UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA ST., N.W.
ATLANTA, GEORGIA 30323

Report No.: 50-302/88-32

Licensee: Florida Power Corporation
3201 34th Street, South
St. Petersburg, FL 33733

Docket No.: 50-302 License No.: DPR-72

Facility Name: Crystal River 3

Inspection Conducted: October 31 - November 2, 1988

Inspector: T. R. Collins 11/29/88
T. R. Collins Date Signed

Approved by: for C. M. Hosey, Section Chief 11/30/88
C. M. Hosey, Section Chief Date Signed
Division of Radiation Safety and Safeguards

SUMMARY

Scope: This special, unannounced inspection was conducted to followup on allegations.

Results: In the area inspected, no violations or deviations were identified.

REPORT DETAILS

1. Persons Contacted

Licensee Employees

*R. Browning, Supervisor, Health Physics
G. Clymer, Manager, Nuclear Waste
S. Gary, Nuclear Support Specialist, Chemistry and Radiation
A. Kazemfar, Supervisor, Radiological Support Services
*S. Robinson, Superintendent, Nuclear Chemistry and Radiation Protection
W. Rossfeld, Manager, Nuclear Compliance
P. Skramstad, Superintendent, Nuclear Outage Planning
*D. Wilder, Manager, Radiation Protection
M. Williams, Nuclear Compliance Specialist

Other licensee employees contacted during this inspection included craftsmen, security force members, technicians, and administrative personnel.

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P. Holmes-Ray, Senior Resident Inspector
J. Tedrow, Resident Inspector

*Attended exit interview

2. Allegation Followup RII-88-A-0020 (99014)

a. Allegation (2880020001)

The alleger stated that co-worker radiation dose records were rolled back.

Discussion and Findings

The inspector discussed this issue with licensee management representatives and was informed by licensee representatives that the dosimetry program (HP-1000) data base after the 1986 year end processing, was found to be incorrect due to a defective computer tape. The licensee began an evaluation of this problem when notified by the alleger, that his lifetime radiation dose record was reduced (rolled back) by 910 milliRem (mRem). The licensee then began reconstructing the dosimetry data base using another computer tape. Upon completion of the reconstructed data base, the licensee discovered that there were still errors in the lifetime dose for other individuals. The licensee's dosimetry staff was directed by Health Physics (HP) management to reconstruct the dosimetry data base using thermoluminescent dosimeters (TLDs) data from the licensee's

TLD vendor reports for all individuals from December 31, 1985 to March 30, 1988. The inspector reviewed the occupational radiation exposure records for all of the individuals that were alleged to have had their exposure reduced or corrected (rolled back) and determined that the errors due to the defective computer tape were corrected. The inspector determined after review of all dosimetry records which were corrected, that these personnel were notified of the changes and the changes were appropriate. This allegation was substantiated, in that several dosimetry records for individuals were corrected due to errors encountered in the dosimetry data base. However, no regulatory requirements were violated.

b. Allegation (2880020002)

The alleger stated that workers were denied respirators in high radiation areas and contaminated areas.

Discussion and Findings

The inspector discussed this issue with licensee management representatives and was informed that in March 1988, contract workers were to perform work in the A and B Decay Heat Pits, on the 75 foot elevation of the Auxiliary Building, under Radiation Work Permit (RWP) R88-0058. The inspector reviewed RWP R88-0058 and associated radiological survey results of the work area and determined that the surface contamination levels were less than 5000 dpm/100 cm^2 and the airborne radioactivity levels were well below the values specified in 10 CFR 20, Appendix B limits, while work was in progress. The licensee informed the inspector that the equipment to be worked on had been deconned prior to commencing work and that engineering controls, high efficiency particulate air (HEPA) filters, had been provided to reduce any airborne radioactivity during the work to eliminate the use of respiratory equipment. The inspector also reviewed contamination surveys performed after decontamination of the work area. The inspector reviewed the results of whole body counts performed for the individuals after the completion of their work and determined that all personnel involved had not received any positive uptakes of radioactive material. This allegation was substantiated, in that respirators were not provided to workers performing work under RWP R88-0058, in the A&B Decay Heat Pits, on the 75 foot elevation of the Auxiliary Building. However, respirators were not required, therefore, no regulatory requirements were violated.

c. Allegation (2880020004)

The alleger stated that he became contaminated while working in the A and B Decay Heat Pits. This contamination event was due to HP Supervision refusal to permit a smear of the work area.

Discussion and Findings

The inspector discussed this event with licensee management representatives and was informed that there had been a personnel contamination event that occurred during work in the A and B Decay Heat Pits on March 15, 1988. The inspector reviewed the Personnel Contamination Report (PCR) of the individual involved, and determined that the individual had received a skin contamination of 25,000 dpm on his left shoulder. The licensee deconned the individual's left shoulder by use of soap and water and performed a skin dose calculation. The individual had worn protective clothing (PC) while performing work inside the RCA. The inspector reviewed the licensee's skin dose calculation. The skin dose calculation was performed using appropriate methodology and the skin dose assessment was calculated to be 8.8 millirem (mrem) to the skin of the whole body. The inspector was informed by licensee representatives that the area where the individual was working had been deconned and additional surveys to determine the radiological conditions were not necessary. The inspector concluded by interview of health physics personnel and by review of contamination survey results of the area where the individual was working, that the licensee had performed sufficient surveys to determine the contamination levels present. This allegation was partially substantiated, in that an individual had received a skin contamination of 25,000 disintegrations per minute (dpm) on the left shoulder. However, the licensee did perform adequate surveys of the work area to determine the surface contamination levels, therefore, no regulatory requirements were violated.

d. Allegation (2880020005)

The alleger stated that yellow badge and green badge tests were given orally to individuals who fail the written test.

Discussion and Findings

The inspector discussed this issue with licensee management representatives and determined that only one individual had been administered an oral green badge/yellow badge training test rather than a written test. The licensee stated that this individual was recommended by his management to be administered an oral General Employee Training (GET) yellow badge/green badge training examination for unescorted access in the restricted area. The licensee's procedure TDP-301, Revision 7, dated August 25, 1988, GET Program, requires that a written examination be administrered for GET training however, this individual was administered an oral examination after failure of the written examination. The licensee's GET Program procedure neither prohibits or permits an oral exam if an individual fails to pass the written exam. The inspector interviewed the individual who had been administered the oral examination and concluded that the individual had been employed at the facility for

approximately sixteen years and was adequately trained and knowledgeable of radiological control and protection practices. The inspector also discussed this individual's performance as related to radiation protection practices with Radiation Protection management personnel and determined that the individual's performance inside the radiation controlled area (RCA) had been satisfactory. The inspector concluded that the licensee had adequately evaluated the individual's knowledge and qualifications to perform activities inside the RCA by administering an oral GET examination. 10 CFR 19.12, Instruction to Workers, requires in part that the licensee provide adequate instruction to workers who work in or frequent any portion of a restricted area. Furthermore, 10 CFR 19.12 does not require the licensee to administer an examination to determine an individual's understanding of radiological protection practices and controls. Regulatory Guide 8.27, Radiation Protection Training for Personnel at Light-Water-Cooled Nuclear Power Plants, recommends that a written exam be administered. This allegation was substantiated, in that an oral examination was administered to one contract worker for yellow badge/green badge training. However, no regulatory requirements were violated.

No violations or deviations were identified.

3. Exit Interview

The inspection scope and results were summarized on November 12, 1988, with those persons indicated in Paragraph 1. The inspector described the areas inspected and discussed in detail the inspection results. Proprietary information is not contained in this report. Dissenting comments were not received from the licensee.