



GULF STATES UTILITIES COMPANY

RIVER BEND STATION POST OFFICE BOX 220 ST. FRANCISVILLE, LOUISIANA 70775
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December 17, 1990
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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. 90-042 for River Bend Station - Unit 1. This report is being submitted pursuant to 10CFR50.73.

Sincerely,

W. H. Odell
W. H. Odell
Manager-Oversight
River Bend Nuclear Group

AE *PDG* *EMC* *DCE* *CLF* *pg*
IAE/PDG/EMC/DCE/CLF/pg

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LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST 500 HRS FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH IF 3301, U.S. NUCLEAR REGULATORY COMMISSION WASHINGTON, DC 20555 AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET WASHINGTON, DC 20503

FACILITY NAME (1)

RIVER BEND STATION

DOCKET NUMBER (2)

05000458 OF 03

PAGE (3)

TITLE (4) Improperly Restored Barriers for Three Posted High Radiation Areas and One Posted Very High Radiation Area

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)
11	16	90	90	042	00	12	17	90			05000
<p>THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)</p>											

OPERATING MODE (9)	POWER LEVEL (10)	20.402(b)		20.406(e)		50.73(a)(2)(i)(A)		73.11(b)	
*	0	20.406(a)(1)(iii)		50.38(a)(1)		50.73(a)(2)(iv)		73.11(d)	
		20.406(a)(1)(ii)(B)		50.38(a)(2)		50.73(a)(2)(iv)(A)		OTHER (Specify in Abstract below and in Text, NRC Form 306A)	
		20.406(a)(1)(ii)(C)	X	50.73(a)(2)(i)		50.73(a)(2)(iv)(ii)(A)			
		20.406(a)(1)(ii)(D)		50.73(a)(2)(ii)		50.73(a)(2)(iv)(ii)(B)			
		20.406(a)(1)(ii)(E)		50.73(a)(2)(iii)		50.73(a)(2)(ix)			

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
L. A. England, Director - Nuclear Licensing	5104 3181 1414 15

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRPDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRPDS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (if yes, complete EXPECTED SUBMISSION DATE)	NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
X			01	30	91

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

On three separate dates, 11/16/90, 11/23/90 and 11/29/90, there were four occurrences in which Technical Specification required radiation area barriers were discovered to have been restored improperly. The barriers were located at the entrances to three high radiation areas (HRAs) and one very high radiation area (VHRA). As a result, these areas were in a condition that is prohibited by Technical Specifications 6.12.1 and 6.12.2, respectively. Therefore, this report is submitted pursuant to 10CFR50.73(a)(2)(i)(B) as operation prohibited by the Technical Specifications.

The root cause for these incidents was that personnel failed to properly restore the barriers for undetermined reasons.

GSU has concluded that a generic problem exists with regard to posted radiation protection barriers. As a result, a task force headed by the Director-Radiological Programs has been established to determine the causal factors associated with these incidents. Verifications of Technical Specification requirements (i.e., personnel dosimetry and radiation work permit requirements) were performed with no violations. The problem reflected in these incidents has no operational impact. Therefore, the health and safety of the public were not adversely affected by these incidents.

* Operational Conditions 5, 4, and 2 for occurrences on 11/16, 11/23, 11/29.

**LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION**

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST. SEE HRS FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (2160-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1) RIVER BEND STATION	DOCKET NUMBER (2) 0 5 0 0 0 4 5 8 9 0	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
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TEXT (if more space is required, use additional NRC Form 366A's) (17)

REPORTED CONDITION

On three separate dates, 11/16/90, 11/23/90 and 11/29/90, there were four occurrences in which Technical Specification required radiation area barriers were discovered to have been restored improperly. The barriers were located at the entrances to three high radiation areas (HRAs) and one very high radiation area (VHRA). As a result, these areas were in a condition that is prohibited by Technical Specifications 6.12.1 and 6.12.2, respectively. Therefore, this report is submitted pursuant to 10CFR50.73(a)(2)(i)(B) as operation prohibited by the Technical Specifications.

INVESTIGATION

The root cause for these incidents was that personnel failed to properly restore the barriers for undetermined reasons. The barricades were immediately restored upon discovery. In each area, personnel accountability, Technical Specification dosimetry and radiation work permit (RWP) requirements were verified with no violations found.

On 11/16/90 at approximately 1615 hours, an NRC representative exiting the drywell notified a radiation protection (RP) technician that a rope used to barricade and post the entrance to a VHRA was improperly restored. During shutdowns and when major work is being performed in the drywell, VHRAs are posted with a rope and flashing red light as required by Technical Specification 6.12.2. The rope in this case was strung across the handrail to a stairway leading from 95' elevation to 82' elevation in the drywell. A hook was used to attach the rope to allow ease of access and egress to this area. Although this area was posted as a VHRA, actual radiation levels were less than 1000 mRem/hr at 18" with the temporary shielding installed. Typically, VHRAs are posted when radiation levels exceed 1000 mRem/hr.

Upon notification, an RP technician was sent to restore the barrier (i.e., attach the rope to the hook) and to verify that all individuals in the area were authorized and met Technical Specification requirements for entry. No discrepancies were found and no unauthorized individuals were found in the area. All VHRA postings/barriers in the drywell were checked and found satisfactory. Personnel responsible for failing to restore the rope barrier could not be determined.

On 11/23/90 at approximately 1030, an RP technician discovered a safety chain which was used to barricade the entrance to a platform posted as a high radiation area not properly restored. The platform is located at approximately 150' elevation in the containment. The RP technician immediately restored the barrier and inspected the area for unauthorized individuals. No personnel were found in the area.

**LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION**

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 500 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-520), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (4)			PAGE (3)																
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER																	
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TEXT (if more space is required, use additional NRC Form 305A's) (17)

Consequently, personnel responsible for failing to restore the chain barrier could not be determined.

On 11/29/90 an RP foreman and an RP technician performing a building tour found an unsecured rope barrier at the entrance to residual heat removal (RHR) "B" cubicle, a posted HRA, on the 70' elevation in the auxiliary building. The RP technician immediately restored the barrier and inspected the area for unauthorized individuals. No personnel were found in the area. Consequently, personnel responsible for failing to restore the rope barrier could not be determined.

In another incident on 11/29/90, an RP foreman and an RP technician performing a building tour found an unsecured rope barrier at the entrance to RHR "A" cubicle, a posted HRA, on the 70' elevation in the auxiliary building. The RP technician immediately restored the barrier and inspected the area for unauthorized individuals. No personnel were found in the area. The rope barrier was attached at one end by the use of tape. This was a poor method and the barrier could have been removed by an unknown individual or became unattached due to failure of the tape.

A review of previous LERs revealed a similar event reported in LER 90-010. In this case, an operator placed a rope barricade to one side and entered an HRA without meeting the Technical Specifications requirements for entry. The HRA was left in an unbarricaded condition while the operator was in the HRA.

CORRECTIVE ACTION

As a result of the two instances on 11/29/90 all high radiation areas were inspected and no additional barriers were found unsecured. GSU has concluded that a generic problem exists with regard to posted radiation protection barriers. As a result, a task force headed by the Director-Radiological Programs has been established to determine the causal factors associated with these incidents. The task force will provide recommendations to the Plant Manager concerning its findings. A supplemental report documenting corrective actions will be issued by April 30, 1991.

SAFETY ASSESSMENT

Verifications of Technical Specification requirements (i.e., personnel dosimetry and RWP requirements) were performed with no violations. The problem reflected in these incidents has no operational impact. Therefore, the health and safety of the public were not adversely affected by these incidents.