## TENNESSEE VALLEY AUTHORITY

Browns Ferry Nuclear Plant Post Office Box 2000 Decatur, Alabama 35609-2000

August 18, 1989

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

Dear Sir:

TVA - BROWNS FERRY NUCLEAR PLANT (BFN) UNIT 2 - DOCKET NO. 50-260 - FACILITY OPERATING LICENSE DPR-52 - REPORTABLE OCCURRENCE REPORT BFR0-50-260/89024

The enclosed report provides details concerning a contract engineer entering a high radiation area without proper dose monitoring equipment. This report is submitted in accordance with 10 CFR 50.73 (a)(2)(i).

Very truly yours,

TENNESSEE VALLEY AUTHORITY

y. R. Bynum

Vice President Nuclear Power Production

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Enclosures cc (Enclosures): Regional Administration U.S. Nuclear Regulatory Commission Office of Inspection and Enforcement Region II 101 Marietta Street, Suite 2900 Atlanta, Georgia 30303

INPO Records Center Suite 1500 1100 Circle 75 Parkway Atlanta, Georgia 30339

NRC Resident Inspector, BFN

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#### U.S. NUCLEAR REGULATORY COMMISSION APPROVED OMB NO. 3150-0104

## LICENSEE EVENT REPORT (LER)

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

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES: 8/31/88

FACILITY NAME (1)

NRC Form 366A

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Description of Event

On July 18, 1989 at 1820 hours, a contract engineer was found alone inside a high radiation area posted around the unit 2 fuel pool cooling (FPC) (EIIS code DA) heat exchangers (HX) without a continuous reading dose rate warning device. The unit 2 reactor building elevation 621' FPC heat exchanger area has dose rates in excess of 100 millirems per hour (mR/hr). Browns Ferry Technical Specification (TS) 6.8.3.1, requires that any individual or group of individuals permitted to enter the area shall be provided with, or accompanied by, one or more of the following:

- a. A radiation monitoring device which continuously indicates the radiation dose rate in the areas.
- b. A radiation monitoring device which continuously integrates the radiation dose rate in the area and alarms when a preset integrated dose is received. Entry into such areas with this monitoring device may be made after the dose rate level in the areas has been established and personnel have been made knowledgeable of them.
- c. An individual qualified in radiation protection procedures who is equipped with a radiation dose rate monitoring device. This individual shall be responsible for providing positive control over the activities within the area and shall perform periodic radiation surveillances at the frequency specified by the facility Health Physicist in the Radiation Work Permit (RWP).

Contrary to the high radiation area entry requirements of the RWP and TS 6.8.3.1, the engineer did not have in his possession a digital alarming dosimeter (DAD), a dose rate instrument, nor was he accompanied by anyone who had one of these devices in their possession. A plant Radiation Control (RADCON) technician (utility, non-licensed) passing near the unit 2 FPC heat exchanger area noted that the worker was standing between the heat exchangers and asked what his DAD was reading. When the worker replied that he did not have a DAD, the technician knew he was in violation of the RWP requirements. The individual was immediately directed to leave the contaminated zone and subsequently the radiologically controlled area. The individual was properly signed on the RWP timesheet from 1740 hours to 1830 hours, and he received a 30 millirem dose during this entry.

Units 1 and 3 were defueled and unit 2 was in cold shutdown during this event.

### Cause of Event

The contract engineer failed to pay proper attention to and comply with the requirements stated on the RWP. The RWP contained the requirement of individuals entering posted high radiation areas to have a "dose warning device."

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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#### Cause of Event (continued)

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> The worker, who had entered the area for structural inspections, did not use the high radiation area posting at the FPC heat exchanger area boundary nor the RWP to determine the requirement for the dose warning device. He instead, indicated that the dose rate fields greater than 100 mR/hr, marked on the radiological survey map, were used as his guidance. Additionally, a new RWP form put into effect on July 17, 1989, presented requirements in a different format which may have added to his confusion. The same individual entered the same area earlier in the month and used a DAD on that occasion.

> The entire unit 2 FPC heat exchanger area was properly posted as a high radiation area. Based upon a random sampling of workers in the radiologically controlled area, there is no indication of a general lack of understanding of RWP requirements for work in high radiation areas or of RWP survey maps. The RWP form contained all the necessary information for the individual to perform his job and not violate the RWP or TS requirements.

#### Corrective Action

Upon exit from the high radiation area the worker's pocket chamber dosimeter reading was recorded. After properly processing through a Beta Max frisker (RA) and getting dressed, the worker reported to the RADCON lab to review the RWP requirements.

An incident investigation was conducted, and a radiological incident report was prepared for the event. The individual's thermoluminescent dosimeter (TLD) badge was pulled and read. The individual's Health Physics general training and protected area access were revoked to prevent his entry into the radiologically controlled area. Site management does not expect to reinstate security clearance for the worker.

RADCON shift coverage is amply provided to resolve any confusion about RWP requirements before entering radiation or contaminated areas. No further corrective actions are planned.

### LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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FACILITY NAME (1)

NRC Form 366A

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#### Analysis of Event

The unit 2, elevation 621' FPC heat exchanger area is a high radiation area with the maximum whole body dose rate of 110 mR/hr. Under the criteria of 10 CFR 50.73(a)(2)(i)B, this event is reportable as a violation of plant TS 6.8.3.1. Although this event violated RWP and TS requirements, the individual did not approach any dose limits. The individual's exposure time was less than one hour and his pocket dosimeter indicated that he received 30 millirems while in the area. Subsequent to this incident the individual's TLD was processed and he was assigned a total dose for the quarter of 145 millirems.

### Previous Similar Events

It was subsequently determined that the same individual worked in the unit 2 FPC heat exchanger area the previous evening also without a DAD. The last similar event occurred in 1983 when a RADCON technician carrying a survey meter strayed from other individuals in the group he accompanied. The corrective action for that event was the requirement for individual DADs for each person.

#### Commitments

All corrective actions were completed by July 24, 1989. There are no commitments.

## CONCURRENCE SHEET

DOCUMENT NAME: _	LER 260/89024	
ORIGINATING ORG:	Browns Ferry Nuclear Plant	
DOCUMENT PREPARED	BY: Stephen C. Willard	DATE:

ACCESSION NO.:

CONCURRENCES						
NAME	SIGNATURE - COMMENT	DATE				
Preparer Steve Willard	Stawillal	8-10-89				
Reviewer Lawry Newman	Larry Newman	8/11/89				
PORC Chairman	Sup Chapter	8/14/89				
Plant Manager	Buy & Capter	8/14/89				
Site Director	Of Lumque	8/15/89				

# Instructions

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3. Other instructions.