AEC DISTRIBUTION FOR PART 50 DOCKET MATERIAL			
	(TEMPORARY F		CONTROL NO: 6595
-			FILE:
PROM:	DATE OF DOC	DATE REC'D	LTR TWX RPT OTHER
Carolina Power & Light Company			
Raleigh, N.C. 27602	:		
Mr. E.E. Utley	7-15-74	7-19-74	X
TO:	ORIG	CC OTHER	SENT AEC PDR XXX
J.F. O'Leary	2 signed		SENT LOCAL PDR XXX
CLASS UNCLASS PROP INFO	INPUT	NO CYS REC'D	DOCKET NO:
XXX		40	50-261
DESCRIPTION: Ltr reporting an abnormal occurrencetrans the Abnormal occurrence concerningExposure			
tr reporting an abnormal occurrencetrans the Abnormal occurrence concerningExposure of an individual to excessive airborne			
			of radioactive materials
	•		
•		AU.	KNOWLEDGED
		DO	NOT REMOVE
PLANT NAME: U.B. Baldana	· · · ·	(40 cys	encl rec'd)
FLANI NAME: H.B. Robinson	·		
	FOR ACTION/IN	FORMATION	7-19-74 JB
		******************	NY MARTIN' GANGARAN' DI BURANCE AND
BUTLER (L) SCHWENCER (L)	ZIEMANN (I	•	•
W/ CYS W/ CYS	W/ CYS	W/ CYS	
CLARK (L) STOLZ (L) W/ CYS W/ CYS	DICKER (E) W/ CYS	$\frac{1}{W/7} CYS$	
	W/ 615 WNTCUTCH	•	
W/ CYS W/ CYS	W/ CYS	W/ CYS	· · ·
KNIEL (L) PURPLE (L)	YOUNGBLOOD	•	
W/ CYS W/ CYS	W/ CYS	W/ CYS	• •
INTERNAL DISTRIBUTION			
REG FILE TECH REVIEW	DENTON	LIC ASST	A/T IND
JAEC PDR HENDRIE	GRIMES	DIGGS (L)	BRAITMAN
CHROEDER	GAMMILL	GEARIN (L)	SALTZMAN
MUNTZING/STAFF MACCARY	KASTNER	GOULBOURNE	•••
VCASE KNIGHT GIAMBUSSO PAWLICKI	BALLARD	KREUTZER (I	•
BOYD SHAO	SPANGLER	LEE (L) MAIGRET (L)) <u>PLANS</u> MCDONALD
MOORE (L)(LWR-2) STELLO	ENVIRO	REED (E)	CHAPMAN
DEYOUNG (L)(LWR-1) HOUSTON	MULLER	SERVICE (L)	
SKOVHOLT (L) NOVAK	DICKER	SHEPPARD (I	
COLLER (L) ROSS	KNIGHTON	SLATER (E)	1
P. COLLINS / IPPOLITO DENISE / TEDESCO	YOUNGBLOOD		D. THOMPSON (2)
REG OPR	REGAN PROJECT MG	R WILLIAMS (H	KLECKER E) EISENHUT
FILE & REGION (3) LAINAS	INODECT NG	WILLIAMS (E WILSON (L)	C) VEISENHUI
MORRIS BENAROYA	HARLESS		é (.
STEELE VOLLMER			
	XTERNAL DISTRI	BUTION	
1 - LOCAL PDR Hartsville, S.C. 1 - TIC (ABERNATHY) (1)(2)(10)-NATIO	NAL TARC	1-DDD CAN (LA (NW O
1 - NSIC (BUCHANAN)		(E/W Bldg, Rm 52	1-PDR-SAN/LA/NY 1-BROOKHAVEN NAT LAB
1 - ASLB			201 GT 1-G. ULRIKSON, ORNL
1 - P. R. DAVIS	1- B&M S	WINEBROAD, Rm E-	201 GT 1-AGMED (RUTH GUSSMAN)
V16 - ACRS SENT TO LIC ASST Teets 1-CONSULTANTS Rm B-127 GT			
7-19-74	De Neuma	RK/BLUME/AGBABIA	•
ана. 	:		GT

Regulatory

File C

Carolina Power & Light Company July 15, 1974

File: NG-3513 and NG-3514

Serial: NG-74-873

Mr. John F. O'Leary, Director Directorate of Licensing Office of Regulation U.S. Atomic Energy Commission Washington, D. C. 20545

Mr. Norman C. Moseley, Director Directorate of Regulatory Operations U. S. Atomic Energy Commission Region II, Suite 818 230 Peachtree Street, N.W. Atlanta, Georgia 30303



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Dear Sirs:

50-267

H. B. ROBINSON UNIT NO. 2 LICENSE DPR-23 EXPOSURE OF AN INDIVIDUAL TO EXCESSIVE AIRBORNE CONCENTRATIONS OF RADIOACTIVE MATERIALS

In accordance with 10CFR20, Paragraph 20.405 (a) the attached report is submitted for your information.

