DMB

Florida Power
CORPORATION

December 4, 1986
3F1286-07

Dr. J. Nelson Grace
Regional Administrator, Region II
U.S. Nuclear Regulatory Commission
101 Marietta Street N.W., Suite 2900
Atlanta, GA 30323

Subject: Crystal River Unit 3
Docket No. 50-302
Operating License No. DPR-72
NRC Inspection Report No. 86-26
Revised Response

Dear Sir:

Florida Power Corporation provides the attached as our revised response to the subject inspection report.

Sincerely,

Rolf C. Widell

Rolf C. Widell
Manager, Nuclear Operations
Licensing and Fuel Management

AEF/feb

Attachment

IE01

FLORIDA POWER CORPORATION
RESPONSE
INSPECTION REPORT 86-26

VIOLATION 86-26-05

Technical Specification 6.12.1(a) requires that a High Radiation Area in which the radiation intensity is greater than 100 millirem per hour (mrem/hr) but less than 1000 mrem/hr be barricaded and conspicuously posted as a High Radiation Area, the entrance controlled by issuance of a Radiation Work Permit and any individual or group of individuals permitted to enter such areas be provided with a radiation monitoring device which continuously indicates the radiation dose rate in the area.

Contrary to the above, the requirement that any individuals or group of individuals permitted to enter a high radiation area be provided with a radiation monitoring device which continuously indicates the radiation dose rate in the area was not met in that on February 18 and 19, 1986, individuals were present in posted high radiation areas where the intensity of radiation was greater than 100 mrem/hr, and did not possess radiation monitoring devices which continuously indicated the radiation dose rate in the area.

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

This violation is similar to the Notice of Violation contained in Inspection Report No. 50-302/86-06 sent to you in our March 25, 1986 letter.

RESPONSE

Florida Power Corporation's Position

Florida Power Corporation (FPC) agrees that individuals were present in a posted high radiation area and did not possess radiation monitoring devices which continuously indicated the radiation dose rate in the area. However, the occurrence was a single incident involving two FPC personnel. The date of February 18, was incorrectly put on one of the Radiological Safety Incident Reports (RSIR) written describing this event. This violation was licensee identified.

Apparent Cause of Violation

The cause of the violation was personnel error. The individuals were well aware of the requirements prior to entering a high radiation area and inquired about monitors. They were informed that there was work going on in the area and there was a Health Physics Technician in the area with a radiation monitor. Upon entry the individuals realized there was no one in the decay heat pit and immediately left the area. The event resulted from belief that there was a monitor in the high radiation area.

Corrective Actions

The individuals immediately left the high radiation area and reported the incident.

Date of Full Compliance

Full compliance was achieved upon immediate departure from the high radiation area on February 19, 1986.

Corrective Action to Prevent Recurrence

The incident was discussed with the individuals by their supervisor. No additional corrective action is considered necessary.

Background/FPC Enhancements

Several initiatives have been taken by FPC to increase the awareness and involvement of all plant personnel in our radiation safety program. We believe these initiatives should create a greater awareness of radiation safety requirements in the work force and result in elevated levels of compliance with our procedures. Several examples of increased management attention are as follows:

1. The penalties for non-compliance with radiation protection procedures have been elevated; days off without pay and dismissal have been exercised.

2. Supervisor performance appraisals have been amended to include the need for work force compliance with radiation protection procedures.

3. The radiological safety committee established in April 1985 has addressed these issues.

4. Radiation safety subject matter has been incorporated into shop industrial safety meetings.

5. The radiation safety incident report program has been revised to make it more usable; trending of these reports has been initiated.

6. Management review boards have been established to review root cause, corrective actions, and disciplinary actions associated with these types of non-compliances.

7. "Fire-side" chats on radiation safety are being conducted by plant management personnel.

8. Health physics procedures are being re-written to make them more understandable and usable by our employees.

9. A radiation safety concern suggestions form and incentive program has been implemented.

10. The General Employee Training Program has been amended to require all employees with unescorted access to the radiation control area to demonstrate proficiency in certain radiation safety work practices.

Florida Power management is continuing to evaluate mechanisms to increase employee awareness, involvement, and adherence to radiation protection procedures and policies. The programs highlighted above may be revised, cancelled, or improved as we monitor employee progress in this area through our station self-assessment.

VIOLATION 86-26-04

10 CFR 20.201(b) requires that each licensee make or cause to be made, such surveys as may be necessary for the licensee to comply with the regulations in this part and are reasonable under the circumstance to evaluate the extent of the radiation hazards that may be present. A survey is defined as an evaluation of the radiation hazards incident to the production, use, release, disposal or presence of radioactive materials under a specific set of conditions.

Contrary to the above, during the period of January through July, 1986, the licensee failed to perform surveys as were necessary and reasonable under the circumstances to evaluate alpha radiation hazards that may have been present in containment in that alpha contamination was known to be present in containment, yet personnel and equipment leaving the controlled area within the containment were not routinely surveyed for alpha contamination nor were airborne radioactivity and smear survey samples, taken to establish personnel protective measures, routinely evaluated for alpha radioactivity.

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

RESPONSE

Florida Power Corporation's Position

Florida Power Corporation (FPC) agrees with the stated violation.

Apparent Cause of Violation

The guidance concerning airborne activity given to FPC personnel by way of HPP-202, Radiological Surveys, was inadequate.

Corrective Actions

An Inter-Office Correspondence has been issued to all health physics personnel to re-emphasize FPC's policy on surveying for alpha contamination.

Date of Full Compliance

Full compliance was achieved on September 10, 1986, upon issuance of the above mentioned memorandum.

Action Taken to Prevent Recurrence

Additional procedural guidance (i.e., inside/outside monitoring to eliminate naturally occurring isotopes, alpha smear and air sample counting on specified systems) was provided in HPP-202 on October 24, 1986.

FLORIDA POWER CORPORATION
REVISED RESPONSE
INSPECTION REPORT 86-26-02

VIOLATION 86-26-02

10 CFR 71.5 prohibits transport of any licensed material outside the confines of a plant or other place of use, or delivery of licensed material to a carrier for transport unless the licensee complies with applicable regulations of the Department of Transportation in 49 CFR 170- 189.

49 CFR 173.425(b)(6) requires that exclusive use shipments of LSA material must be braced so as to prevent shifting of lading under conditions normally incident to transportation.

Contrary to the above, on June 5, 1986, at the Barnwell waste burial facility, a State of South Carolina inspector found that, due to inadequate blocking and bracing, some of the drums in the rear of the transport vehicle underwent a shift of lading during transport of LSA exclusive use Shipment Number 0686-061-A.

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

RESPONSE

Florida Power Corporation's Position

Florida Power Corporation (FPC) concurs with the above stated violation in that a shift of lading occurred due to the bracing not contacting each drum at the rear of the van.

Apparent Cause of Violation

The shipment, 0686-061-A, was braced using the locking bars provided by Chem/ Nuclear System, Inc., the company contracted for transportation of the shipment. This shipment was braced using the locking bars, like several other shipments of the same material, and no previous problems with the bracing had been identified. Therefore no problem was expected with the identified shipment.

Corrective Actions

Bracing will be in contact with each drum at the rear of the shipment so that a lading shift during shipment cannot occur. The Florida state inspector will perform an inspection to verify bracing of each drum shipment bracing prior to departure from the site.

Date of Full Compliance

Full compliance was achieved on November 6, 1986, when the above corrective actions were implemented.

Actions Taken to Prevent Recurrence

The above corrective actions should prevent any future problems concerning a shift of lading.