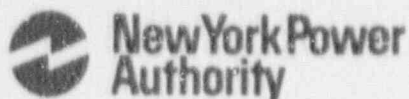


James A. FitzPatrick
Nuclear Power Plant
P.O. Box 41
Lycoming, New York 13093
315 342-3840



William Fernandez II
Resident Manager

April 9, 1991
JAFFP-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,

A handwritten signature in dark ink, appearing to be 'W. Fernandez II', written over the typed name.

WILLIAM FERNANDEZ

WF:JAS:las

Enclosure

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

9840796055

9104190336 910409
PDR ADOCK 05000333
S PDR

IE22
11

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO 3150-0104

EXPIRES 8/31/85

| | | | | | | | |
|--|--|----------------|----------------------|--------------------|----------|----|-----|
| FACILITY NAME (1) JAMES A. FITZPATRICK NUCLEAR POWER PLANT | DOCKET NUMBER (2) 0 5 0 0 0 3 3 3 | LER NUMBER (6) | | | PAGE (3) | | |
| | | YEAR | SEQUENTIAL NUMBER | REVISION NUMBER | | | |
| | | 9 1 | — 0 0 3 | — 0 0 | 0 2 | OF | 0 3 |

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

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 immediately 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 Efficiency 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 was 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].

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO 3150-0104

EXPIRES 8/31/85

| | | | | | | | |
|--|--|----------------|----------------------|--------------------|----------|----|-----|
| FACILITY NAME (1) JAMES A. FITZPATRICK NUCLEAR POWER PLANT | DOCKET NUMBER (2) 0 5 0 0 0 3 3 3 | LER NUMBER (6) | | | PAGE (3) | | |
| | | YEAR | SEQUENTIAL NUMBER | REVISION NUMBER | | | |
| | | 9 1 | 0 0 3 | 0 0 | 0 3 | OF | 0 3 |

TEXT (If more space is required, use additional NRC Form 365A'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.