



Omaha Public Power District  
444 South 16th Street Mall  
Omaha NE 68102-2247

June 27, 1997  
LIC-97-0100

U. S. Nuclear Regulatory Commission  
Attn: Document Control Desk  
Mail Station P1-137  
Washington, DC 20555

Reference: Docket No. 50-285

Subject: Licensee Event Report 97-005 Revision 0 for the Fort Calhoun  
Station

Please find attached Licensee Event Report 97-005 Revision 0 dated  
June 27, 1997. This report is being submitted pursuant to  
10 CFR 50.73(a)(2)(i)(B). If you should have any questions, please  
contact me.

Sincerely,

S. K. Gambhir  
Division Manager  
Engineering & Operation Support

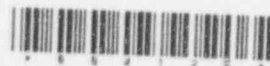
EPM/epm

Attachment

c: Winston and Strawn  
E. W. Merschhoff, NRC Regional Administrator, Region IV  
L. R. Wharton, NRC Project Manager  
W. C. Walker, NRC Senior Resident Inspector  
INPO Records Center

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## LICENSEE EVENT REPORT (LER)

(See reverse for required number of  
digits/characters for each block)ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY  
INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED  
ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO THE  
INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE  
INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), 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)

Fort Calhoun Station Unit No. 1

DOCKET NUMBER (2)

05000285

PAGE (3)

1 OF 3

TITLE (4)

Improper Entry into a High Radiation Area

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 NAME	DOCKET NUMBER
05	30	97	97	-- 005	-- 00	06	27	97		05000
OPERATING MODE (9)		1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR§ (Check one or more) (11)							
POWER LEVEL (10)		85	20.2201(b)		20.2203(a)(2)(v)		<input checked="" type="checkbox"/>		50.73(a)(2)(i)	50.73(a)(2)(viii)
			20.2203(a)(1)		20.2203(a)(3)(i)				50.73(a)(2)(ii)	50.73(a)(2)(x)
			20.2203(a)(2)(i)		20.2203(a)(3)(ii)				50.73(a)(2)(iii)	73.71
			20.2203(a)(2)(ii)		20.2203(a)(4)				50.73(a)(2)(iv)	OTHER
			20.2203(a)(2)(iii)		50.36(c)(1)				50.73(a)(2)(v)	Specify in Abstract below or in NRC Form 366A
			20.2203(a)(2)(iv)		50.36(c)(2)				50.73(a)(2)(vii)	

## LICENSEE CONTACT FOR THIS LER (12)

NAME  
Scott A. Lindquist, Shift Technical AdvisorTELEPHONE NUMBER (Include Area Code)  
(402) 533-6829

## 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)

YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
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## ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

At approximately 1500 on May 30, 1997, with Fort Calhoun Station operating in Mode 1 with a power ascension in progress. An equipment operator entered a High Radiation Area (HRA) without an integrating alarming dosimeter. This is a violation of Technical Specification 5.11.1. Technical Specification 5.11.1 provides for HRA access controls which are approved alternatives to the requirements of 10 CFR 20.1601(a).

This event was caused by a lack of self-checking and inattention to detail on the part of the individual involved.

Corrective actions include, discussion of this event with plant staff and disciplinary action taken against the individual involved.

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Fort Calhoun Station Unit No. 1	05000285	97	- 005	- 00	2 OF 4

TEXT (if more space is required, use additional copies of NRC Form 366A) (17)

## BACKGROUND

Fort Calhoun Station (FCS) Technical Specification (TS) 5.11.1 provides for High Radiation Area (HRA) access controls which are approved alternatives to the requirements of 10 CFR 20.1601(a). One of the requirements specified for dose measurement is that any individual or group entering a HRA be provided with a radiation monitoring device which continuously integrates the radiation dose rate in the area and alarms when a preset integrated dose is received (FCS uses a device whose trade name is "ALNOR"). This requirement is reflected in Radiation Protection (RP) procedure RP-204 "Radiological Area Controls" and appropriate Radiation Work Permits (RWP), and is normally met through the use of an ALNOR integrating alarming dosimeter. RWP 97-0002 specifically details radiological requirements for routine auxiliary building operations.

