty in the amount proposed above. Should Florida Power and Light Company elect to file an answer in accordance with 10 CFR 2.205 protesting the civil penalty, such answer may: (1) deny the violations listed in this Notice in whole or in part; (2) demonstrate extenuating circumstances; (3) show error in this Notice; or (4) show other reasons why the penalty should not be imposed. In

addition to protesting the civil penalty in whole or in part, such answer may request remission or mitigation of the penalty. In requesting mitigation of the proposed penalty, the five factors addressed in Section IV(B) of 10 CFR Part 2, Appendix C should be addressed. Any written answer in accordance with 10 CFR 2.205 should be set forth separately from the statement or explanation in reply pursuant to 10 CFR 2.201, but may incorporate by specific reference (e.g., citing page and paragraph numbers) to avoid repetition. The attention of Florida Power and Light Company is directed to the other provisions of 10 CFR 2.205 regarding the procedure for imposing a civil penalty.

Upon failure to pay the penalty due, which has been subsequently determined in accordance with the applicable provisions of 10 CFR 2.205, this matter may be referred to the Attorney General, and the penalty, unless compromised, remitted, or mitigated, may be collected by civil action pursuant to Section 234c of the Act, 42 U.S.C. 2282.

FOR THE NUCLEAR REGULATORY COMMISSION



James P. O'Reilly
Regional Administrator

Dated at Atlanta, Georgia
this 2nd day of February 1984