

**ILLINOIS POWER** *orig + 1*

PRIORITY ROUTING	
First	Second
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✓ DRA <i>hac</i>	EIC
✓ DRP	SGA
✓ DRS <i>hac</i>	OI
DNMS	PAO
DRMA	

FILE *hac*

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Clinton, IL 61727  
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*Public*

U-602688  
1A.120

January 29, 1997

Docket No. 50-461

10CFR30.9(b)

Mr. A. Bill Beach  
Regional Administrator  
Region III  
U. S. Nuclear Regulatory Commission  
801 Warrenville Road  
Lisle, Illinois 60532-4351

Subject: Deliberate Misuse of Licensed Material

Dear Mr. Beach:

The purpose of this letter is to provide a follow-up to the telephone notification provided to Mr. James L. Caldwell of your staff by myself on January 28, 1997 at 1300 hours, related to a potential deliberate misuse of licensed material at the Clinton Power Station (CPS). Pursuant to 10CFR30.9(b) and as exemplified in NRC Information Notice 95-51, "Recent Incidents Involving Potential Loss of Control of Licensed Material," a notification shall be provided to the Administrator of the appropriate Regional Office within two working days if deliberate misuse of licensed material is suspected.

The facts related to the potential misuse of licensed material which were provided to Mr. Caldwell are as follows:

On January 27, 1997, at approximately 2230 hours, a Radiation Protection (RP) technician exiting the CPS radiologically controlled area (RCA) at the Service Building RCA egress point alarmed the personnel contamination monitor (PCM). The alarming PCM indicated contamination of the head and forehead zones. After acknowledging the PCM alarm, the RP technician proceeded to a portable RM-20 frisker to perform a frisk of the head and forehead areas. The results of the frisk indicated approximately 100-150 corrected counts per minute (ccpm) contamination in the head and brow area. The RP technician proceeded to the RP counting room on the 737 foot elevation of the Turbine Building where his hardhat was located for the purpose of performing a

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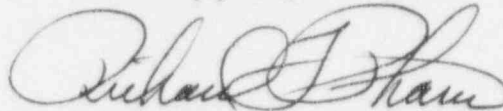
contamination survey of the hardhat (the hardhat had been removed just prior to entering the RCA egress area). Upon retrieving his hardhat, the RP technician observed a smear fixed to the inner shell of the hardhat directly behind the hardhat sweatband. The RP technician removed the hardhat sweatband and the smear. The RP technician performed a survey of the smear with survey results indicating 500 ccpm contamination. Subsequent to the above, the following actions were taken:

- The RP technician notified the Radiation Protection Shift Supervisor (RPSS) of the circumstances discussed above.
- The subject RP technician successfully performed a self-personal decontamination and exited the RCA after performing a whole body frisk via an RCA egress point PCM.
- A CPS Condition Report was generated to document the event.
- The Supervisor-Radiological Operations was notified of the event at approximately 2315 hours.
- The Operations Shift Supervisor was notified of the event at approximately 2330 hours.
- After reviewing CPS procedure 1909.20, "Radiological Reporting to Regulatory Agencies," the RPSS determined that the event involved the potential misuse of licensed material which requires that a report be made to the Region III Regional Administrator within two days pursuant to 10CFR30.9(b) and 10CFR30.10.
- The Operations Shift Supervisor notified the Supervisor-Licensing Administration of the event. The Supervisor-Licensing Administration concurred with the reporting requirement as defined in CPS procedure 1909.20.
- Notifications were made to the Director-Plant Radiation and Chemistry, the CPS Plant Manager, and the CPS NRC Resident Inspector.
- A search was performed of hardhats in the CPS RCA to determine if other potential deliberate misuses of licensed material could be identified. No other instances were identified as a result of this search.
- A gamma isotopic analysis of the subject smear was performed. The results of this analysis indicated isotopes commonly found in CPS waste streams.

The hardhat, the hardhat sweatband, and the contaminated smear were confiscated by the RPSS and are now in the possession of the Supervisor-Radiological Operations pending an investigation of this event. The services of Mr. Gene Pawlick, former Office of Investigation Field Office Director, Region III, have been obtained to perform an investigation of the potential deliberate misuse of licensed material. Mr. Pawlick has begun his investigation.

While no safety consequences to the affected individual occurred as a result of the events described above, CPS management considers this a very serious event and will take every step necessary to determine the circumstances surrounding the contamination event. The results of Mr. Pawlick's investigation and any CPS actions taken as a result will be provided to your office.

Sincerely yours,



Richard F. Phares  
Manager - Nuclear Assessment

MAR/krk

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Illinois Department of Nuclear Safety