GULF STATES UTILITIES COMPA RIVER BEND STATION POST OFFICE BOX 120 ST. FRANCISVILLE LOUISIANA 70775 AREA CODE 504 535-6094 346-8661 December 5 , 1990 RBG- 34120 File Nos. G9.5, G9.25.1.3 U.S. Nuclear Regulatory Commission Document Control Desk Washington, D.C. 20555 Gentlemen: River Bend Station - Unit 1 Docket No. 50-458 Please find enclosed Licensee Event Report No. 90-037 for River Bend Station - Unit 1. This report is being submitted pursuant to 10CFR50.73. Sincerely, W. H. Odell Manager-Oversight River Bend Nuclear Group LAE/PDG/DRD/DCH/SWG/pg cc: U.S. Nuclear Regulatory Commission 611 Ryan Plaza Drive, Suite 1000 Arlington, TX 76011 NRC Resident Inspector P.O. Box 1051 St. Francisville, LA 70775 INPO Records Center 1100 Circle 75 Parkway Atlanta, GA 30339-3064 Mr. C. R. Oberg Public Utility Commission of Texas 7800 Shoal Creek Blvd., Suite 400 North Austin, TX 78757

REPORTABLE TO NERDS

SUPPLEMENTAL REPORT EXPECTED (14)

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ABSTRACT (Limit to 1400 spaces, i.e. approximately fifteen single-space typewritten lines) [16]

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On November 5, 1990 and again on November 6, 1990, with the plant in Operational Condition 5 (Refueling), two workers entered a high radiation area (HRA) without satisfying the requirements of Technical Specification 6.12.1. Therefore, this event is reportable pursuant to 10CFR50.73(a)(2)(i)(b) as operation prohibited by the Technical Specifications.

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBLO IN THIS REPORT (13)

CAUSE SYSTEM

COMPONENT

The root cause of this event was failure of the 2 employees to observe the HRA boundary. To preclude a recurrence of this type, the contractor issued a self-imposed stop work order at approximately 1700 hours on 11/6/90. The purpose of which was to allow for the retraining of all contractor employees to the requirements of RP boundaries and procedures. The two employees responsible were trained, counseled and terminated.

The total dose for both workers for both entries as indicated by pocket dosimeter was 43 mRem. This event involving the two individuals violating the high radiation boundary does not constitute a plant operational safety concern. Therefore, this event did not adversely affect the health and safety of the public.

CAUSE

SYSTEM

COMPONENT

YES III yes complete EXPECTED SUBMISSION DATE!

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P.530). J.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3)50-0104). OFFICE OF MANAGEMENT AND RUDGET WASHINGTON DC 20503.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

### REPORTED CONDITION

On November 5, 1990 and again on November 6, 1990 with the plant in Operational Condition 5 (Refueling), two workers entered a high radiation area (HRA) without satisfying the requirements of Technical Specification 6.12.1. Therefore, this event is reportable pursuant to 10CFR50.73 (a) (2) (i) (b) as operation prohibited by the Technical Specifications.

### INVESTIGATION

The two employees first entered the high radiation area (HRA) of the auxiliary building residual heat removal (RHR) 'A' cubicle on 11/05/90. Prior to entering the area, they neglected to check in at the radiologically controlled area (RCA) checkpoint. They did not obtain the proper radiation work permit (RWP) number, nor did they obtain the proper dosimetry. The workers entered the cubicle by following other workers who were authorized to enter. The unauthorized workers were in the area for approximately 20 minutes and were assigned 20 mRem each.

On 11/06/90, the two individuals entered the same area again, under the same conditions. Once again, they crossed the boundary rope without any apparent realization that they were in violation of site radiological procedures, and proceeded down the stairs. It was at this time that an RP technician within the area noted the two employees entering the high radiation area without meeting Technical Specification requirements. The two men were escorted from the area by the technician and returned to the RCA checkpoint for counseling and incident investigation. For 11/06/90, the employees stayed in the area for approximately 1 minute and were assigned doses of 0 and 3 mRem, respectively, based on their individual pocket dosimeters.

A review of previously submitted LERs reviewed similar events in LER 90-010 and LER 90-020. In LER 90-010, an operator removed a rope barricade for a HRA. LER 90-020 reported HRA violations by a radwaste operator and a security officer.

#### CORRECT VE ACTION

To preclude a recurrence of this type, the contractor issued a self-imposed stop work order at approximately 1700 hours on 11/06/90. The purpose of which was to allow for the retraining of all contract employees to the requirements of RP boundaries and procedures. All personnel in each of the two shifts were re-trained by contractor management, which was observed by representatives of the GSU RP department and the Quality Assurance department. The training sessions were completed at approximately 2000 hours on 11/06/90 and

#### APPROVED OMB NO. 3150-0104 EXPIRES 4/30/92

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the self-imposed stop work order was lifted by contractor management. The two employees responsible were trained, counseled and terminated.

#### SAFETY ASSESSMENT

The total doses received were below NRC and River Bend Station administrative limits. This event does not constitute a plant operational safety concern. Therefore, this event did not adversely affect the health and safety of the public.