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Atlantic**

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The Northeast Utilities System

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NYN- 94091

August 12, 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

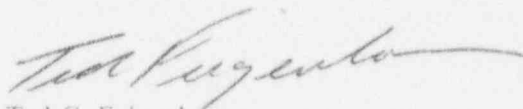
Subject: Licensee Event Report (LER) No. 94-012-00: "Non-compliance with High Radiation Area Controls"

Gentlemen:

Enclosed please find Licensee Event Report (LER) No. 94-012-00 for Seabrook Station. This submittal documents an event which occurred on July 14, 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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August 12, 1994
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cc: Mr. Thomas T. Martin
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NRC FORM 366 (5-92)				U.S. NUCLEAR REGULATORY COMMISSION				APPROVED BY OMB NO. 3150-0104 EXPIRES 5/31/95			
LICENSEE EVENT REPORT (LER)											
(See reverse for required number of digits/characters for each block)											
FACILITY NAME (1) Seabrook Station								DOCKET NUMBER (2) 05000443		PAGE (3) 1 OF 4	
TITLE (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	
07	14	94	94	12	00	08	12	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)							
				20.402(b)		20.405(c)		50.73(a)(2)(iv)		73.71(b)	
POWER LEVEL (10)		0		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)		<input checked="" type="checkbox"/> 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 Manager								TELEPHONE 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 (If yes, complete EXPECTED SUBMISSION DATE).				<input checked="" type="checkbox"/> NO		EXPECTED SUBMISSION DATE (15)		MONTH		DAY	
ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)											
<p>On July 14, 1994 at approximately 1100 EDT, the requirements of Seabrook Station Technical Specification 6.11, "High Radiation Area", were not complied with.</p> <p>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 an individual qualified in radiation protection procedures who has a radiation dose rate monitoring device. Contrary to this requirement, a test engineer entered a High Radiation Area for approximately 2 minutes without possessing the aforementioned requisite controls.</p> <p>There were no adverse safety consequences as a result of this event. The individual that entered the posted area did not receive any excessive doses.</p> <p>The root cause for this event was determined to be a failure to implement self checking on the part of the test control engineer. Specifically, the test control engineer failed to follow the procedural requirements which allow entry into a High Radiation Area.</p> <p>Immediate corrective actions included escorting the individual from the Containment Building. Other corrective actions included counselling and disciplinary actions for the individual. In addition the following corrective actions will be implemented to help prevent events of this type from recurring: North Atlantic management will evaluate the need for a specific disciplinary policy which will address violations of the radiation protection program, Health Physics procedures will be revised to require workers to wear alarming dosimeters for entries into High Radiation Areas, a radiation worker refresher training program will be developed for presentation to radiation workers prior to their working in future refueling outages, and High Radiation Area postings will be enhanced to incorporate the use of alarming swing arm gates and evaluated for permanent use based on their effectiveness.</p>											

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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 (MNBB 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.

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Seabrook Station		05000443		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 OF 4
				94	12	00	

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

I. DESCRIPTION OF EVENT

On July 14, 1994 at approximately 1100 EDT, the requirements of Seabrook Station Technical Specification 6.11, "High Radiation Area", were not complied with.

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 an individual qualified in radiation protection procedures who has a radiation dose rate monitoring device. Contrary to this requirement, a test control engineer entered a high radiation area for approximately 2 minutes without the aforementioned requisite controls.

A test control engineer was leading a work party that was performing safety injection accumulator check valve leakage testing in the Containment Building. The test control engineer was assisted by another test engineer and three outage support pipefitters. This evolution required installing and removing test equipment at various test connections. The test control engineer had reviewed the procedure and the piping layout drawings the day before the testing began to become familiar with the evolution and valve alignments. The piping layout drawings did not list the specific valve locations which are used to accomplish the testing. The test control engineer had performed this same testing on other occasions and did not recall that any of the valves were located in High Radiation Areas. Based on the test control engineers initial assessment of this evolution the Health Physics (HP) Control Point did not issue alarming dosimeters to the members of the work party. A HP technician was assigned to assist the work party by performing smear sampling during the system breeches, for the installation of the test equipment. This HP technician was also assigned to other jobs within the Containment Building.

When the work party and HP technician reached the first check valve to be tested the test control engineer discovered at that time that two of the valves had test connections located inside the boundary of a High Radiation Area. The options were discussed by the test control engineer and the HP technician regarding entries into these areas. It was determined that the HP technician would provide the requisite High Radiation Area coverage for the work party during these activities, instead of issuing personal electronic dosimetry. Three entries had been made into these High Radiation Areas to install and remove test equipment, at which time the HP technician assigned to the work party was called away to support another job within the Containment Building.

To facilitate completion of the testing, the test control engineer asked the test engineer to get the HP technician. The test control engineer was thinking at the time that the HP technician was needed to take smears on the test connections for the next valve to be tested. The test control engineer directed the pipefitter to remove the test equipment from a test connection located outside the High Radiation Area. The test control engineer then proceeded to remove the test equipment from the test connection located inside the High Radiation Area. This entry was made without the requisite controls as required by Technical Specification 6.11, "High Radiation Area". The test control engineer was not wearing the requisite alarming dosimetry or escorted by an individual qualified in radiation protection procedures who has a radiation dose rate monitoring device. The test control engineer realized this mistake upon exiting the area. An HP supervisor arrived at the scene as the test control engineer and the HP technician were discussing the incident. The HP supervisor escorted the test control engineer out of the Radiologically Controlled Area (RCA).

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.

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Seabrook Station		05000443		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	3 OF 4
				94	12	00	

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

II. 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).

III. CAUSE OF EVENT

The root cause for this event was determined to be a failure of the individual to implement self checking prior to entering the High Radiation Area. Specifically, the test control engineer failed to follow the procedural requirements which allow entry into a High Radiation Area. The test control engineer understood the seriousness of violating the Technical Specification requirements for entry into a High Radiation Area, as he had received a briefing on a previous event two weeks prior. He was focused on getting the job done correctly but failed to "Stop and Think" prior to entering the High Radiation Area. A contributing cause is that the managerial actions/methods taken in previous events have not been effective in preventing these types of events from occurring.

IV. CORRECTIVE ACTIONS

Immediate corrective actions included escorting the individual from the Containment Building. In addition, the individual was counseled and disciplined. The individuals access to the Radiologically Controlled Area was revoked until remedial Radiation Worker training could be completed.

North Atlantic management will evaluate the need for a specific disciplinary action policy to address serious violations of the Radiation Protection Program.

This seriousness of the event will be discussed in the Operating Experience Newsletter. This newsletter, which will be provided to all Site employees, will summarize the recent High Radiation Area events including the disciplinary actions taken and management's expectations concerning compliance with radiation protection policies.

Health Physics procedures will be revised to require the use of electronic dosimetry for all future entries into High Radiation Areas, unless specifically authorized by Health Physics supervision. This will be the primary or preferred method of assuring that all High Radiation Area entries are in compliance with Technical Specification entry requirements.

Health Physics will enhance High Radiation Area postings by incorporating the use of alarming swing arm gates at the entrance to High Radiation Areas, where practical. The use of alarming swing arm gates will be evaluated for permanent use based on their effectiveness. An alarm and/or flashing light would be activated when the gate is opened and/or approached to provide an audio or visual mechanism to alert workers of a High Radiation Area barricade.

A radiation worker refresher training program will be developed for presentation to all radiation workers prior to their working during future refueling outages. This training will include emphasis of current practices as well as a review of recent radiological incidents.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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

V. PLANT CONDITIONS

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

This is the fourth 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) 94-011-00, 92-018-00 and 90-017-00.