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AUTH.NAME AUTHOR AFFILIATION
SCHAEFER,R. Wisconsin Public Service Corp.
SCHROCK,C.A. Wisconsin Public Service Corp.
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 93-015-00:on 930618,high radiation area found closed but unsecured & unattended.Caused by personnel error.Individual involved w/incident counseled on potential safety consequences of error.W/930719 ltr.

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July 19, 1993

10 CFR 50.73

U. S. Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

Ladies/Gentlemen:

Docket 50-305
Operating License DPR-43
Kewaunee Nuclear Power Plant
Reportable Occurrence 93-015-00

In accordance with the requirements of 10 CFR 50.73, "Licensee Event Report System," the attached Licensee Event Report for reportable occurrence 93-015-00 is being submitted.

Sincerely,

C. A. Schrock
Manager-Nuclear Engineering

RTS/cjt

Attach.

cc - INPO Records Center
US NRC Senior Resident Inspector
US NRC, Region III

IE22

NRC FORM 366 (5 92)

U. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 5/31/95

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.

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Kewaunee Nuclear Power Plant	05000305	1 OF 6

TITLE (4)
High Radiation Area Gate Left Unsecured Due to Personnel Error

EVENT DATE (5)			LER NUMBER (6)			REPORT NUMBER (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
									N/A	05000
06	18	93	93	-- 015 --	00	07	19	93	FACILITY NAME: N/A	DOCKET NUMBER: 05000

OPERATING MODE (9)	N
POWER LEVEL (10)	87

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)
	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	TELEPHONE NUMBER (Include Area Code)
Russell Schaefer, Associate Nuclear Engineer	(414) 433-7606

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 15 single-spaced typewritten lines) (16)

At approximately 1500 hours on June 18, 1993, with the plant at 87 percent power, a sliding gate to the low level radioactive waste drumming area, which is a High Radiation Area (HRA), was found closed but unsecured and unattended. A Nuclear Auxiliary Operator (NAO) was performing his routine plant rounds when he found the gate (#18) unsecured and unattended. The NAO secured the gate and reported the condition to the Shift Supervisor.

The cause of this event has been determined to be personnel error. A plant electrician finished performing maintenance on equipment in this HRA at approximately 1130 hours. He remembers engaging the lock after exiting the HRA, but does not remember if he routed the chain through the wall-mounted metal tube prior to engaging the lock.

The individual involved with this incident has been counseled on the potential safety consequences of this type of error. This event will also be discussed at KNPP safety meetings, which are attended by KNPP personnel (WPSC and Contractors). Additionally, the plant's weekly newsletter, which is distributed for all KNPP personnel, will include a message emphasizing the potential impact of this event for KNPP personnel.

Description of Event

This report describes a violation of Kewaunee Technical Specification (TS) 6.13.b. For enclosed areas that have radiation levels such that a major portion of the body could receive a dose > 1000 mrem in 1 hour, TS 6.13.b requires the area be provided with locked doors (gates) to prevent unauthorized entry.

At approximately 1500 hours on June 18, 1993, with the plant at 87 percent power, a Nuclear Auxiliary Operator (NAO) found gate [GATE] 18 closed but unsecured and unattended (see Figure 1). Gate 18 provides access to the low level radioactive waste (radwaste) drumming area, which is currently posted as a "High Radiation Area, (potential of >/= 10,000 mr/hr)". After checking the area, the NAO immediately secured the gate and notified the Shift Supervisor of the condition.

An internal review of personnel activities was performed by WPSC personnel to determine how long the gate was unsecured and unattended. This review revealed that a Plant Electrician finished working in the radwaste drumming area at approximately 1130 hours on June 18, 1993. When the electrician exited the High Radiation Area (HRA), he properly secured the gate by: 1) closing the gate, 2) putting the chain through the wall-mounted metal tube, 3) attaching the lock to the end of the chain, and 4) engaging the lock (see Figure 2). However, before he left the auxiliary building, he realized that a piece of equipment in the HRA should be returned to its preferred storage position. He proceeded to unlock the gate and re-enter the area to reposition the equipment. He distinctly recalls engaging the lock before leaving this HRA the second time; however, he cannot remember routing the chain through the wall-mounted metal tube prior to engaging the lock the second time.

At approximately 1500 hours, while performing routine plant rounds, a Nuclear Auxiliary Operator (NAO) found that the chain on gate #18 was not routed through the metal tube. Consequently the gate was unsecured, even though the lock was engaged and hanging on the end of the chain. The NAO did not find anyone in the area and determined that the gate had been left unsecured and unattended. He promptly secured the gate and reported the condition to the Shift Supervisor.

Cause of Event

The cause of this event has been determined to be personnel error. The error was failure to route the chain through the wall-mounted metal tube prior to engaging the lock, which resulted in the gate being unsecured.

