



**Florida
Power**
CORPORATION

July 22, 1994
3F0794-11

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

Subject: Licensee Event Report (LER) 94-003-00

Dear Sir:

Attached is Licensee Event Report (LER) 94-003-00 which is submitted in accordance with 10 CFR 50.73.

Sincerely,

G.L. Boldt
Vice President
Nuclear Production

GLB/JAF:ab

Attachment

xc: Regional Administrator, Region II
Project Manager, NRR
Senior Resident Inspector

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A Florida Progress Company

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LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HOURS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON DC 20503.

FACILITY NAME (1)

CRYSTAL RIVER UNIT 3 (CR-3)

DOCKET NUMBER (2)

0 5 0 0 0 3 0 2 1 OF 0 4

PAGE (3)

TITLE (4)

Personnel Error Leads to Entry into a High Radiation Area without Proper Dosimetry Equipment and Violation of Technical Specifications

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)										
0	6	1	5	9	3	9	4	0	0	3	0	0	0	0	0	0	0	0	0	0
N/A										0	5	0	0	0	0	0	0	0	0	0

OPERATING MODE (9)

1

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (CHECK ONE OR MORE OF THE FOLLOWING) (11)

POWER LEVEL (10)

1 0 0

20.402(b)

20.405(a)(1)(i)

20.405(a)(1)(ii)

20.405(a)(1)(iii)

20.405(a)(1)(iv)

20.405(a)(1)(v)

20.405(c)

50.36(c)(1)

50.36(c)(2)

50.73(a)(2)(i)

50.73(a)(2)(ii)

50.73(a)(2)(iii)

50.73(a)(2)(iv)

50.73(a)(2)(v)

50.73(a)(2)(vi)

50.73(a)(2)(vii)(A)

50.73(a)(2)(vii)(B)

50.73(a)(2)(x)

73.71(b)

73.71(c)

OTHER (Specify in Abstract below and in Text, NRC Form 306A)

LICENSEE CONTACT FOR THIS LER (12)

NAME

K. R. Wilson, Nuclear Licensing Manager

TELEPHONE NUMBER

AREA CODE

9 0 4 5 6 3 - 4 5 4 9

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

SUPPLEMENTAL REPORT EXPECTED (14)

EXPECTED SUBMISSION DATE (15)

MONTH DAY YEAR

YES (If yes, complete EXPECTED SUBMISSION DATE)

X

NO

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

On June 15, 1993, Florida Power Corporation's (FPC) Crystal River Unit 3 (CR-3) was in MODE 1 (POWER OPERATION), operating at 100% reactor power and generating 862 megawatts. A contract employee entered the Auxiliary Building Triangle Room, posted as a "High Radiation Area", without a dose rate meter or an alarming dosimeter, contrary to the requirements of Technical Specification 6.12.1. The individual had properly logged onto the appropriate Radiation Work Permit (RWP).

After realizing that he was in a High Radiation Area without the proper dosimetry equipment he exited the area and Health Physics (HP) personnel were notified of the event. A subsequent survey performed by HP technicians determined that the highest dose rate in the area traversed by the individual was 7 millirem/hour. Personal dosimeter data indicated that the individual received a dose less than the lower limit of detection. The root cause of this event was an isolated personnel error. Corrective actions include counseling the individual and a review of this event by engineering personnel. This report is submitted in accordance with 10CFR50.73(a)(2)(i)(B).

The delay in reporting this event is attributed to a series of two separate administrative errors. Corrective actions have been implemented to prevent recurrence of these delay problems.

EXPIRES 5/31/95

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HOURS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON DC 20503.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (3)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
CRYSTAL RIVER UNIT 3 (CR-3)	0 5 0 0 0 3 0 2	9 4	0 0 3	0 0	0 2 OF 0 4

TEXT (If more space is required, Use additional NRC Form 308A's (17)

EVENT DESCRIPTION:

On June 15, 1993, Florida Power Corporation's (FPC) Crystal River Unit 3 (CR-3) was in MODE 1 (POWER OPERATION), operating at 100% reactor power and generating 862 megawatts. A contract employee entered the Auxiliary building Triangle Room, posted as a "High Radiation Area", without a dose rate meter or an alarming dosimeter, contrary to the requirements of a Radiation Work Permit (RWP), an approved procedure, and technical Specification 6.12.1.

