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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 Revision 1 to Licensee Event Report No. 90-042 for River Bend Station - Unit 1. This revision is submitted as a supplement to the original report.

Sincerely,

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

ABJ
IAE/PDG/GAB/DCH/CLF/pg
ONJ

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

9101150250 910107
PDR ADOCK 05000458
S PDR

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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 (P-530), 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 PAGE 3 1 OF 04

TITLE (4) Improperly Restored Barriers for High Radiation Areas

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
11	16	90	90	042	010	10	07	91	
								DOCKET NUMBER(S) 050000	
								050000	

OPERATING MODE (9) * 20 402(b) 20 406(c) 50 73(a)(2)(iv) 73.71(b)

POWER LEVEL (10) 0 20 406(a)(1)(ii) 50 36(a)(1) 50 73(a)(2)(iv) 73.71(a)

20 406(a)(1)(iii) 50 36(a)(2) 50 73(a)(2)(iv) OTHER (Specify in Abstract below and in Text, NRC Form 366A)

20 406(a)(1)(iv) X 50 73(a)(2)(viii)(A) 50 73(a)(2)(viii)(B)

20 406(a)(1)(iv) 50 73(a)(2)(iv) 50 Total(a)(x)

LICENSEE CONTACT FOR THIS LER (12)

NAME L. A. England, Director-Nuclear Licensing TELEPHONE NUMBER 504 381-4145

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) 03 31 91

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

On four separate dates, 11/16/90, 11/23/90, 11/29/90 and 12/06/90, there were five occurrences in which Technical Specification required radiation area barriers were discovered to have been restored improperly. The barriers were located at the entrances to four 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 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 5,4,2 and 1 for occurrences on 11/16, 11/23 11/29, and 12/6, respectively.

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-630), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
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TEXT (If more than 1 page, use additional NRC Form 366A's) (17)

REPORTED CONDITION

On four separate dates, 11/16/90, 11/23/90, 11/29/90 and 12/06/90, there were five occurrences in which Technical Specification required radiation area barriers were discovered to have been restored improperly. The barriers were located at the entrances to four 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 12" 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: 600 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20545, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503

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TEXT (If more space is required, use additional NRC Form 366A (1-77))

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.

On 12/6/90 at approximately 2200, a (RP) technician on a tour of the containment building discovered a rope used to post and barricade a high radiation area (HRA) unattached to its anchor on one end. The rope was immediately restored. The barrier was located at approximately the 141' elevation and was used to indicate an HRA associated with the reactor sample sink drain line that ran against the wall. This area is not normally accessible and the rope barrier was attached to permanent structures at both ends using tie wraps and tape. Also this area was inspected earlier on 12/05/90 and found to be satisfactory. Explicit verifications of personnel dosimetry and RWP requirements were not required. This area is limited in size and visual observation by the RP technician was sufficient to confirm that personnel were not in the area.

The root cause for this incident is indeterminate, the tape could have failed or the rope could have been removed by an individual and not restored properly.

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

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
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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. As an interim measure, daily inspections of high radiation area postings will be performed pending completion of the task force investigation. A supplemental report documenting corrective actions will be issued by March 31, 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.