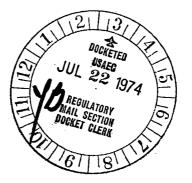
Yours very truly,

Vice-President

Bulk Power Supply

JLH:DBW:mvp Attachment

- cc: Messrs. N. B. Bessac
 - T. E. Bowman
 - B. J. Furr
 - W. E. Graham
 - D. V. Menscer
 - D. B. Waters
 - R. A. Watson





6535

336 Fayetteville Street • P. O. Box 1551 • Raleigh, N. C. 27602

VIOLATION OF 10CFR20, PARAGRAPH 20.103 (b)

- 1. Report Number 74-13
- 2a. <u>Date</u> July 10, 1974
- 2b. Occurrence Date June 15, 1974
- 3. Facility

H. B. Robinson Unit No. 2 Hartsville, South Carolina 29550 いましての変換

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4. Identification of Occurrence

Personnel exposure of an individual to airborne concentrations such that MPC_A x stay time was greater than 1.

5. <u>Conditions Prior to Occurrence</u>

Reactor in a refueling shutdown condition.

6. Description of Occurrence

Contractor employee opened a vacuum cleaner being used to clean the channel heads of steam generators following tube plugging. As a result the individual was exposed to a very localized high airborne concentration of radiation contaminates.

7. Designation of Apparent Cause of the Occurrence

Lack of awareness by the individual involved of radiological hazards presented by vacuum cleaners containing radioactively contaminated dust. Although the individual involved is very well-trained and experienced from many years of work with nuclear systems, he failed to consider possible radiological hazards when opening the vacuum cleaner which was clearly marked as being contaminated.

8. Analysis of the Occurrence

Following plugging of steam generators on June 14 and 15, 1974, cleanup of the channel heads was begun. The individual involved was supervising the effort. In his desire to speed the job up he decided to directly aid in the work. After properly dressing for work in the steam generators, but prior to obtaining his respirator, the man checked the vacuum cleaner and found to to be inoperable. He, therefore, opened the vacuum cleaner to attempt to repair it. When attempts to repair the vacuum cleaner proved unsuccessful, he donned respiratory equipment and entered the steam generator for five minutes.

Immediately exiting the containment, the individual discovered himself to be contaminated when checking through the control point. Extensive showering appeared to remove the contamination and the individual cleared himself through the control point.

Shortly thereafter the individual returned to the control point area to conduct a conversation. Upon attempting to clear himself through the personnel monitors he found himself to be still contaminated. Further efforts were made to remove the contamination by showering and sweating the man. Radiation readings appeared to be centered about old scar tissue on his abdomen. After further efforts to lower radiation levels proved unsuccessful, the suspected area of contamination was enclosed in gauze and tape and the individual sent to get some sleep.

Early the next morning, June 16, medical advice was obtained and a skin cleansing agent acquired from the local hospital. Use of the cleansing agent showed no results. This fact when coupled with the now generalized radiation levels throughout the abdominal cavity indicated that the contamination was probably internal rather than external. Accordingly, the chest and abdominal areas of the man were wrapped in towels and he was given a bottle and plastic bag for collection of urine and fecal samples.

These samples became available the morning of June 17. Analysis of these samples proved conclusively that significant levels of radioactive contaminates were present internally in the individual. In ensuing conversations with the man's supervisors, he was scheduled for a whole body count on June 19.

The whole body count was made on June 19, followed by subsequent counts on June 21 and July 2. As a result of these counts it was determined that the Juan had lung burdens of Co-60 of 1.4 microcuries and of Co-58 of 1.63 microcuries.

Lung burdens of these magnitudes will result in a lung exposure in one year of 16.6 rem and a lifetime exposure of 17.4 rem. Calculations of initial intake of these isotopes indicate that 13 microcuries of cobalt 60 and 15.2 microcuries of cobalt 58 was inhaled.

Further calculations as to actual air concentrations to which the individual was exposed are complicated by the individual not being certain as to the amount of time he was working on the vacuum cleaner and by the individual being a mouth breather. However, if conservative assumptions are made that the exposure lasted two minutes at average respiratory rate and tidal volumes, air concentrations of cobalt 60 of 3.0×10^{-4} uCi/cc and cobalt 58 of 3.5×10^{-4} uCi/cc can be assumed to be ingested by the individual.

Based on a two-minute stay time maximum permissible airborne concentrations of cobalt 58 and cobalt 60 are, respectively, 6.0×10^{-5} uCi/cc and 1.08×10^{-5} uCi/cc. Therefore, this incident resulted in a violation of 10CFR20, Paragraph 20.103 (b).

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9. Corrective Action

Locks have been placed on all vacuum cleaners to ensure that this type of incident does not recur. In addition, the potential of this type of incident occurring from radioactive dusts is to be discussed with all plant employees.

10. Previous Failure Data

None