## EVENT DESCRIPTION

On May 30, 1997 the plant was operating in Mode 1 with a power ascension in progress. At 0600 the on-coming day shift operating crew received a pre-shift brief on plant status by the off-going Shift Supervisor. At about 0615 the on-coming auxiliary building operator proceeded to the RP sign-in desk, signed in on the appropriate RWP (RWP 97-0002) and obtained an ALNOR. The on-coming operator then relieved the off-going auxiliary building operator and commenced normal auxiliary building duties.

At approximately 0850 the auxiliary building operator was relieved by another auxiliary building operator in order to attend an offsite requalification physical scheduled for that day. The operator then signed out of RWP 97-0002 and returned the ALNOR to its charging rack.

Upon returning to the plant site following the physical, the operator received a turnover in the Operations Control Center (OCC) and resumed auxiliary building operator duties at approximately 1245. At approximately 1300 the operator entered the Radiation Controlled Area (RCA) not realizing he had failed to re-sign in on RWP 97-0002 and obtain an ALNOR. At approximately 1325 the operator exited the RCA after performing routine operations in non-HRA of the auxiliary building and reported to the Control Room.

At approximately 1430 the operator re-entered the RCA without being signed in on a RWP and without an ALNOR. At approximately 1500 the operator entered HRA Room 7, the charging pump valve room, to assist in the performance of Waste Holdup Tank level instrument flushes. At approximately 1510 the operator attempted to check his dose on the ALNOR digital readout and realized that he had failed to sign in on a RWP and was without an ALNOR. The operator

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TEXT (if more space is required, use additional copies of NRC Form 366A) (17)

immediately exited the HRA and informed the Shift RP Technician and the Control Room Shift Supervisor of the situation. Operations, Radiation Protection, Plant Management and the Senior Resident NRC Inspector were notified of this event. The operator dose for this entry was estimated to be 5 millirem. The operator was excluded from the RCA and his thermoluminescent dosimeter (TLD) was sent off-site for dose assessment. The TLD reading was 4 millirem less than the sum of the ALNOR readings during the same period confirming the accuracy of the estimated dose for the unmonitored entry.

This event constituted a failure to comply with the HRA entry requirements of TS 5.11.1. This report is submitted pursuant to the requirements of 10 CFR 50.73 (a) (2) (i) (B).

## SAFETY ASSESSMENT

The inappropriate monitoring of this individual did not adversely affect nuclear safety or the health and safety of the public. No overexposure resulted from this error.

## CONCLUSIONS

This event was caused by a lack of self-checking and inattention to detail on the part of the individual involved. At the FCS RCA access point there is a talking sign, activated by a motion sensor, which asks if you have an ALNOR and if it is on. This is intended to remind individuals entering the RCA to perform self-checking to ensure they have signed in on an RWP and have an ALNOR. Station Standing Order G-101 "Radiation Work Practices" requires individuals working in the RCA to frequently check their dosimetry.

## CORRECTIVE ACTIONS

The following corrective actions have been taken to prevent occurrence of a similar event.

1. The oncoming operating crews were briefed on the event as part of shift turnover.
2. A memorandum was issued by the Operations Manager to all Operations Department personnel on RCA entry requirements and expectations on frequently checking dosimetry.

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TEXT (if more space is required, use additional copies of NRC Form 366A) (17)

3. This event was discussed with plant staff during Human Performance Day on June 11, 1997.
4. The individual involved was counseled and disciplinary action was administered in accordance with Omaha Public Power District (OPPD) Policy.

**PREVIOUS SIMILAR EVENTS**

There have been several events similar to this at FCS including: LERs 89-005 and 89-023 describing failure to comply with HRA entry requirements.