



GULF STATES UTILITIES COMPANY

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AREA CODE 504 636-8394 345 9651

April 10, 1992
RBG- 36729
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 License Event Report No. 92-006 for River Bend Station - Unit 1. This report is submitted pursuant 10CFR50.73.

Sincerely,

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

LAE/PDG/EMC/DCH/WCH/kvm

cc: U.S. Nuclear Regulatory Commission
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LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST 500 HRS FORWARD COMMENTS REGARDLESS OF BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-630) U.S. NUCLEAR REGULATORY COMMISSION WASHINGTON DC 20545 AND TO THE PAPERWORK REDUCTION PROJECT (3190-0104) OFFICE OF MANAGEMENT AND BUDGET WASHINGTON DC 20503

FACILITY NAME: RIVER BEND STATION
DOCKET NUMBER (2): 05000045H
PAGE: 1 OF 5

TITLE (1): UNSECURED HIGH RADIATION AREA BOUNDARY ROPE DISCOVERED AT THE ENTRANCE TO THE DRYWELL

EVENT DATE (3)			LER NUMBER (3)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (3)		
MONTH	DAY	YEAR	YEAR	SEQUENT NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)
03	14	92	92	006	00	04	10	92			050000
											050000

OPERATING MODE (1): 4
POWER LEVEL (10): 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)

<input type="checkbox"/> 20.406(a)(1)(i)(v)	<input type="checkbox"/> 20.406(a)	<input type="checkbox"/> 30.73(a)(2)(iv)	<input type="checkbox"/> 73.71(a)
<input type="checkbox"/> 20.406(a)(1)(i)(x)	<input type="checkbox"/> 30.73(a)(1)	<input type="checkbox"/> 30.73(a)(2)(v)	<input type="checkbox"/> 73.71(a)
<input type="checkbox"/> 20.406(a)(1)(ii)(a)	<input checked="" type="checkbox"/> 30.73(a)(2)(ii)	<input type="checkbox"/> 30.73(a)(2)(vi)	OTHER (Specify in Appendix B, 10 CFR Part 306)
<input type="checkbox"/> 20.406(a)(1)(ii)(b)	<input type="checkbox"/> 30.73(a)(2)(iii)	<input type="checkbox"/> 30.73(a)(2)(vii)(A)	
<input type="checkbox"/> 20.406(a)(1)(ii)(c)	<input type="checkbox"/> 30.73(a)(2)(iv)	<input type="checkbox"/> 30.73(a)(2)(vii)(B)	
<input type="checkbox"/> 20.406(a)(1)(ii)(d)	<input type="checkbox"/> 30.73(a)(2)(v)	<input type="checkbox"/> 30.73(a)(2)(viii)	

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 NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

SUPPLEMENTAL REPORT EXPECTED (14): YES () NO (X)

EXPECTED SUBMISSION DATE (15): MONTH: DAY: YEAR:

ABSTRACT (Limit to 1400 spaces or approximately fifteen single space typewritten lines) (16)

At approximately 0715 on 3/14/92 with the unit shutdown during the fourth refueling outage (RF-4) (Operational Condition 4), a radiation protection technician discovered an unsecured high radiation area (HRA) entrance boundary rope. This condition created an opening in the barrier. The rope barrier was located on the 95' elevation of the reactor building at the drywell equipment hatch. This HRA entrance was established as an authorized entry point into the drywell. Technical Specification 6.12.1 requires that high radiation areas be barricaded. This report is submitted pursuant to 10CFR50.73 (a)(2)(i)(B) as operation prohibited by Technical Specifications. The boundary was immediately restored. An immediate search of the area revealed that no personnel were inside the HRA at the time of discovery. All other postings within the drywell were found to be properly posted.

Work was stopped in the RCA and all non-essential personnel having authorized RCA access were required to leave the RCA to attend meetings with management. For four consecutive days, meetings were held at the beginning of each shift with personnel having access to the RCA to emphasize the importance of compliance with radiological procedures and postings.

