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Docket Nos. 50-348, 50-364 License Nos. NPF-2 and NPF-8

Alabama Power Company ATTN: Mr. R. P. McDonald Senior Vice President P. O. Box 2641 Birmingham, AL 35291-0400

Gentlemen:

SUBJECT: ENFORCEMENT CONFERENCE SUMMARY (NRC INSPECTION REPORT NOS. 50-348/88-02 AND 50-364/88-02)

This letter refers to the Enforcement Conference held at our request on February 17, 1988. This meeting concerned activities authorized for your Farley facility. The issues discussed at this conference related to the potential for excessive personnel exposure as a result of the unauthorized entry into an exclusion area/high radiation area. A summary, a list of attendees, and a copy of your handout are enclosed.

It is our opinion that this meeting was beneficial and has provided a better understanding of the inspection findings, the enforcement issues, and the status of your corrective actions. We are continuing our review of these issues to determine the appropriate enforcement action.

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 its enclosures will be placed in the NRC Public Document Room.

Should you have any questions concerning this letter, please contact us.

Sincerely,

J. Nelson Grace Regional Administrator

Enclosures:

- 1. Enforcement Conference Summary
- 2. List of Attendees
- 3. Handout

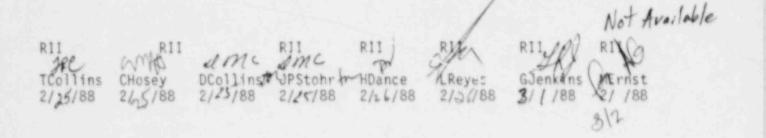
cc w/encls: (See page 2)

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cc w/encls:

- W. O. Whitt, Executive Vice President J. D. Woodard, General Manager -
- Nuclear Plant G. Hairston, III, Vice President -
- Nuclear Support W. McGowan, Manager-Safety Audit and Engineering Review
- S. Fulmer, Supervisor-Safety Audit and Engineering Review

bçc w/encls: WRC Resident Inspector DBS Technical Assistant E. Reeves, Project Manager, NRR Document Control Desk State of Alabama



### ENCI JRE 1

Enforcemer Conference Summary

Licensee: Alabama Power f pany

Facility: Farley

Docket Nos.: 50-348 and 50-364

Subject: Potential for Excessive Exposure as a Result of Unauthorized Entry into an Exclusion Area/High Radiation Area

An Enforcement Conference was held at the Region II office on February 17, 1988, to discuss the potential for excessive radiation exposure as a result of an unauthorized entry into an Exclusion Area (areas with radiation levels in excess of 1,000 mrem per hour)/High Radiation Area.

Licensee representatives discussed the sequence of events surrounding the entry of a contract laborer into the spent fuel pool demineralizer room and, using a mock-up, demonstrated the radiological controls that were in place when the entry occurred. The licensee discussed the results of their investigation. During this discussion, the licensee indicated that they disagreed with two statements made in the NRC Inspection Report which discussed the event (Inspection Report 50-348/88-02 and 50-364/88-02). The licensee stated that the door at the access to Room 450 automatically locked when the door closed; therefore, the door could not have been left unlocked. The licensee also stated that they had not intended that anyone enter the exclusion area in Room 450/449; therefore, there was no need for a radiation survey to be performed in the exclusion area entered by the laborer.

The licensee stated that they believed that the root cause for the event was the failure of the laborer to heed the radiological warning signs and controls at the entrance to the exclusion area. In addition, the licensee discussed other contributing causes for the unauthorized entry. The licensee also discussed their temporary and permanent corrective actions to control access to exclusion areas.

NRC representatives discussed the seriousness of the event and emphasized the potential for excessive exposures and the need to take action as necessary to preclude such events. NRC representatives stated that the contributing causes of the event should include inadequate identification of Room 449 in that the laborer was unaware that when he entered the exclusion area he was actually in Room 449 rather than Room 450, the room he was assigned to decontaminate.