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. For enclosed areas having the potential to exceed a radiological dose rate of 1000 mr/hr, TS 6.13.b requires the area be provided with locked doors (gates) to prevent unauthorized entry into these areas.

When the gate was found unsecured, it was closed but not locked. This means that if someone were to try entering the radwaste drumming area, they would have to consciously slide the gate open. Furthermore, as required, this gate is posted with a highly visible "High Radiation Area" sign. This sign would easily be observed prior to entry. These conditions reduced the likelihood of an unauthorized or inadvertent entry.

After talking with each person that was in the auxiliary building between the hours of 1130 and 1500, it was concluded that there were no entries, authorized or unauthorized, into the radwaste drumming area during this time. A radiation survey was taken of the radwaste drumming area and only two locations were found to

have a dose rate in excess of 1000 mrem. These were at the fill ports of two separate radwaste containers (shielded High Integrity Containers), which are not in an easily accessible part of the HRA. It can be reasonably concluded that if an unauthorized entry was made into the radwaste drumming area, it would be unlikely that a significant dose would have been received. Additionally, there were no significant personnel dose totals recorded on the HP department's daily log sheets for June 18, 1993.

Corrective Actions

The individual involved with this incident has been counseled on the potential safety consequences of this type of error. The Plant Electrical Maintenance Supervisor will have a meeting with all the Plant Electricians to review this event and discuss ways of preventing this type of error. This event will also be discussed at KNPP safety meetings, which are presented for all KNPP personnel. Additionally, the plant's weekly newsletter will include a message emphasizing the potential safety consequences of this event.