There is no evidence that unauthorized individuals entered the drywell. This event did not affect plant systems and had no operational impact.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATIONESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS
INFORMATION COLLECTION REQUEST: 500 HRS. FORWARD
COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS
AND REPORTS MANAGEMENT BRANCH (F-530), U.S. NUCLEAR
REGULATORY COMMISSION, WASHINGTON, DC 20548 AND TO
THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE
OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (5)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
RIVER BEND STATION	0 6 1 0 0 0 4 5 8 9 2	— 0 1 0 6	— 0 1 0	0 2	OF	0 5	

TEXT IF THIS SPACE IS REQUIRED, USE ADDITIONAL NRC FORM 388A (4-89)

REPORTED CONDITION

At approximately 0715 on 3/14/92 with the unit shutdown during the fourth refueling outage (RI-4) (Operational Condition 4), a radiation protection technician discovered an unsecured high radiation area (HRA) entrance boundary rope. This condition created an opening in the barrier. The rope barrier was located on the 95' elevation of the reactor building at the drywell equipment hatch. This HRA entrance was established as an authorized entry point into the drywell. Technical Specification 6.12.1 requires that high radiation areas be barricaded. This report is submitted pursuant to 10CFR50.73 (a)(2)(i)(B) as operation prohibited by Technical Specifications. The boundary was immediately restored. An immediate search of the area revealed that no personnel were inside the HRA at the time of discovery. All other postings within the drywell were found to be properly posted.

INVESTIGATION

On 3/14/92 at 0715 a radiation protection technician assigned to support work activities at the 95' level of the containment building identified a deficient rope barrier configuration at the drywell entrance. The barrier had last been observed to be in place by RP at approximately 0550. This barrier was posted in accordance with RP procedures for established HRA entrances.

No individuals were found to be in the area and all other postings within the drywell were secured as required. Within the confines of the drywell there existed nine very high radiation area (VHRA) boundaries, all were in place, and properly posted. The remainder of the drywell was posted as an HRA. General accessible dose rates within the HRA ranged from 5 to 180 mR/hr using an eighteen inch reading.

Between 0550 and 0715, when the unsecured barrier was discovered, two groups of workers had reasonable access to the barrier. Only one group was authorized access to the drywell via this entrance. The other group was working outside the area in an adjacent contaminated area. A review of the containment security card access history files revealed that the personnel who were working in the drywell left after the group working in the adjacent containment area. All four personnel who exited the drywell stated that they did in fact restore the HRA boundary when they exited.

The last individual in the drywell crew exited the containment at 0638. Allowing for several minutes to traverse from the drywell exit to the containment card reader, it can be concluded that the high radiation barrier was probably unsecured and unattended for no more than 45 minutes. Since the entrance to the drywell is highly visible and within the confines of a contaminated area, it is unlikely that unauthorized personnel entered the HRA or removed the HRA rope.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST ADD HRS FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (F-530) U.S. NUCLEAR REGULATORY COMMISSION WASHINGTON, DC 20548 AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104) OFFICE OF MANAGEMENT AND BUDGET WASHINGTON, DC 20503

FACILITY NAME (1)

DOCKET NUMBER (2)

LER NUMBER (8)

PAGE (3)

RIVER BEND STATION

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YEAR SEQUENTIAL REVISION

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TEXT (if more space is required, use additional NRC Form 386A (1/77))

ROOT CAUSE

The root cause of this event is indeterminate. It is not known who left the HRA rope in an unsecured position. The four members of the work crew last known to have exited the drywell all have stated that they restored the HRA boundary prior to exit. However, due to (1) the limited time available between their exit and discovery of the unsecured barrier rope, (2) the highly visible HRA entrance and (3) location of the HRA within a contaminated area, GSU concludes that one or more members of the work crew failed to properly restore the HRA barricade rope.