NRC representatives also stated that the use of the rope barrier and flashing light was inappropriate to secure access to the exclusion area. Farley Technical Specification 6.12.2 permits the licensee to rope off, conspicuously post, and use a flashing light as a warning device for securing access to individual areas with radiation levels in excess of 1,000 mrem per hour that are located within large areas, such as PWR containment, where no enclosures exist for purposes of locking, and no enclosure can be reasonably constructed around the individual areas. NRC representatives stated it is the NRC position that a locked barrier could have reasonably been constructed at the entrance to the exclusion area.

### ENCLOSURE 2

### List of Attendees

### Alabama Power Corporation

- P. McDonald, Senior Vice President
- G. Hairston, Vice President
- J. Woodard, Plant Manager
- 2. McGowan, Manager, Safety Audit and Engineering Review
- C. Nesbitt, Technical Manager M. Mitchell, Health Physics and Radwaste Supervisor
- M. Graves, Health Physics Sector Supervisor

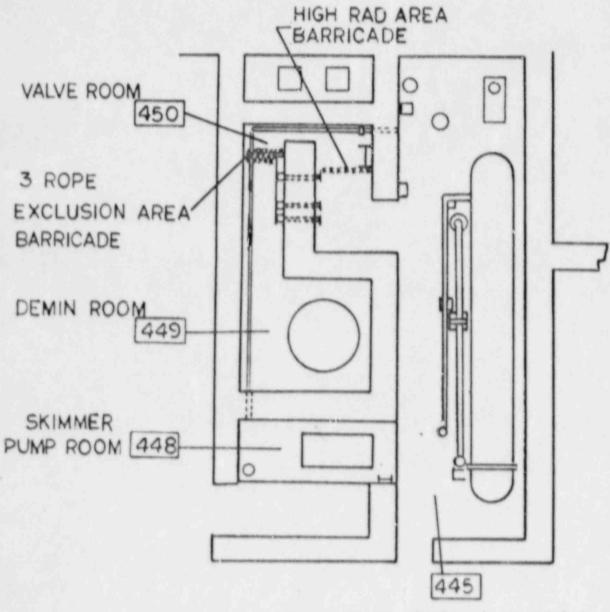
#### Nuclear Regulatory Commission

- J. Nelson Grace, Regional Administrator
- L. Reyes, Director, Division of Reactor Projects (DRP)
- G. Jenkins, Director, Enforcement and Investigations Coordination Staff
- D. Collins, Chief, Emergency Preparedness and Radiological Protection Branch (EPRP)
- H. Dance, Chief, Project Section 18, DRP
- C. Hosey, Chief, Facilities Radiation Protection Section (FRP), EPRP
- T. Collins, Radiation Specialist. FRP, EPRP
- R. Shortridge, Radiation Specialist, FRP, EPRP
- M. Lauer, Radiation Specialist, FRP, EPRP
- L. Modenos, Project Engineer, DRP
- L. Trocine, Enforcement Specialist

## F ENCLOSURE 3

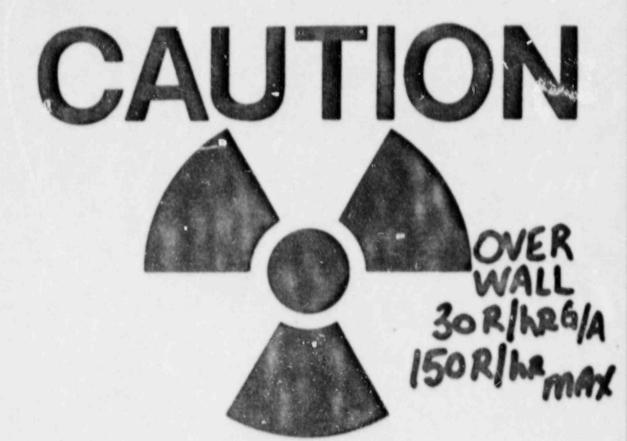
## ALABAMA POWER COMPANY NRC ENFORCEMENT CONFERENCE POTENTIAL OVEREXPOSURE INCIDENT OF 12-28-87 AGENDA

