

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) <b>Sequoyah, Unit 1</b>	DOCKET NUMBER (2) <b>0 5 0 0 0 3 2 7 1</b>	PAGE (3) <b>1 OF 0 3</b>
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**Inadequate Radiological Control Coverage In The Transfer Of Radioactive Waste Caused By Personnel Error Results In Technical Specification Violation**

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	
0	5	2	6	8	7	8	7	8	7	Sequoyah, Unit 2
				0	2	6		0	0	0 5 0 0 0 3 2 8
										0 5 0 0 0 3 2 8

OPERATING MODE (9) <b>5</b>	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5. (Check one or more of the following) (11)								
POWER LEVEL (10) <b>0 0 0</b>	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(e)(1)(i)	<input type="checkbox"/> 20.405(e)(1)(ii)	<input type="checkbox"/> 20.405(e)(1)(iii)	<input type="checkbox"/> 20.405(e)(1)(iv)	<input type="checkbox"/> 20.405(e)(1)(v)	<input type="checkbox"/> 20.405(c)	<input type="checkbox"/> 50.36(e)(1)	<input type="checkbox"/> 50.36(e)(2)
	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 50.73(a)(2)(vi)	<input checked="" type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(vii)(A)	<input type="checkbox"/> 50.73(a)(2)(vii)(B)	<input type="checkbox"/> 50.73(a)(2)(ix)
	<input type="checkbox"/> 73.71(b)	<input type="checkbox"/> 73.71(c)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)						

LICENSEE CONTACT FOR THIS LER (12)		TELEPHONE NUMBER	
NAME <b>D. W. Morison, Plant Operations Review Staff</b>		AREA CODE <b>6 1 5</b>	<b>8 7 0 - 6 1 4 6</b>

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO				

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

On May 26, 1987, with both units in mode 5 (cold shutdown) at zero percent power (unit 1 at 3 psig, 140 degrees F and unit 2 at 250 psig, 140 degrees F), a radwaste cask shipping liner containing solidified radwaste was transferred within the Auxiliary Building from the railroad access bay up to the refueling floor to be lowered into the cask decontamination room. Dose rates from the liner exceeded 1,000 mrem/hr. At two times in the transfer process while the liner was in transit and while the liner was being lowered into the decontamination room, Radiological Control (RAD CON) coverage did not provide positive control over the activities within these areas resulting in violation of units 1 and 2 Technical Specification (TS) 6.12.2.

This event was the result of personnel error when first, the movement of the liner from the railroad bay to the decontamination room was not properly covered as required by TS 6.12.2 and Radiological Control Instruction (RCI)-13, "Access Control to High Radiation Areas When Radiation Intensity is Greater Than or Equal to 1,000 mrem/hr." Second, when the liner was lowered into the decontamination room, an individual was present in the room without proper RAD CON coverage as required by TS 6.12.2 and RCI-13. This event demonstrates two specific violations of TS 6.12.2 and RCI-13 and is reportable in accordance with 10 CFR 50.73, paragraph a.2.i.B.

The event that occurred on May 26, 1987, was determined to be reportable on June 2, 1987, subsequent to a detailed review of the event by plant management. The RAD CON technicians and boilermaker personnel involved in the event were counseled. Further RAD CON management were instructed to provide better planning on radiation waste shipment activities.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
		0 2 6 -	0 0 0	2	OF	0 3

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

DESCRIPTION OF EVENT

On May 26, 1987, with both units in mode 5 (cold shutdown) at zero percent power (unit 1 at 3 psig, 140 degrees F and unit 2 at 250 psig, 140 degrees F), Radiation Work Permit (RWP) 87-0563-004 was issued to allow work to be performed on a radwaste cask shipping liner (EIS Code WB) to prepare the liner for offsite shipment. The RWP required continuous Radiological Control (RAD CON) monitoring of the task. Part of the job of preparing the liner for shipment involved transferring the liner from the railroad access bay to the cask decontamination room, both of which are inside the Auxiliary Building. To effect this transfer, it was necessary that the liner be raised to the Auxiliary Building refueling floor and then lowered into the decontamination room.

