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SUBJECT: LER 89-001-00:on 890125,access to extreme high area not controlled per Tech Spec due to personnel error.

W/8 ltr.

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 TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) D. C. Cook Nuclear Plant - Unit 2														DOCKET NUMBER (2) 0 5 0 0 0 3 1 6										PAGE (3) 1 OF 0 3							
TITLE (4) Access to Extreme High Radiation Area Not Controlled In Accordance With Technical Specifications. As a Result of Personnel Error																															
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)			
																		D. C. Cook Plant Unit 1										0 5 0 0 0 3 1 5			
0 1		2 5		8 9		8 9		0 0 1		0 0		0 2		1 0		8 9												0 5 0 0 0			
OPERATING MODE (9)				THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)																											
6				20.402(b)						20.405(c)						50.73(a)(2)(iv)						73.71(b)									
POWER LEVEL (10)				20.405(a)(1)(i)						50.36(c)(1)						50.73(a)(2)(v)						73.71(c)									
0 0 0				20.405(a)(1)(ii)						50.36(c)(2)						50.73(a)(2)(vii)						OTHER (Specify in Abstract below and in Text, NRC Form 366A)									
				20.405(a)(1)(iii)						X 50.73(a)(2)(i)						50.73(a)(2)(viii)(A)															
				20.405(a)(1)(iv)						50.73(a)(2)(ii)						50.73(a)(2)(viii)(B)															
				20.405(a)(1)(v)						50.73(a)(2)(iii)						50.73(a)(2)(ix)															

LICENSEE CONTACT FOR THIS LER (12)																	
NAME							TELEPHONE NUMBER										
							AREA CODE										
J. T. Wojcik - Technical Physical Sciences Department Superintendent							6	1	6	4	6	5	-	5	9	0	1

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)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO				

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

On January 25, 1989, it was discovered that controls to limit access to an extreme high radiation area, which was not lockable, at the bottom of the refueling transfer canal had not been implemented. As a result, from December 20, 1988, when the transfer canal was drained, to December 27, 1988, when it was refilled, access to this extreme high radiation area was not positively controlled.

The cause of this event was due to poor communications in that a request to Security for the setup of positive controls for access to transfer canal was mistakenly assumed by Radiation Protection to be in effect. Also contributing to this event was the failure to verify that the positive controls had been implemented.

To preclude recurrence a design change has been approved by Plant Management which would provide a means of locking this area.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) D. C. Cook Nuclear Plant Unit 2	DOCKET NUMBER (2) 0 5 0 0 0 3 1 6 8 9 — 0 0 1 — 0 0 0 2 OF 0 3	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		89	001	00			

TEXT (If more space is required, use additional NRC Form 366A's) (17)

Conditions Prior to Occurrence

Unit 1 at 90 percent reactor thermal power, Unit 2 in refueling mode with no fuel in reactor vessel.

Description of Event

On January 25, 1989, it was discovered that controls to limit access to an extreme high radiation area at the bottom of the refueling transfer canal (EIIS/DF) had not been implemented. As a result, from December 20, 1988, when the transfer canal was drained to December 27, 1988, when it was refilled access to an extreme high radiation area in the refueling transfer canal was not controlled.

On December 20, 1988, during the initial survey of the transfer canal after draining, dose rates in excess of 1000 mR/hr were found. In accordance with procedures, the area was posted as an extreme high radiation area. However, because the area was not capable of being locked, as required by Technical Specification 6.12.2, Security was requested to have the guard who was already in the area controlling access to Unit 2 Upper Containment also control access to the transfer canal area. It was not until further investigation on January 25, 1989 that it was discovered that the guard, controlling access to Unit 2 Upper Containment, was not controlling access to the transfer canal area. There were no inoperable structures, components, or systems that contributed to this event.

Cause of Event

The cause of this event was due to poor communications in that a request to Security for the setup of positive controls for access to transfer canal was mistakenly assumed by Radiation Protection to be in effect. Also contributing to this event was the failure to verify that the positive controls had been implemented.

Analysis of Event

This event is considered reportable under the criteria of 10CFR50.73(a)(2)(i) as a violation of Technical Specifications.

During this event, although there was no continuous positive control of access to the transfer canal, work in the area was controlled by the Radiation Work Permits. Also, during the period of time when access wasn't controlled there were no unplanned exposures due to this condition. Based on this it is our belief this event did not adversely impact the health and safety of the public.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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		8 9	— 0 0 1	— 0 0	0 3	OF	0 3

TEXT (If more space is required, use additional NRC Form 366A's) (17)

Corrective Action

During this event an unsuccessful attempt to lower the dose rate below 1R/hr by hydrolazing was performed. Since the condition had ceased prior to the discovery that no continuous positive control of access to the area existed, no corrective action was possible for this. However to preclude recurrence a design change has been approved by Plant Management which would provide a means of locking this area.

Failed Component Identification

None.

Previous Similar Events

None.

Indiana Michigan
Power Company
Cook Nuclear Plant
P.O. Box 458
Bridgman, MI 49106
616 465 5901



February 10, 1989

United States Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

Operating License DPR-58
Docket No. 50-316

Document Control Manager:

In accordance with the criteria established by 10 CFR 50.73
entitled Licensee Event Reporting System, the following
report is being submitted:

89-001-00

Sincerely,

W. G. Smith, Jr.
Plant Manager

WGS:clw

Attachment

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