I.	Opening Remarks	J. N. Grace
п.	Introductions	R. P. McDonald
ш.	Event Description	J. D. Woodard
IV.	Analysis of Incident	J. D. Woodard
v.	Corrective Action	J. D. Woodard
VI.	NRC Inspection Report	J. D. Woodard
VII.	NRC Comments	J. P. Stohr T. R. Collins
vm.	Conclusion and Summary	R. P. McDonald J. D. Woodard
IX.	Closing Comments	J. N. Grace

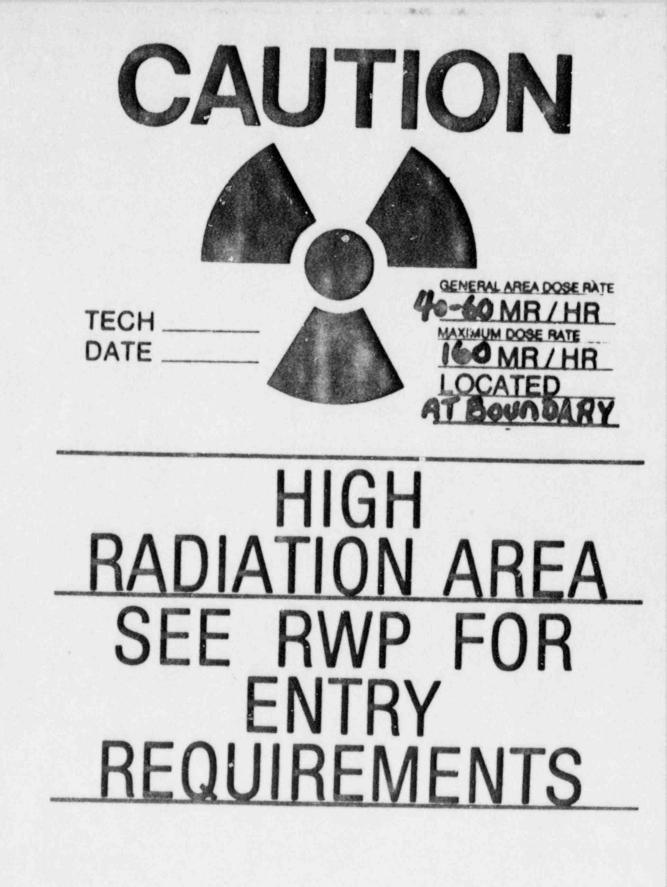


SPENT FUEL POOL IA HX ROOM

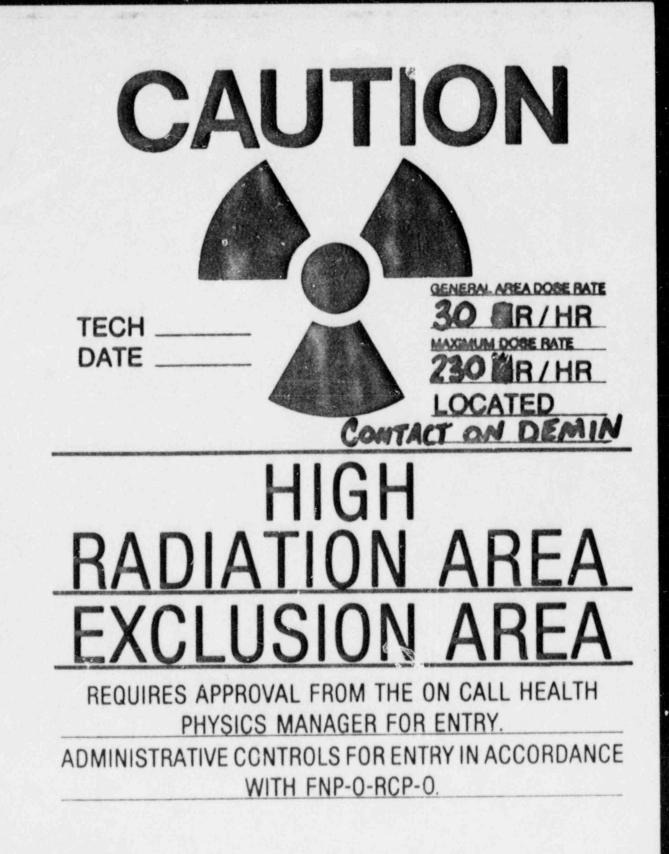
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# HIGH RADIATION AREA EXCLUSION AREA