Additional Information

Equipment failures: NONE

Similar Events: LER 92-012
LER 85-014

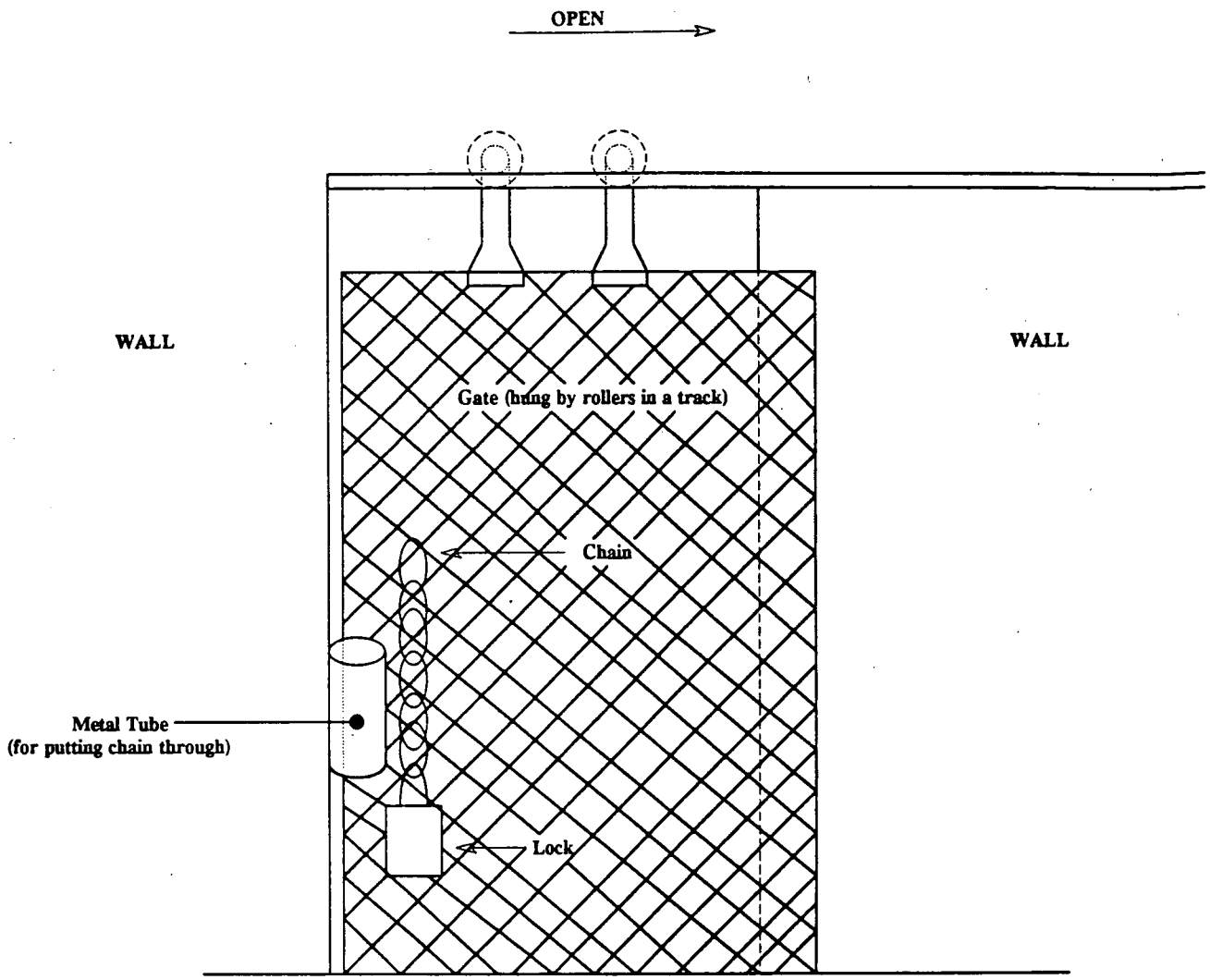

FIGURE 1
(GATE 18 AS FOUND)

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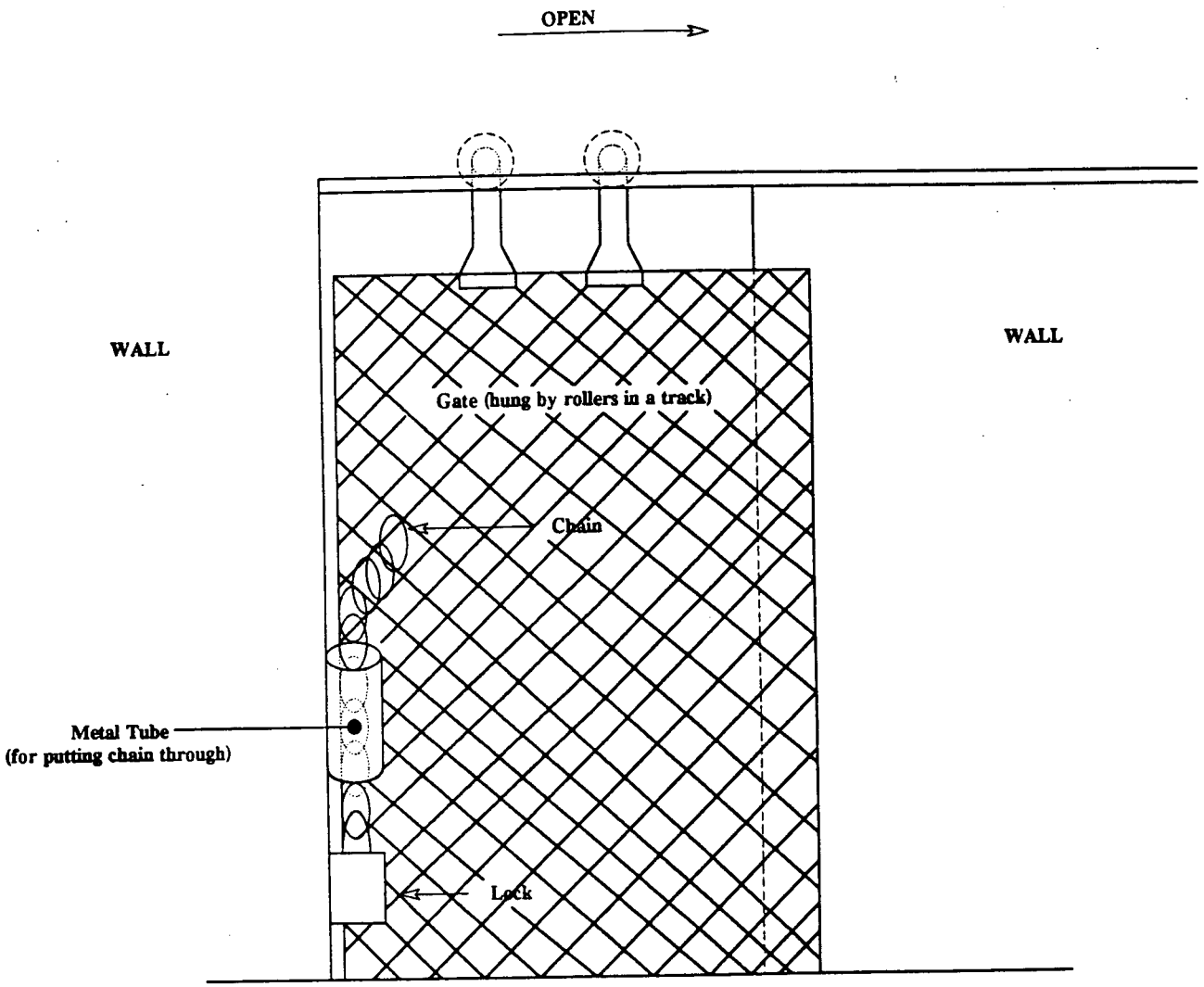

FIGURE 2

(GATE 18 WHEN SECURED)

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