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April 9, 1991
JAFP-91-0206

United States Nuclear Regulatory Commission
Document Control Desk
Mail Station P1-137
Washington, DC 20555

SUBJECT: DOCKET NO. 50-333
LICENSEE EVENT REPORT: 91-003-00
HIGH RADIATION AREA GATE LEFT UNLOCKED AND UNGUARDED DUE TO PERSONNEL ERROR

Dear Sir:

This Licensee Event Report is submitted in accordance with 10 CFR 50.73(a)(2)(i)(B).

Questions concerning this report may be addressed to Mr. John A. Solini at (315) 349-6704.

Very truly yours,

WILLIAM FERNANDEZ

WF:JAS:las

Enclosure

cc: USNRC, Region I
USNRC Resident Inspector
INPO Records Center
American Nuclear Insurers

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NRC Form 366
(5-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
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TITLE (4)
High Radiation Gate Left Unlocked and Unguarded due to 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)
0 3	0 9	9 1	9 1	— 0 0 3	— 0 0	0 4	0 9	9 1	J.A. FitzPatrick	0 5 0 0 0 3 3 3
										0 5 0 0 0

OPERATING MODE (9)	N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)					
POWER LEVEL (10)	0 1 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 (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)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
John A. Solini	AREA CODE 3 1 5 — 3 4 9 — 6 7 0 4

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)	X NO				

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

On March 10, 1991 at 0100 hours, with the plant shutdown in the cold condition, a non-licensed operator (NLO) discovered the primary containment (drywell) entrance gate 272-11 unlocked and unguarded with the latch mechanism taped over. The NLO immediately untaped the latch, shut and locked the gate. A Radiological Technician had taped over the latch mechanism to facilitate moving equipment (HEPA hose) into the primary containment and forgot to remove the tape and lock the gate when he finished because he left the primary containment through a different access point. The gate was left in the unlocked and unguarded condition for a period of approximately four hours and twenty minutes. A check of the access log for the Reactor Building (RB) and a tour of the Primary Containment showed that no unauthorized personnel were in these areas. Corrective actions include a reaffirmation of high radiation area locked gate requirements with all plant radiation workers and disciplinary action.

DESCRIPTION OF OCCURRENCE:

On March 10, 1991 at 0100 hours, with the plant shutdown in the cold condition, a non-licensed operator (NLO) was performing plant Reactor Building (RB) rounds in accordance with the Operations Department Standing Order No. 17, Auxiliary Operator Plant Tours and Operating Logs (ODSO-17). The NLO was performing a check of the high radiation area gates in the RB to ensure they were shut and locked. When checking the gate to the primary containment (drywell) entrance, gate 272-11, the NLO found the gate unlocked and the latch mechanism taped over. He immediatedly untaped the latch, shut and locked the gate. He then notified the Shift Supervisor and the Radiation Protection Supervisor who proceeded to investigate the incident. The Security Department was also notified since primary containment was accessible. A check of the access log for the Reactor Building (RB) and a tour of the primary containment showed that no unauthorized personnel were in these areas.

APPARENT CAUSE OF OCCURRENCE:

On March 9, 1991 at approximately 2035 hours a Radiological Technician (RT) was attempting to install a hose for a High Effeciency Particulate Air (HEPA) filter unit which was to be used in the drywell (DW). The hose was located at the DW entrance area outside gate 272-11. At the time of this incident there were two entrance points available to the DW. The DW equipment hatch area was the normal entry point and wa open and guarded 24 hours per day. The second entry point, gate 272-11, is normally shut and locked during this time. The RT entered the DW through the DW equipment hatch area and proceeded to the DW personnel entrance area (gate 272-11) from inside the DW. While attempting to move the hose into the DW through gate 272-11 he taped the latch mechanism over to facilitate this work evolution so that the gate would not swing closed and lock him out of the DW. Once the hose was in place he exited the DW through the equipment hatch area instead of the now taped open DW entrance gate. In doing so he forgot to untape the latch to gate 272-11. This provided possible access to a high radiation area with dose rates greater than 1000 mrem/hr general area for a period of approximately four hours at which time the gate was discovered unlocked and immediately secured.

This event is attributed to personnel error cause code [A].

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

ANALYSIS OF OCCURRENCE:

This event is submitted in accordance with the requirements of The Code of Federal Regulations, 10 CFR 50.73 (a) (2) (i) (B) as an operation prohibited by the plant Technical Specifications.

Technical Specification 6.11(A) requires that gates or doors providing access to high radiation areas where the dose rates exceed 1000 mrem/hr shall be locked or guarded so that positive control is maintained over that area. The latch mechanism on gate 272-11 was taped over thereby defeating the locking mechanism so that the gate would close but not lock. The gate remained in the unlocked and unguarded condition for a period of approximately four hours and twenty minutes.

The safety implications of this event are insignificant. This gate, clearly posted as a high radiation area, was not used for normal access to the DW. Any personnel desiring to enter through this gate would have had to receive permission from Radiation Protection for the one key to that gate or know that the latch was taped over. This was not evident from just looking at the gate. In addition, that person would have had to enter a double step-off-pad (SOP) area to gain access to gate.

CORRECTIVE ACTION:

A memorandum to all radiation workers was issued by the Superintendent of Power reaffirming the importance of ensuring that all high radiation area gates remain shut and locked after entering and exiting an area. All Department Superintendents were instructed to review this important requirement with their personnel. Appropriate disciplinary action was taken.