



**North  
Atlantic**

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The Northeast Utilities System

Ted C. Feigenbaum  
Senior Vice President &  
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July 21, 1994

United States Nuclear Regulatory Commission  
Washington, D.C. 20555

Attention: Document Control Desk

Reference: Facility Operating License No. NPF-86, Docket No. 50-443

Subject: Licensee Event Report (LER) No. 94-011-00: "Non-compliance with High Radiation Area Controls"

Gentlemen:

Enclosed please find Licensee Event Report (LER) No. 94-011-00 for Seabrook Station. This submittal documents an event which occurred on June 21, 1994. This event is being reported pursuant to 10CFR50.73(a)(2)(i).

Should you require further information regarding this matter, please contact Mr. James M. Peschel, Regulatory Compliance Manager, at (603) 474-9521, extension 3772.

Very truly yours,

Ted C. Feigenbaum

TCF:EWM/ewm

Enclosures: NRC Forms 366, 366A

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United States Nuclear Regulatory Commission  
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cc: Mr. Thomas T. Martin  
Regional Administrator  
United States Nuclear Regulatory Commission  
Region I  
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Mr. Albert W. De Agazio, Sr. Project Manager  
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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 INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNB 7714), 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)  
Seabrook StationDOCKET NUMBER (2)  
05000443PAGE (3)  
1 OF 3TITLE (4)  
Non-compliance With High Radiation Area Controls

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
06	21	94	94	11	00	07	21	94	FACILITY NAME	DOCKET NUMBER
										05000
										05000

OPERATING MODE (9)		6		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)							
POWER LEVEL (10)		0		20.402(b)		20.405(c)		50.73(a)(2)(iv)		73.71(b)	
				20.405(a)(1)(i)		50.36(c)(1)		50.73(a)(2)(v)		73.71(c)	
				20.405(a)(1)(ii)		50.36(c)(2)		50.73(a)(2)(vii)		OTHER	
				20.405(a)(1)(iii)		X 50.73(a)(2)(i)		50.73(a)(2)(viii)(A)		(Specify in Abstract below and in Text, NRC form 366A)	
				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)(x)			

## LICENSEE CONTACT FOR THIS LER (12)

NAME  
Mr. James M. Peschel, Regulatory Compliance ManagerTELEPHONE NUMBER (Include Area Code)  
(603) 474-9521 Ext. 3772

## 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 X (If yes, complete EXPECTED SUBMISSION DATE).				NO		EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR
								08	22	94

## ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On June 21, 1994 at approximately 2340 EDT, the requirements of Seabrook Station Technical Specification 6.11, "High Radiation Area", were not met.

Seabrook Station Technical Specification 6.11.1 requires individuals who enter high radiation areas to either have in their possession alarming dosimetry or a dose rate monitoring device, or to be escorted by a Health Physics (HP) Technician having one of these devices. Contrary to this requirement, a contractor mechanic entered a high radiation area, Reactor Coolant Pump (RCP) cubicle, for approximately 10 seconds without possessing alarming dosimetry or a dose rate radiation monitoring device.

There were no adverse safety consequences as a result of this event. The individual that entered the RCP cubicle did not receive any excessive doses.

The root cause for this event was determined to be a failure to implement self checking on the part of the contractor.

Immediate corrective actions included directing the individual to leave the area. Other corrective actions included counselling and disciplinary actions for the individual. In addition the event was discussed in a station publication, reviewed with station radiation workers stressing the importance of High Radiation Area controls and relationship to Technical Specifications. Additional corrective actions will be provided to the NRC in a supplemental report.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Seabrook Station	05000443	94	11	00	2 OF 3

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

Description of Event

On June 21, 1994 at approximately 2340 EDT, the requirements of Seabrook Station Technical Specification 6.11, "High Radiation Area", were not met.

Seabrook Station Technical Specification 6.11.1 requires individuals who enter high radiation areas to either have in their possession alarming dosimetry or a dose rate monitoring device, or to be escorted by a Health Physics (HP) Technician having one of these devices. Contrary to this requirement, a contractor mechanic entered a high radiation area for approximately 10 seconds without possessing alarming dosimetry or a dose rate radiation monitoring device.

The individual was found exiting the "C" Reactor Coolant Pump (RCP) [AB] cubicle without the controls required by Technical Specification 6.11, "High Radiation Area". An HP Supervisor discovered that the individual was not wearing the requisite alarming dosimetry upon exiting the High Radiation Area barricade. The HP Supervisor directed the individual to immediately leave the area and the containment building.

The access to the area was posted as a "High Radiation Area". The sign clearly stated the requirements necessary for entry into this area. The barricaded entry point provides access to areas where dose rates exist, at 30 centimeters, in excess of 100 mR/hr.

Safety Consequences

There were no adverse safety consequences as a result of this event. The individual did not enter any area where dose rates exceeded 2 mR/hr. During the event the individual did not receive any measurable amount of radiation exposure as indicated by his Self Reading Pocket Dosimeter (SRPD).

Root Cause

The root cause for this event was determined to be a failure to implement self checking on the part of the contractor. In addition, a contributing cause for this event was that the training given for the Radiation Worker Qualification did not adequately emphasize that access beyond the barricade was controlled by specific license conditions (i.e. Technical Specifications). The individual knew he was crossing the High Radiation Area boundary without the requisite alarming dosimeter. Another contributing cause for this event concerns verbal communication as the individual did not notify his supervisor when he encountered unexpected conditions. He expected to meet an HP technician at the entrance of the RCP cubicle but upon arrival did not find a technician present and proceeded into the cubicle to see if the technician was inside. The individual thought he knew the radiological conditions inside the RCP cubicle and felt that this would be an acceptable action for such a short period of time. The final contributing cause regards supervisory methods, in that the worker felt that getting this job done quickly was more important than meeting the specified entry requirements into this area.

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Seabrook Station		05000443		YEAR	SEQUENTIAL NUMBER	REVISION	3 OF 3
				94	11	00	

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

Corrective Actions

Immediate corrective actions included directing the individual to leave the RCP cubicle and the reactor containment building. In addition, the individual was counseled and subject to disciplinary actions. This event was discussed in a Station publication which included a summary of the High Radiation Area entry requirements along with an emphasis placed on the consequences for violating these Technical Specification requirements. North Atlantic and contractor Supervisors reviewed this event with radiation workers emphasizing the importance of High Radiation Area controls and the relationship of these controls to Technical Specifications.

Additional corrective actions to reduce the probability of similar events occurring in the future will be included in a supplemental report. The report is expected to be submitted to the NRC by August 22, 1994.

Plant Conditions

At the time of this event, the plant was in MODE 6 with the reactor defueled.

This is the third occurrence at Seabrook Station where personnel violated High Radiation Area postings, and the requirements of Technical Specification 6.11.1 were not met. These other instances were reported to the NRC in Licensee Event Reports (LER) 92-018-00 and 90-017-00.