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AUTH.NAME AUTHOR AFFILIATION
DRESSEN,J.D. Wisconsin Public Service Corp.
SCHROCK,C.A. Wisconsin Public Service Corp.
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LEB 92-012-00:op 920423 padlock for high radiation area gate

SUBJECT: LER 92-012-00:on 920423, padlock for high radiation area gate found unsecured. Caused by defective padlock or personnel error. One isolated area of radiation found. Evaluation of different locking options underway. W/920526 ltr.

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May 26, 1992

10 CFR 50.73

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Gentlemen:

Docket 50-305 Operating License DPR-43 Kewaunee Nuclear Power Plant Reportable Occurrence 92-012-00

In accordance with the requirements of 10 CFR 50.73, "Licensee Event Report System," the attached Licensee Event Report for reportable occurrence 92-012-00 is being submitted.

Sincerely,

C. a. Schook
C. A. Schrock

Manager-Nuclear Engineering

JDD\jac

Attach.

cc - INPO Records Center Mr. Patrick Castleman, US NRC US NRC, Region III

NRC Form (9-83))) _V	01/2	und	- N	uc l	ear I	2011				E EVI	ENT	REI	PORT	(LER)		CKET NUMBI	APPRI EXPIF	OVED OMB N	PAGE (S			
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High	High Radiation Area Found Unsecured Due to Personnel Error or Mechanical Failure																							
EVE	EVENT DATE (5) LER NUMBER (8) REPORT DATE (7) OTHER FACILITIES INVOLVED (8)																							
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OPERATING THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §. (Check one or more of the following) (11)																								
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At 1340 hours on April 23, 1992, with the plant at 72 percent power, a padlock for a high radiation area gate was found unsecured. An auxiliary operator (AO) was performing his routine plant rounds when he tugged on the padlock and it disengaged. The AO secured the door and notified the Health Physics department and the shift supervisor. A radiation survey was taken of the area and there was one isolated area where a dose rate of 2 R/hr was measured. All other surveys taken of the area were less than 100 mr/hr.

NO

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE)

EXPECTED SUBMISSION DATE (15)

MONTH

YEAR

The cause of this event was determined to be either a defective padlock or personnel error to properly secure the padlock. The padlock was checked by the AO on routine rounds at I100 on April 23 and it was secure. Later in the day at I540, during his routine plant rounds he tugged on the lock, which appeared to be secure, and it disengaged. After speaking with Health Physics personnel and personnel who had access to the keys for the gate, it could not be determined if anyone had entered the room between 1100 and 1340. Immediately following the event the padlock was secured and the failure could not be repeated.

An evaluation is being performed to evaluate different locking options that would minimize the possibility for personnel errors or mechanical failures that could result in a similar event.

NRC Form 386A (9-83) LICENSE	LICENSEE EVENT REPORT (LER) TEXT CONTINUATION APPRO EXPIRE								
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

Description of Event

This report describes a violation of Kewaunee Technical Specification (TS) 6.13.1.b which states that each High Radiation Area (HRA) in which the intensity of radiation is greater than 1000 mr/hr shall have locked doors to prevent unauthorized entry into these areas.

On April 23, 1992, with the plant at 72 percent power, gate [GATE] 18 was found unsecured. Gate 18 provides access to the radwaste drumming area which is a HRA. Gate 18 is currently posted as a "Radiation Hazard Area, (1000 mr/hr or >)."

At approximately 0900 AM on April 23, 1992 personnel finished working in the radwaste drumming area. When the personnel exited the area, gate 18 was verified closed by 2 people. At approximately 1100 AM the Auxiliary Operator (AO) was on his routine plant rounds and as part of his rounds he checked the padlocks on the HRA enclosures. When he tugged on the padlock for gate 18 it remained secure. When the AO performed his routine plant rounds at approximately 1540 PM, the lock which appeared to be secure, was tugged on and disengaged.

After speaking with Health Physics personnel and personnel who had access to the keys for gate 18, it could not be determined who, if anyone entered the room between 1100 AM and 1540 PM.

NRC	Form	366A

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/85

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

Cause of The Event

The cause of this event is either a defective padlock or personnel error to properly secure the padlock. Immediately following the event, the padlock was secured and tugged on and the failure could not be repeated.

Analysis of Event

This event is being reported in accordance with 10 CFR 50.73(a)(2)(i)(B) as a condition prohibited by Kewaunee Technical Specifications. Technical Specification 6.13.1.b requires HRAs with an intensity greater than 1 R/hr shall be locked to prevent unauthorized entry into these areas.

There were no apparent entries, authorized or unauthorized, into the radwaste drumming area between 1100 AM and 1540 PM. A radiation survey was taken of the radwaste drumming area and there was only one significant dose rate measured in the area. A dose rate of 2 R/hr was measured located at an inlet to a radwaste container which is not easily accessible. All other surveys taken of the area showed radiation levels to be less than 100 mr/hr. Although it was possible to receive a dose rate of 2 R/hr, this was in a remote area of the room. It can be reasonably concluded that if an unauthorized entry was made into the radwaste drumming area, it was unlikely that a significant dose would have been received. The Health Physics department did not note any significant dose rates logged on the April 23 log sheets and there were no significant doses from the personnel thermoluminescent Dosimeter monthly readings.

NRC	Form	366A

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES: 8/31/85

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

Corrective Actions

An evaluation is being performed to evaluate different locking options that would minimize the possibility for personnel errors or mechanical failures that could result in a similar event.

Additional Information

Equipment Failures: None.

Similar Events:

LER 85-014