

QCB

PRELIMINARY NOTIFICATION

August 7, 1979

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE--PNO-79-311

This preliminary notification constitutes EARLY notice of events of POSSIBLE safety or public interest significance. The information presented is as initially received without verification or evaluation and is basically all that is known by IE staff on this date.

Facility: Metropolitan Edison Company
Three Mile Island, Unit 2
Middletown, Pennsylvania
(Docket No. 50-320)

Subject: WORKER OVERCOME DURING RESPIRATOR USAGE

At about 2:10 a.m. on August 7, 1979, a contractor supervisor fainted while wearing supplied air respiratory protection equipment. The individual had been supervising work on the alternate decay heat tie-in, a recovery system in Unit 2 Auxiliary Building and was leaving the area when he collapsed. The individual pulled off his respirator just before collapsing. The individual was placed on a stretcher and transported to the health physics control point. Site first aid responded and an ambulance from offsite was dispatched.

Health physics technicians removed his outer paper coveralls. The individual had been working in three sets of coveralls; plastic, cloth, and paper. Prior to the ambulance leaving for the hospital (the Hershey Medical Center), the licensee notified the hospital that a potentially contaminated individual was being sent.

The individual regained consciousness on the way to the hospital.

The licensee dispatched health physics personnel to the hospital to provide radiological assistance. The health physics personnel monitored the hospital treatment area, equipment, the ambulance, attending hospital personnel, the ambulance attendant and the patient. The patient, the ambulance attendant, and the sheets and intravenous apparatus used for treatment of the patient were found to be contaminated up to 66,000 dpm (disintegrations per minute).

After examination, the hospital released the individual who returned to the site with the ambulance attendant for decontamination. The contaminated sheets and intravenous apparatus were disposed of as solid radioactive waste onsite.

The licensee has removed the respirator equipment, which the individual was using at the time, from service and plans to investigate to determine whether the equipment caused or helped to cause the incident. The thermal load on the individual due to wearing three pair of coveralls in a thermally hot work area may also have been a contributing factor.

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Media interest is expected because of the sensitivity to Three Mile Island activities. The Commonwealth of Pennsylvania has been informed. A press release is planned by the licensee.

NRC Region I, (Philadelphia) received notification of this occurrence by a telephone call from the head Radiation Specialist, IE Resident Office - TMI 2, at 9:10 a.m. on August 7, 1979.

Contact: EDFlack, IE x28188 LBHigginbotham, IE x28188

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