

May 26, 1988

TO: W. J. Costley
cc: J. A. Ransohoff

FROM: (b)(6)

SUBJ: Co-60 Contamination Incident

On May 25, 1988, I attended a Nuclear Safety Audit & Review Board meeting at Rochester Gas & Electric's Ginna Nuclear Power Station. On my way out of the plant at about 16:20 I caused the portal radiation monitor to alarm. At the Health Physics area it was determined that my shoes and canvas briefcase were contaminated with cobalt-60 to amounts above the Ginna Station release limit. As I was in office areas only at Ginna, as I was the only person carrying contamination, and as the only radioactive isotope identified was cobalt-60, it is clear that the contamination came from Neutron Products.

I left the Ginna Station without my briefcase and shoes, in a pair of rubber overshoes provided by RG&E.

On May 26, I was told by telephone by RG&E personnel that the contamination incident was discussed at the Ginna Station's regular morning meeting and will be in meeting minutes, that the resident NRC inspector was informed, and that he took "copious notes". I was also told that the contamination was measured to be 11,000 cpm with a 50 cm² detector, which translates to about 200,000 dpm/100 cm², on the briefcase and 2000 cpm with a 50 cm² detector, or about 40,000 dpm/100 cm², on the shoes. All of the contamination was found to be fixed. The briefcase was most contaminated at the handles.

I wore the shoes in our Limited Access Area on numerous occasions, always with paper shoe covers. I carried the briefcase into the LAA a total of no more than six times, never beyond the table in the counting room or the desk in the downstairs office/lab. On leaving the LAA, I always used the portal monitor and occasionally, when I suspected possible contamination, the frisker. Within the past month, I carried the briefcase into the cobalt area at AFRI and it was cleared by their Health Physics personnel when I carried it out.

This incident is additional evidence that Neutron Products should increase the sensitivity of the portal monitor and/or frisker used by personnel exiting the LAA. As we've discussed, possibilities are to construct shielding to reduce background at the existing monitor location and/or to set up a monitor at another, lower background location. The incident also indicates that our paper shoecovers are unreliable and should be replaced or supplemented by other means of protection. We should also determine whether plant areas outside the LAA have become sources of contamination of clothing, briefcases, etc. Finally, some employees spot check their cars and homes for radioactive contamination. It seems that such checks should be made on a regular schedule for all personnel who enter the LAA.

I propose that the Radiation Safety Committee meet to discuss these matters and recommend measures to reduce the spread of radioactive contamination.

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