In 1990, LER 90-042 reported five instances in which Technical Specification required radiation area barriers were not properly secured. These incidents resulted in the formation of a task force and the implementation of several corrective actions to address radiation protection barrier issues. These corrective actions are repeated here for completeness, as follows:

1. All personnel requiring access to high radiation and/or a very high radiation areas were retrained and completed a written examination by 2/15/91.
2. All remaining personnel requiring unrestricted access to the radiologically controlled area were retrained and completed a written examination by 3/1/91.
3. General employee training (GET) was revised to add additional emphasis on HRA/VHRA entry requirements and the examination was revised.

In addition, the below listed actions were initiated:

1. The Plant Manager issued a memorandum to all personnel concerning the problem.
2. The Plant Manager issued a memorandum to all Supervisors stressing their responsibility and involvement in preventing HRA/VHRA violations.
3. New designs for stanchions and fasteners were developed.
4. RP management stressed improved technician professionalism in posting activities.
5. The locking of HRAs, to the greatest extent practical, was implemented.

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 (F30), U.S. NUCLEAR REGULATORY COMMISSION WASHINGTON, DC 20548, 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) 0 5 0 0 0 4 5 8	LER NUMBER (3)			PAGE (3)		
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TEXT (if more space is required, use additional NRC Form 305A (11/77))

6. Selected piping was hydrolazed to reduce radiation levels and some areas were deposited.
7. Installed signs that read "STOP - Technical Specification Monitoring Required" at the entry points to all accessible HRAs and VHRA's.
8. Monthly operability checks of HRA doors have been added in addition to VHRA doors.
9. GSU has changed its usage of removable barriers by reserving them for entrances to HRAs/VHRA's.

Note that the above corrective actions were fully implemented during the 1991 calendar year. In 1991, there were two LERs concerning HRA violations. LER 91-009 documented an event in which two electrical maintenance workers improperly moved an HRA boundary rope. In this event, disciplinary action was taken against the two workers, the electrical maintenance foreman and the acting electrical maintenance supervisor. LER 91-006 reported an event in which an operations engineering cooperative student failed to replace an HRA rope barricade. In this case, a contributing factor was a lack of clear direction to personnel involved concerning task accountability and the definition of their interface.

Prior to this event (LER 92-006), there have been no LERs concerning HRA barricades since LER 91-009, which documented an event that occurred on 4/30/91. GSU is confident that the corrective actions outlined as a result of the task force effort have been and continue to be effective in preventing improper handling of HRA/VHRA barriers.

CORRECTIVE ACTION

On the date of the event, non-essential personnel who were authorized RCA access were directed to stop work and report to meetings conducted by the Plant Manager. Additional meetings with those who had RCA access were conducted by management personnel at the beginning of each shift for four consecutive days. During these meetings, the need for and the importance of adhering to radiological procedures was emphasized.

In view of the amount of work proceeding in the RCA during RF-4 and the number of additional workers involved, GSU has concluded that additional protective measures are warranted. These include, where feasible, tie wrapping rope barriers at unused entrances, installation of self-closing scaffold gates, continuous surveillance of selected barriers with closed circuit television cameras and 4 hour checks of barriers to ensure their integrity. These measures will be implemented on an as-needed basis by RP.

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 (F-830) U.S. NUCLEAR REGULATORY COMMISSION WASHINGTON, DC 20548 AND TO THE PAPERWORK REDUCTION PROJECT (3180-0104) OFFICE OF MANAGEMENT AND BUDGET WASHINGTON, DC 20503

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (3)			PAGE (3)	
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TEXT IF MORE SPACE IS REQUIRED, USE ADDITIONAL NRC Form 288A (2/117)

Controls and procedures currently in place at River Bend have proven to be effective over the past year. In addition, prompt action was taken by management to reemphasize the importance of adherence to basic radiological safety procedures and practices.

SAFETY ASSESSMENT

Based on the available evidence, GSU has concluded that one or more members of the work crew in the drywell were responsible for leaving the HRA barricade in an unsecured position. There is no evidence that any unauthorized personnel entered the HRA. This event has no operational impact on the plant.