



GULF STATES UTILITIES COMPANY

RIVER BEND STATION POST OFFICE BOX 220 ST. FRANCISVILLE, LOUISIANA 70772
AREA CODE 504 835-8094 346-8661

June 1, 1992
RBG- 36900
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. 92-002 for River Bend Station - Unit 1. This report is submitted pursuant 10CFR50.73.

Sincerely,

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

AE PDG DCH
LAE/PDG/GAB/DCH/WCH/kvm

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cc: U.S. Nuclear Regulatory Commission
611 Ryan Plaza Drive, Suite 400
Arlington, TX 76011

NRC Resident Inspector
P.O. Box 1051
St. Francisville, LA 70775

INPO Records Center
1100 Circle Parkway
Atlanta, GA 30339-3064

Mr. C.R. Oberg
Public Utility Commission of Texas
7800 Shoal Creek Blvd., Suite 400 North
Austin, TX 78757

Louisiana Department of Environmental Quality
Nuclear Energy Division
P.O. Box 82135
Baton Rouge, LA 70884-2135
ATTN: Administrator

LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 500 HRS FORWARD COMMENTS REPLYING 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) 0500004581 PAGE (3) 1 OF 04

TITLE (4) WORKER ENTERED POSTED VERY HIGH RADIATION AREA WITHOUT REQUIRED MONITORING DEVICE

| 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) |
| 04 | 30 | 92 | 92 | 002 | 00 | 06 | 01 | 92 | | 050000 |

OPERATING MODE (9) 5 THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)

| | | | |
|-------------------|------------------|---------------------|--|
| 20.402(b) | 20.406(a) | 50.73(a)(2)(iv) | 73.71(b) |
| 20.406(a)(1)(ii) | 50.36(a)(1) | 50.73(a)(2)(v) | 73.71(c) |
| 20.406(a)(1)(iii) | 50.36(a)(2) | 50.73(a)(2)(vi) | OTHER (Specify in Abstract below and in Text, NRC Form 366A) |
| 20.406(a)(1)(iv) | X 50.73(a)(2)(i) | 50.73(a)(2)(vii)(A) | |
| 20.406(a)(1)(v) | 50.73(a)(2)(ii) | 50.73(a)(2)(vii)(B) | |
| 20.406(a)(1)(vi) | 50.73(a)(2)(iii) | 50.73(a)(2)(viii) | |

LICENSEE CONTACT FOR THIS LER (12)

NAME L.A. England, Director - Nuclear Licensing TELEPHONE NUMBER 5104 3811 4145

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

| CAUSE | SYSTEM | COMPONENT | MANUFAC TURER | REPORTABLE TO NPROS | CAUSE | SYSTEM | COMPONENT | MANUFAC TURER | REPORTABLE TO NPROS |
|-------|--------|-----------|---------------|---------------------|-------|--------|-----------|---------------|---------------------|
| | | | | | | | | | |

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE) NO X

EXPECTED SUBMISSION DATE (15)

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

On 4-30-92 at approximately 0315 with the reactor shutdown during the fourth refueling outage (RF-4) (Operational Condition 5), a chemical decontamination contractor was discovered by a radiation protection (RP) technician to be within the boundary of a posted very high radiation area (VHRA) without the required monitoring device (alarming dosimeter) or administrative controls (pre-established stay time) as required by River Bend Technical Specification 6.12.2. Therefore, this report is submitted pursuant to 10CFR50.73(a)(2)(i)(B) as operation prohibited by the Technical Specifications.

The root cause of this event is personnel error. The contractor failed to comply with radiation work permit (RWP) 92-4024 and failed to notify RP of the extent of work and the specific work location. The contractor disregarded general employee training (GET) II. Physical barriers violated or ignored were the VHRA posting, the rope barrier, the self-closing scaffold gate, flashing red lights, and TS monitoring stop sign. All of these barriers were properly installed in accordance with RP procedures.

Since the contractor was aware of the location of the VHRA dose rates and was not working in that area, GSU concludes that this event did not have a high potential for significant exposure. In addition, this event had no operational impact on the plant.

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 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.

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TEXT (If more space is required, use additional NRC Form 386A (1/17))

REPORTED CONDITION

On 4/30/92 at approximately 0315 with the reactor shutdown during the fourth refueling outage (RF-4) (Operational Condition 5), a chemical decontamination contractor was discovered by a radiation protection (RP) technician to be within the boundary of a posted very high radiation area (VHRA) without the required monitoring device (alarming dosimeter) or administrative controls (pre-established stay time) as required by River Bend Technical Specification (TS) 6.12.2. Therefore, this report is submitted pursuant to 10CFR50.73(a)(2)(i)(B) as operation prohibited by the Technical Specifications.

INVESTIGATION

Following discovery, the contractor's work was placed in a safe condition, and radiologically controlled area (RCA) access was suspended for the contractor. Radiation protection management was notified and an investigation was initiated.

