NON-PUBLIC?: N
ACCESSION #: 8609240027
LICENSEE EVENT REPORT (LER)

FACILITY NAME: Three Mile Island Unit 2 PAGE: 1 of 4

DOCKET NUMBER: 05000320

TITLE: Contaminated Tripod Discovered in Dumpster in an Unrestricted Area
EVENT DATE: 07/15/86 LER #: 86-006-01 REPORT DATE: 08/12/86

OPERATING MODE: N POWER LEVEL: 000

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR: 20.405(a)(1)(v)

LICENSEE CONTACT FOR THIS LER:
NAME: Russell D. Wells, TMI-2 Licensing Engineer TELEPHONE: 717-948-8244

SUPPLEMENTAL REPORT EXPECTED: NO

ABSTRACT: At 1400 hours on Tuesday, July 15, 1986, during a routine survey by Radiological Controls personnel, a contaminated camera tripod was discovered in a scrap metal dumpster in an unrestricted area. The smear samples of the tripod indicated that the removable surface contamination level ranged from 8,000 to 12,000 dpm/lOO cm2 (beta-gamma) with a maximum exposure rate of 0.8 mR/hr (gamma). The contamination level was in excess of ten (10) times the limits established in the GPU Nuclear Corporation Radiation Protection Plan which is a TMI-2 Licensing Basis Document per the Technical Specification; therefore, this event is reportable pursuant to 10 CFR 20.4O5(a)(1)(v).

The root cause of this event was the failure, by a person or persons unknown to properly implement the established controls for transferring contaminated materials from a controlled area to an unrestricted area. The dumpster was last surveyed on July 7, 1986; thus, this event occurred after that date. The origin of the tripod, the method of transport and responsible personnel could not be determined.

The tripod and dumpster were decontaminated and the dumpster was re-surveyed on July 16, 1986. It was found to be within acceptable limits. This event was highlighted at the monthly TMI-2 Radiological Awareness Meeting on July 16, 1986. This event was discussed with the TMI-2 Department Managers at the Office of the Director Staff Meeting on July 24, 1986. Further, this event will be discussed with Radiological Controls personnel and a follow-up discussion of this event will be held at the next Radiological Awareness Meeting.

TEXT:

I. PLANT OPERATING CONDITIONS BEFORE THE EVENT

The TMI-2 facility is in a long-team cold shutdown state; the defueling evolution is in progress. The Reactor decay heat was being removed via loss to ambient. Throughout this event there was no effect on the Reactor Coolant System or the core.

II. STATUS OF STRUCTURES, COMPONENTS, OR SYSTEMS THAT WERE INOPERABLE AT
THE START OF THE EVENT AND THAT CONTRIBUTED TO THE EVENT

N/A

III. EVENT DESCRIPTION

At 1400 hours on Tuesday, July la, 1986, during a routine survey by Radiological Controls personnel, a contaminated camera tripod was discovered in a scrap metal dumpster in an unrestricted area. The duty Group Radiological Controls Supervisor was notified and the dumpster was posted as a radiologically controlled area. The tripod was removed from the dumpster and moved inside the protected area to be surveyed. Smear samples indicated that the removable surface contamination level of the tripod ranged from 8,000 to 12,000 dpm/lOO cm2 (beta-gamma) with a maximum exposure rate of 0.8 mR/hr (gamma).

Section 8.2 of the GPU Nuclear Corporation Radiation Protection Plan specifies a limit of 1000 dpm/lOO cm2 (beta-gamma) for removable surface contamination for unrestricted releases of materials and equipment. 10 CFR 2O.4Oa(a)(1)(v) requires licensees to report, within 30 days, "Levels of radiation or concentration of radioactive material (whether or not involving excessive exposure of any individual) in an unrestricted area in excess of ten times any applicable limit set forth in this part or in the license."

