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CONTROL NO: 3531

FILE: _____

FROM: Carolina Power & Light Co. Raleigh, N.C. E.E. Utley		DATE OF DOC 3-27-75	DATE REC'D 4-2-75	LTR xx	TWX	RPT	OTHER
TO: Mr. Norman C. Moseley		ORIG 1-signed	CC	OTHER	SENT AEC PDR <u>xxx</u> SENT LOCAL PDR <u>xxx</u>		
CLASS	UNCLASS xxxxxx	PROP INFO	INPUT	NO CYS REC'D 1	DOCKET NO: 50-261		

DESCRIPTION:

Ltr furn Violation of Administrative Procedure
Exposure of Contractor Personnel TO More than
300 MREM of Radiation..... trans the following:

ENCLOSURES:

Abnormal Occurrence #75-6 on 3-14-75
concerning exposure of contractor
personnel to radiation

PLANT NAME: H.B. Robinson #2

FOR ACTION/INFORMATION

4-8-75 JGB

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Thoenbueg
A.D. 4

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1 - ASLB	NEWMARK/BLUME/AGBABIAN	1 - AGMED (RUTH GUSSMAN) Rm B-127 GT
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Carolina Power & Light Company

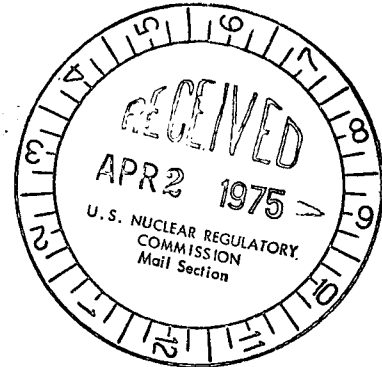
March 27, 1975

50-261

File: NG-3513 (R)

Serial: NG-75-428

Mr. Norman C. Moseley, Director
U. S. Nuclear Regulatory Commission
Region II, Suite 818
230 Peachtree Street, N. W.
Atlanta, Georgia 30303



Dear Mr. Moseley:

H. B. ROBINSON UNIT NO. 2
LICENSE DPR-23
VIOLATION OF ADMINISTRATIVE PROCEDURE
EXPOSURE OF CONTRACTOR PERSONNEL TO MORE THAN 300 MREM OF RADIATION

In accordance with Paragraph 6.6.2.a of the Technical Specifications for H. B. Robinson Unit No. 2, the attached Abnormal Occurrence report is submitted for your information.

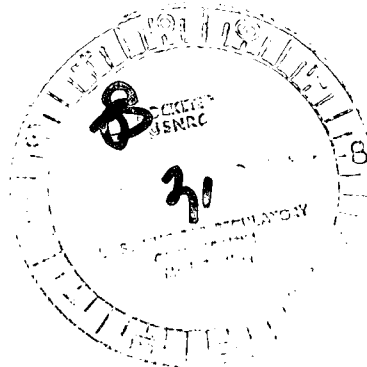
This report fulfills the requirement for a written report within ten days of an Abnormal Occurrence and is in accordance with the format set forth in Regulatory Guide 1.16, Revision 1.

Yours very truly,

E. E. Utley
Vice-President
Bulk Power Supply

DBW:mc
Attachment

cc: Messrs. N. B. Bessac
T. E. Bowman
P. W. Howe
R. E. Jones
D. Knuth
J. B. McGirt
D. B. Waters



3531

Abnormal Occurrence Report

1. Report No. 50-261/75-6
- 2a. Report Date March 17, 1975
- 2b. Occurrence Date March 14, 1975
3. Facility H. B. Robinson Unit No. 2
Hartsville, South Carolina 29550

4. Identification of Occurrence

Exposure of contractor personnel to radiation in excess of administrative limits constituting an abnormal occurrence as defined in Section 1.8.g of the Technical Specifications.

5. Conditions Prior to Occurrence

The plant was operating at 100% nuclear power with 696 MW net electrical output. Transfer of spent resin from the Spent Resin Storage Tank to a spent resin transport vehicle had just been completed.

6. Description of Occurrence

At 1130 hours, March 14, 1975, the transfer of resin from the Spent Resin Storage Tank to a contractor's spent resin transport vehicle had been completed under Special Radiation Work Permit 3-121. To disconnect the transfer hose an individual was required to mount the vehicle and enter a local field of 16 rem/hour. This was accomplished by a health physics technician employed by Chem Nuclear Inc. of Barnwell, South Carolina.

Immediately prior to performing the task the technician's pocket chamber was read as 60 mrem (0-500 mrem full scale). While performing the disconnect a Carolina Power & Light Company Radiation Control and Test Technician covered the work from the base of the vehicle. High

range survey instrumentation was in use. After completing the task, (approximately one to two minutes time), the individual was checked by the covering Company technician. It was immediately noted that the hair line on the exposed individual's pocket chamber, although visible, was beyond the 500 mrem marking.

The individual was immediately removed from the radiation area and his TLD badge sent special delivery to Raleigh, N. C. for reading.

At 1157, March 17, 1975, the result of the TLD reading was received at this facility.

Volume 8, Radiation Protection Manual, paragraph 4.2 states in part: "Any visitor... shall be limited to a whole body exposure of 300 mrem/quarter unless the individual's accumulated occupational dose, and the occupational exposure for the current quarter are furnished by the individual or his organization." Since no exposure records existed for the exposed individual at this facility this occurrence constitutes a reportable incident as defined by Section 1.8.g of the Plant Technical Specification.

7. Designation of Apparent Cause of the Incident

Stay time in a localized field of high radiation was exceeded for the authorized exposure permitted for the individual involved.

8. Analysis of Occurrence

Plant safety was not involved, and at no time was there any danger to the general public. No 10CFR20 limits were exceeded. The individual's total exposure for the quarter was 665 mrem prior to this incident.

9. Corrective Action

A memorandum has been routed to all H. B. Robinson Radiation Control and Test Technicians reemphasizing the hazards of work in high radiation areas and cautioning them of their responsibility to limit and control personnel exposures.

Chem-Nuclear, Inc. and Carolina Power & Light Company are investigating the feasibility of utilizing additional shielding during the hose-disconnect operation. If additional shielding can be utilized effectively, appropriate procedures will be implemented to require its use during the hose-disconnect operation.

10. Failure Data

January 15, 1973	Violation of Administrative Procedure (employee exposure to 672 mrem)
August 16, 1973	Violation of Administrative Limit (employee exposure to 824 mrem)