Prior to entering the Radiation Controlled Area (RCA), the individual donned proper protective clothing, and logged onto RWP 93-0018. However, he did not comply with two of the RWP requirements. Specifically, the two requirements he did not adhere to were: "Follow all posted radiological instructions" and "Dose rate instrument, alarming dosimeter, or HP (Health Physics) escort required to enter a posted High Radiation Area".

After entering the RCA, in order to enter the Triangle Room the individual crossed a step off pad and passed through a swing gate. A radiological posting affixed to the gate provided the following information: "High Radiation Area"; "Survey Instrument Required for Entry"; and "Contaminated Area". Immediately upon realizing that he had entered a high radiation area without the proper dosimetry equipment the individual exited the high radiation area with the intention of notifying the HP office of the situation. As he approached the step-off pad and began to remove his protective clothing he was then observed by a second radiation worker who then questioned the individual about his lack of required dosimetry equipment and reported his observation to the HP office.

A subsequent survey performed by HP technicians determined that the highest dose rate in the area traversed by the individual was 7 millirem/hour (mrem/hr). No other high radiation area was entered by the individual, and when he exited the RCA his personal dosimetry equipment, a pocket ion chamber, (PIC) indicated 0 mrem. An analysis of his primary dosimetry equipment, a thermoluminescent dosimeter (TLD) later verified that the individual received a radiation dose less than the lower limit of detection. The individual was questioned concerning his knowledge and understanding of the applicable procedures, RCA entry and RWP requirements. Based on his correct responses to questions regarding these activities it was determined that the root cause of this event was an isolated personnel error.

The contract employee was performing work for the engineering department and had been trained and badged as a radiation worker since September 1992. The conduct of personnel and performance of activities within the RCA, and specifically within a high radiation area, is well documented and procedurally governed.

This report is submitted in accordance with 10CFR50.73(a)(2)(i)(B).

EXPIRES 5/31/95

LICENSEE EVENT REPORT (LER)
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		0 5 0 0 0 3 0 2	9 4	0 0 3	

TEXT (If more space is required, Use additional NRC Form 305A's (17))

The delay in reporting this event is attributed to a series of two administrative errors. The first was the failure to identify this event as reportable and upon its reclassification as reportable, the second error was in not forwarding the reportable Problem Report, the initiating document for a Licensee Event Report (LER), for preparation and submittal of an LER. Corrective actions have been implemented to prevent recurrence of these delay problems.

EVENT EVALUATION

This event involved one individual briefly entering a high radiation area (greater than 100 mrem/hr). Since the maximum dose rate in the area traversed by the individual was 7 mrem/hr, and no other high radiation area was entered by the individual, his exposure was minimal. This was verified by his personal dosimetry equipment (PIC) and primary dosimetry equipment (TLD), both indicating that the individual had received a radiation dose less than the lower limit of detection.

This event could have had the potential to present a safety hazard to the single individual involved if he would have spent an inordinate period of time in the area, and/or the area would have had substantially higher dose rates.

This event had no effect on the health and safety of the general public.

CAUSE

The cause of this event was personnel error by a contract employee, contrary to the requirements of an RWP, an approved procedure, and Technical Specification 6.12.1. It is considered to be an isolated event. The individual was properly trained and understood the procedure and was familiar with both the RCA and the RWP under which he was working since he enters the RCA approximately once per month. However, during his entries into the RCA he does not routinely enter any high radiation areas, and therefore does not normally carry a dose rate meter or an alarming dosimeter. This may have contributed to his error.

CORRECTIVE ACTION

Corrective actions for this event include the following:

1. The employee and his supervisor met with the Director, Nuclear Plant Operations to discuss this event and reviewed the regulatory implications and importance of compliance with all plant radiological program requirements to personnel safety.

EXPIRES 5/31/95

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REGULATION: 50.0 HOURS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON DC 20503.

FACILITY NAME (1)

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CRYSTAL RIVER UNIT 3 (CR-3)

YEAR

SEQUENTIAL
NUMBERREVISION
NUMBER

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TEXT (If more space is required, Use additional NRC Form 386A's (17))

2. The Manager, Nuclear Operations Engineering (NOE) has discussed with all NOE engineering personnel the circumstances surrounding this event. He reiterated the regulatory implications and importance of compliance with all plant radiological program requirements to personnel safety. He addressed the potential for numerous entries under the same RWP to cause complacency about reading and thoroughly understanding all RWP requirements as they relate to each particular entry.

PREVIOUS SIMILAR EVENTS

There have been two previous reportable occurrences involving personnel error and high radiation areas. These events were reported in LER 85-021 and LER 87-024.