The GPU Nuclear Corporation Radiation Protection Plan is a TMI-2 Licensing Basis Document, per the TMI-2 Technical Specifications, and has been approved by the NRC. Therefore, this event is reportable pursuant to 10 CFR 20.4O5(a)(1)(v) since the contamination levels of the tripod, which was located in an unrestricted area, were in excess of ten times the limit set forth in that plan.

GPU Nuclear has determined that the dumpster containing the contaminated tripod was last surveyed on July 7, 1986, at which time no radiological contamination was detected. Thus, this event occurred between

the period of July 7, 1986 to July 15, 1986 (i.e., the discovery date of this event).

TEXT:

IV. ROOT CAUSE OF THE EVENT

The root cause of this event was the failure by a person or persons unknown to properly implement the established controls for transferring contaminated material from a controlled area to an in order to determine the causal details of this event:

o Personnel were interviewed and purchasing records were reviewed in order to determine if there was any evidence of missing tripods.

o Workers in shops an the vicinity of the dumpster were interviewed.

o Interviews were conducted with drivers of vehicles transmitting through the protected area between July 7, 1986 and July la, 1986, who routinely carry trash or contaminated materials.

o Decontamination workers who removed stored materials from the 281 elevation of the Auxiliary Building were interviewed.

o Waste Management personnel responsible for equipment storage areas were interviewed.

o Surveys were taken of facilities in proximity to the dumpster.

Based on the above actions, GPU Nuclear has been unable to determine the origin of the tripod, the method of transport from the controlled area to the unrestricted area, or the responsible personnel.

V. CORRECTIVE ACTIONS

Immediate - The camera tripod and dumpster were decontaminated and have been released for unrestricted use. The dumpster was re-surveyed on July 16, 1986 and was observed to be within acceptable radiological limits. This event was highlighted at the monthly TMI-2 Radiological Awareness Meeting on July 16, 1986. This event was also discussed with the TMI-2 Department Managers at the Office of the Director Staff Meeting on July 24, 1986.

Long-Term - This event will be discussed with Radiological Controls Personnel to stress the importance of answering proper surveys when transporting equip-

ment and materials from a controlled area to an unrestricted area. Additionally a follow-up discussion of this event will be held at the next TMI-2 Radiological Awareness Meeting.

TEXT:

VI. COMPONENT FAILURE DATA
N/A

VII. AUTOMATIC OR MANUALLY INITIATED SAFETY SYSTEM RESPONSES
N/A

VIII. ASSESSMENT OF THE SAFETY CONSEQUENCES AND IMPLICATIONS OF THE EVENT

This event was discovered as a result of the Radiological Controls Department's continuing program to survey trash dumpsters on a routine basis. The measured contamination levels and dose rates of the tripod were sufficiently low as to not constitute a significant personnel exposure hazard.

GPU NUCLEAR CORPORATION
Post Office Box 480
Route 441 South
Middletown, Pennsylvania 17057-0191
717-944-7621
TELEX 84-2386
Writer's Direct Dial Number

(717) 948-8461

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September 18, 1986

US Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

Dear Sir:

Three Mile Island Nuclear Station, Unit 2 (TMI-2)
Operating License No. DPR-73

Docket No. 50-320
Licensee Event Report 86-06

Attached is an update to Licensee Event Report 86-06 concerning a contanunated camera tripod discovered in an unrestricted area on July 15, 1986. This update is being submitted to reflect corrections in Section IV, "Root Cause of the Event" and Section VIII, "Assessment of the Safety Consequences and Implications of the Event" of the report.

This event was considered reportable pursuant to Title 10 of the Code of Federal Regulations, Section 20.405(a) (l)(v).

Sincerely

F. R. Standerfer
Vice President/Director, TMI-2

FRS/RDW/eml

Attachments

cc: Regional Administrator - Office of I & E, Dr. T. E. Murley
Director - TMI-2 Cleanup Project Directorate, Dr. W. D. Travers

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