

CONTROL NO. 12601

FILE: INCIDENT 50-289

FROM: Metropolitan Edison Co. Reading, PA. R.C. Arnold		DATE OF DOC 10-29-75	DATE REC'D 11-3-75	LTR XXX	TWX	RPT	OTHER
TO: NRC		ORIG 1 Signed	CC 0	OTHER	SENT AEC FOR XXX		
CLASS XXX		PROP INFO	INPUT	NO CYS REC'D 1		DOCKET NO: 50-289	

DESCRIPTION:
Abnormal Occurrence # 75-36, on 10-19-75,
Concerning Failure of an auxiliary operator....

ENCLOSURES:

POOR ORIGINAL

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PLANT NAME: Three Mile Island

FOR ACTION INFORMATION

SAB 11-5-75

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METROPOLITAN EDISON COMPANY

POST OFFICE BOX 542 READING, PENNSYLVANIA 19603

TELEPHONE 215 - 929-3601

October 29, 1975
CGL 1655

Director of Nuclear Reactor Regulation
Division of Reactor Licensing
U. S. Nuclear Regulatory Commission
Washington, D.C. 20555

Dear Sir:

Docket No. 50-289
Operating License No. DPR-50

In accordance with the Technical Specifications of our Three Mile Island Nuclear Station Unit 1 (TMI-1), we are reporting the following abnormal occurrence.

- (1) Report Number: AO 50-289/75-36
- (2a) Report Date: October 29, 1975
- (2b) Occurrence Date: October 19, 1975
- (3) Facility: Three Mile Island Nuclear Station Unit 1
- (4) Identification of Occurrence:

Title: Failure of an auxiliary operator to obtain a Radiation Work Permit and carry a radiation monitoring device upon entrance to a High Radiation Area.

Type: An abnormal occurrence as defined by the Technical Specifications, paragraph 1.8g, in that an auxiliary operator did not obtain a Radiation Work Permit nor carry a radiation monitoring device which continuously indicates the radiation dose rate upon entrance to a High Radiation Area, which constitutes a violation of Technical Specification 6.6.2.a.

- (5) Condition Prior to Occurrence:

Power: Core: 0%

Elec.: 0

RC Flow: 139×10^6 lb/hr.

RC Pressure: 2155 psig

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RC Temp.: 535°F

PRZR Level: 120"

PRZR Temp.: 650°F

(6) Description of Occurrence:

On October 19, 1975, an auxiliary operator was ordered to isolate, vent, and drain the Makeup and Purification System's Prefilter MU-F-2A for filter replacement. The auxiliary operator was informed that a Radiation Work Permit was issued for this job and that it should be confirmed in the Health Physics Laboratory and the applicable procedures followed.

Upon arrival at the Health Physics Laboratory, the auxiliary operator observed that no health physics personnel were in the area. Having knowledge that a Standing Radiation Work Permit existed for the work area, the auxiliary operator proceeded to proceed with the venting, draining, and tagging operation without discussing it with the health physics personnel. The auxiliary operator assumed that the levels of radiation shown on the Standing Radiation Work Permit covered the area that contained the filter as well as the valve alley. The permit only covered the valve alley.

After completing the assignment, the auxiliary operator observed an off scale reading on his self-reading dosimeter. The auxiliary operator locked the area and notified the Shift Supervisor, who instructed the Radiation Chemistry Technician to evaluate the auxiliary operator's Thermoluminescent Dosimeter (TLD). A reading of 1260 mrem (Whole Body Gamma) was confirmed. Further, it should be noted that the individual's film badge indicated a dose of 1910 mrem \pm 382 and the TLD reading is considered to be more accurate at 1260 \pm 126 mrem.

Within one hour of the incident, the Unit Superintendent held a meeting with the Radiation Protection Supervisor and all the individuals involved to determine the cause of the high exposure. An investigating committee was convened by the Unit Supervisor to investigate the circumstances surrounding the incident and recommend appropriate corrective actions to preclude future occurrences.

(7) Designation of Apparent Cause of Occurrence:

The cause of this occurrence has been determined to be personnel/procedure in that the proper Administrative and implementing procedures were not followed to perform the above described operation. Additionally, the requirement for a radiation monitoring device which continuously indicates the radiation dose rate in the area was not fulfilled.

(8) Analysis of Occurrence:

It has been determined that this occurrence did not constitute a threat to the health and safety of the public in that only the subject auxiliary operator was involved, and his exposure was less than 3 rem/calendar quarter.

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(9) Corrective Action:

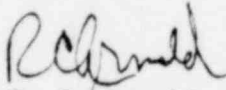
In addition to the immediate action described above, long term corrective actions are as follows:

- a. Procedural changes have been initiated to increase Administrative controls for entry into areas greater than 1000 mR/hr.
- b. Installation of a window in the locker door of the Makeup & Purification Prefilter Valve Alley to eliminate entry into area for routine shift checks will be evaluated.
- c. The installation of the filters and piping will be reviewed to determine if external manual operators can be installed on the drain valves of MU-F2A and MU-F2B (Makeup and Purification System Prefilters).
- d. Additional training will be conducted for all personnel in the areas of Radiation Work Permits and Administrative Controls for entry into areas greater than 1000 mR/hr.
- e. Procedure changes will be initiated to clearly state that dose rate indicating instruments must be carried in all areas in which radiation levels exceed 100 mR/hr.
- f. Areas with radiation levels greater than 100 mR/hr. will be posted with signs indicating the requirements to carry dose rate indicating instruments upon entry.

(10) Failure Data: Not applicable.

Similar Occurrences: None

Sincerely,



R. C. Arnold
Vice President

RCA:JMC:tas

cc: Office of Inspection and Enforcement, Region 1

File: 20.1.1 / 7.7.3.5.1

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