The contractor had entered the VHRA located in the auxiliary building at the 141 ft. elevation. This area is posted to control access to the main steam tunnel while the floor plug is removed. Access to the VHRA fields (ie., greater than 1000 mRem/hour) requires going down two ladders to the 114 ft. elevation of the steam tunnel. The contractor was in the access area on the 141 ft. elevation. This area measures about 20 ft. by 20 ft., having a maximum doserate of 10 mRem/hour. The investigation revealed that the contractor had made entries to this area on the day shift, 4/28/92 and on the night shift, 4/29/92 to 4/30/92. Two entries made on the day shift were in full compliance with the Technical Specifications. In addition, the contractor has stated that he made a non-complying entry on the day shift (4/28/92). However, this cannot be independently confirmed. Interviews with personnel involved and a review of applicable documents indicates that a total of 2 entries were made on the night shift without meeting the Technical Specification requirements. Therefore, it is clear that there were two, and possibly as many as three, non-complying entries by the contractor into the VHRA. An interview with the contractor indicated that he understood that an alarming dosimeter and a stay time were required for entry inside the main steam tunnel. Thus, he was aware of the doserates, however; the TS monitoring and stay time are requirements within any posted VHRA regardless of the doserates.

The VHRA located at the auxiliary building 141 ft. elevation was inspected by RP management. The area was correctly posted in accordance with RP department procedures and standing instructions. This posting includes a rope boundary, scaffold rail boundary, multiple flashing red lights, a self closing scaffold gate, VHRA postings, a fluorescent stop sign that states "STOP TECH SPEC MONITORING REQUIRED BEYOND THIS POINT," and a camera set that allows

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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TEXT (if more space is required, use additional NRC Form 388A's (17))

MONITORING REQUIRED BEYOND THIS POINT," and a camera set that allows remote monitoring of the access rope at the control point.

Note that the actual VHRA dose fields were not entered by the contractor. Self-reading pocket dosimeter readings indicated zero mRem for the two non-complying entries on the night shift.

ROOT CAUSE

The root cause of this event is personnel error. Administrative and physical barriers were violated in the course of this event, as follows:

Administrative:

The contractor failed to comply with radiation work permit (RWP) 92-4024. This RWP requires an alarming dosimeter or doserate meter and a stay time record sheet for entry into a VHRA.

The contractor disregarded general employee training (GET) II. This training program places significant emphasis on VHRA entry requirements, including testing of all individuals on TS entry requirements.

The contractor failed to notify RP of the extent of work and the specific work location. While checking in at the control point, the contractor stated twice to the lead RP technician that his work was not in a VHRA. This was not correct. The pump he was to work on was within the VHRA boundary.

Physical:

Physical barriers violated or ignored were the VHRA posting, the rope barrier, the self-closing scaffold gate, flashing red lights, and TS monitoring stop sign. All of these barriers were properly installed in accordance with RP procedures.

A contributing factor to this event was inadequate communication between the contractor and the RP lead technician. The contractor stated that he did not require access to the VHRA, but requested that the tie wrap securing the rope be cut. The lead technician dispatched an RP technician to cut this tie wrap, thus allowing entry into the VHRA. Tie wraps are used for high radiation area (HRA) and VHRA entrances to secure rope barriers in accordance with RP standing instructions.

LICENSEE EVENT REPORT (LER)
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| FACILITY NAME (1) RIVER BEND STATION | DOCKET NUMBER (2) 0500045992 | LER NUMBER (3) | | | PAGE (3) | |
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TEXT (If more space is required, use additional NRC Form 305A's) (17)

Similar events were reported in LERs 90-020, 90-030 and 90-037. LER 90-020 reported violations of TS requirements for HRAs by a radwaste operator and a security officer. LER 90-030 reported that two workers were permitted entry into an HRA by a contract RP technician contrary to TS requirements. LER 90-037 reported violations of HRAs by two contract workers.

CORRECTIVE ACTION

Immediate corrective actions included suspension of the contractor's RCA access and initiation of the investigation.

Radiation protection management has reviewed procedure RPP-0005, "Posting of Radiologically Controlled Areas," GET II, standing instruction 92-0009, and the corrective actions implemented as a result of LER 92-006. Based on this review, GSU concludes that existing procedures and practices are adequate. Disciplinary action has been initiated against the contractor and the lead RP technician. In addition, the contractor was required to re-take and pass the River Bend Station HRA/VHRA exam prior to re-instatement of his RCA access.

SAFETY ASSESSMENT

The root cause of this event is personnel error, in that multiple administrative and physical barriers were disregarded. Since the contractor was aware of the location of the VHRA dose rates and was not working in that area, GSU concludes that this event did not have a high potential for significant exposure. In addition, this event had no operational impact on the plant.