Technical Specification (TS) 6.12.2 and Radiological Control Instruction (RCI)-13, "Access Control to High Radiation Areas When Radiation Intensity is Greater Than or Equal to 1,000 mrem/hr," require an area that has an intensity of radiation greater than 1,000 mrem/hr to be secured by locked doors to prevent unauthorized entry into such areas or provide positive control over the activities within these areas. The RAD CON technicians failed to follow these requirements.

When the liner was lifted from the railroad bay to the refueling floor, the two RAD CON technicians covering the job lost sight (contact and coverage) of the liner. This was the first violation of TS 6.12.2 and RCI-13. In order to provide the required coverage, one of the two technicians proceeded to the refueling floor. The second technician remained in the railroad bay to cover the personnel in the bay. When the first technician arrived on the refueling floor, the technician could see down into the decontamination room where the liner was already being lowered. In the room was an individual (boilermaker) signaling the crane operator to lower the liner into the room. The individual did not have proper RAD CON coverage. This was the second violation of TS 6.12.2 and RCI-13. The technician on the refueling floor, realizing that the individual in the decontamination room did not have adequate RAD CON coverage, proceeded to the decontamination room to provide this coverage.

CAUSE OF EVENT

The cause of the event was personnel error by the two RAD CON technicians covering the liner transfer. The first violation occurred when the technician lost contact with the liner when it was transferred from the railroad bay to the decontamination room. The second occurred moments later when the liner was lowered into the decontamination room where an individual was present without adequate RAD CON coverage. The boilermaker entered the decontamination room without realizing that adequate RAD CON coverage did not exist.

Subsequent questioning of both technicians indicated that they were familiar with the requirements involved with high radiation areas, but the job did not receive adequate planning for the scope of the work involved.

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

ANALYSIS OF EVENT

This event is a failure to follow both units 1 and 2 TS 6.12.2 and is reportable in accordance with 10 CFR 50.73, paragraph a.2.i.B.

General area dose rates in the vicinity of the liner exceeded 1,000 mrem/hr. The highest dose rate was 2,500 mrem/hr at contact with the liner. The maximum dose received by any individual was 20 mrem. Review of the timesheets of RWP 87-0563-004 showed that no other individuals were involved. Further, the area was properly posted as a high radiation area. Plant operational mode did not affect this occurrence. At no time was the health and safety of the general public jeopardized.

CORRECTIVE ACTION

The RAD CON personnel involved with this event were counseled on procedural and TS compliance requirements. Further, RAD CON management have also been instructed to make arrangements and efforts to prevent the recurrence of this event by providing adequate training to technicians and planning jobs such that adequate coverage of liner transfer is maintained. The supplemental individual (the boilermaker) was also counseled to prevent recurrence of this event.

ADDITIONAL INFORMATION

Previous similar occurrences - Three - SQRO-50-327/85047, 86004, and 86052.

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TENNESSEE VALLEY AUTHORITY  
Sequoyah Nuclear Plant  
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July 2, 1987

U. S. Nuclear Regulatory Commission  
Document Control Desk  
Washington, DC 20555

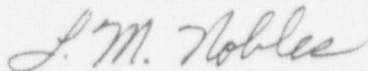
Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 1 - DOCKET NO.  
50-327 - FACILITY OPERATING LICENSE DPR-77 - REPORTABLE OCCURRENCE REPORT  
SQRO-50-327/87026

The enclosed licensee event report provides details concerning inadequate Radiological Control coverage in the transfer of radioactive waste caused by personnel error resulting in technical specification violation. This event is reported in accordance with 10 CFR 50.73, paragraph a.2.i.B.

Very truly yours,

TENNESSEE VALLEY AUTHORITY



L. M. Nobles  
Plant Manager

Enclosure  
cc (Enclosure):

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