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## PRINCIPAL CAUSE

Hollinger crossed the exclusion area barricade which consisted of three ropes (knee, waist and shoulder height), a flashing light and an exclusion area sign (stating: HP Manager Approval Required Prior to Entry, also stating dose rates). He made this entry without an RWP and in disregard of radiation postings.

### CONTRIBUTING CAUSES

- a. Davcon Laborers did not read and follow the RWP for Room 450. Davcon Foreman did not ensure that his crew complied with the RWP while he was in direct control of their actions.
- b. Davcon laborers over-relied on health physics instructions rather than their own training and administrative controls.
- c. Lack of accurate communications between workers and HP Technician concerning conditions at the job site and work requirements.
- d. Inadequate knowledge and understanding of exclusion area and high radiation area work requirements by Davcon personnel.
- e. Lack of specific training on exclusion areas.

## TEMPORARY CORRECTIVE ACTION

- 1. Dosimetry for the Davcon Foreman and laborers was pulled.
- Closed circuit TV cameras were set up to avoid the need to enter Room 450 and Room 2450 (comparable area on Unit 2) on a routine basis.
- The doors to Room 450 and Room 2450 were established as exclusion area boundaries.
- 4. All other jobs at FNP in the proximity of exclusion area boundaries were reviewed for adequacy of radiation controls.
- 5. The doors to the Waste Gas Compressor Rooms and Waste Gas Decay Tank Rooms were established as exclusion area boundaries, eliminating similar situations in which exclusion area barricades were established inside high radiation areas.

### PERMANENT CORRECTIVE ACTION

- Steps will be taken to provide additional assurance that contractor personnel, at all levels understand the significance of following FNP radiological controls and feel free to question supervisory instructions that appear to be in conflict with those controls.
- 2. The Davcon personnel were retrained by APCo and then counseled by Davcon supervision.
- 3. Wherever possible, exclusion area bc. ries in the Auxiliary Building will be expanded such that access can be controlled by a locked door. Design changes will be considered for all instances in which exclusion area boundaries require frequent entries.
- Keys to exclusion area doors were removed from all key rings except for the Emergency key ring in the sole custody of the Shift Supervisor.
- 5. The system for issuance of exclusion area keys was segregated from that of other keys.
- Training was conducted for each FNP work group (both APCo personnel and contractors) in January, 1988. This training has been incorporated into the basic Radiation Worker Training and retraining course.

## INPO ROOT CAUSE ANALYSIS

- 1. Inaccurate or incomplete radiation survey.
- 2. RWP inadequate for the work to be performed.
- Radiological protection technicians not reacting to changing or unusual radiological conditions.
- Workers not following procedures or exhibiting improper radiological work practices.
- Need for more involvement by the supervisor or foreman of the workers.

## CONCLUSION

- A. Hollinger received an <u>administrative</u> <u>overexposure</u> because he followed what he thought were accurate verbal instructions from health physics rather than following radiological postings, procedures and training.
- B. Hollinger did not receive a <u>regulatory</u> <u>overexposure</u> because he was conscious of the high radiation level, he worked quickly as instructed and checked his pocket ion chamber as instructed.

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