REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 8710290120 DOC. DATE: 87/10/26 NOTARIZED: NO DOCKET #
FACIL: 50-275 Diablo Canyon Nuclear Power Plant, Unit 1, Pacific Ga 05000275
AUTH. NAME AUTHOR AFFILIATION
HUG, M. T. Pacific Gas & Electric Co.
SHIFFER, J. D. Pacific Gas & Electric Co.
RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 87-015-00: on 870924, requirements for Tech Spec 6.12.2 not met when very high radiation area door left unlocked. Caused by personnel error. Procedures revised to address qualifications required for checking out key. W/871026 ltr.

DISTRIBUTION CODE: IE22D COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 7
TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

NOTES:

	RECIPIENT ID CODE/NAME	COPIES LTTR	COPIES ENCL	RECIPIENT ID CODE/NAME	COPIES LTTR	COPIES ENCL
	PD5 LA	1	1	PD5 PD	1	1
	TRAMMELL, C	1	1			
INTERNAL:	ACRS MICHELSON	1	1	ACRS MOELLER	2	2
	AEOD/DOA	1	1	AEOD/DSP/NAS	1	1
	AEOD/DSP/ROAB	2	2	AEOD/DSP/TPAB	1	1
	ARM/DCTS/DAB	1	1	DEDRO	1	1
	NRR/DEST/ADS	1	0	NRR/DEST/CEB	1	1
	NRR/DEST/ELB	1	1	NRR/DEST/ICSB	1	1
	NRR/DEST/MEB	1	1	NRR/DEST/MTB	1	1
	NRR/DEST/PSB	1	1	NRR/DEST/RSB	1	1
	NRR/DEST/SGB	1	1	NRR/DLPQ/HFB	1	1
	NRR/DLPQ/QAB	1	1	NRR/DOEA/EAB	1	1
	NRR/DREP/RAB	1	1	NRR/DREP/RPB	2	2
	NRR/DRIS/SIB	1	1	NRR/PMAS/ILRB	1	1
	REG FILE 02	1	1	RES DEPY GI	1	1
	RES TELFORD, J	1	1	RES/DE/EIB	1	1
	RGN5 FILE 01	1	1			
EXTERNAL:	EG&G GROH, M	5	5	H ST LOBBY WARD	1	1
	LPDR	2	2	NRC PDR	1	1
	NSIC HARRIS, J	1	1	NSIC MAYS, G	1	1

TOTAL NUMBER OF COPIES REQUIRED: LTTR 46 ENCL 45

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
DIABLO CANYON UNIT 1	0 5 0 0 0 2 7 5	1 OF 0 6

TITLE (4) FAILURE TO MEET REQUIREMENTS FOR TECHNICAL SPECIFICATION 6.12, HIGH RADIATION AREA, WHEN AREA WAS LEFT UNLOCKED

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 9	2 4	8 7	8 7	0 1 5	0 0	1 0	2 6	8 7	DIABLO CANYON UNIT 2	0 5 0 0 0 3 2 3
										0 5 0 0 0

OPERATING MODE (9): 1

POWER LEVEL (10): 1 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (11)

[X] 10 CFR 50.73(a)(2)(i)(B)

[ ] OTHER (Specify in Abstract Below and in Text, NRC Form 366A)

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (AREA CODE)
MARTIN T. HUG, REGULATORY COMPLIANCE ENGINEER	8 0 5 5 9 5 - 7 3 5 1

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)

[X] NO

EXPECTED SUBMISSION DATE (15): MONTH | DAY | YEAR

ABSTRACT (16)

At 1130 PDT, September 24, 1987, with the unit in Mode 1 (Power Operation) at 100 percent power, the requirements for Technical Specification (TS) 6.12.2 were not met. TS 6.12.2 was not met when a very high radiation area (VHRA) door was left unlocked and the VHRA was not posted with a flashing warning light. The door was relocked on September 28, 1987, at 1130 PDT.

This event resulted from a combination of two events: a Chemistry and Radiation Protection (C&RP) foreman failing to invoke VHRA key issuance procedure RCP G-130, "Control of Access for Radiation Protection Purposes," and a C&RP technician forgetting the requirement to post warning lights before leaving the area unattended. There was no significant radiation exposure associated with this event, as the VHRAs within the facility were posted (with the exception of the flashing warning lights) and are normally inaccessible, due to the configuration of the facility. Therefore, no adverse safety consequences or implications resulted from this event.

Corrective actions to prevent recurrence include: revising procedures addressing the qualifications required for checking out a VHRA key; reviewing the event with all C&RP technicians; issuing a memo to all C&RP foremen stressing the importance of controlling the activity in the C&RP foreman office and using caution when issuing VHRA keys; requiring the concurrence of the Senior Radiation Protection Engineer when a VHRA is left unlocked and posted with flashing warning lights; segregating into a locked box important VHRA keys; and reviewing the positions of all VHRA high radiation area locked barricades.

I. Initial Conditions

Unit 1 was in Mode 1 (Power Operation) at 100 percent power.

II. Description of Event

A. Event:

At 1130 PDT, September 24, 1987, with the unit in Mode 1 (Power Operation) at 100 percent power, the requirements of Technical Specification (TS) 6.12.2 were not met when a very high radiation area door (VHRA)(DR) was left unlocked and the VHRA was not posted with a flashing warning light (IL). A painter requested that the normally locked door, which provides the locked barrier for the VHRA, be unlocked so he could paint the floor in the radwaste cask storage area (radiation area - see attached floor plan). The access senior chemistry and radiation protection (C&RP) technician requested that a C&RP technician unlock the VHRA door. The C&RP technician received the key from the C&RP foreman, unlocked the door, checked that the VHRA was posted, instructed the painter to observe the posted boundaries, but forgot that warning lights were to have been posted before the area was left unattended.

The door to the VHRA remained unlocked until a C&RP foreman noticed that the door was unlocked at 1130 PDT, September 28, 1987. The door was promptly locked and the event was reported to management.

B. Inoperable structures, components, or systems that contributed to the event:

None

C. Dates and approximate times for major occurrences:

1. September 24, 1987, 1130 PDT: Event date: Requirements of TS 6.12.2 not met when a VHRA was left unlocked without flashing warning lights in place.

2. September 28, 1987, 1130 PDT: Discovery date: VHRA found unlocked with no flashing warning lights in place. Room was checked, door relocked and management notified.

D. Other systems or secondary functions affected:

None

E. Method of discovery:

At 1130 PDT, September 28, 1987, a C&RP foreman noticed that the door was unlocked.

F. Operator actions:

The door was promptly locked.

G. Safety system responses:

None

III. Cause of Event:

A. Immediate cause:

This event resulted from a combination of two events:

1. A C&RP foreman failed to invoke the VHRA key issuance procedure, RCP G-130, "Control of Access for Radiation Protection Purposes."

2. A C&RP technician failed to post warning lights before leaving the area unattended.

B. Root cause:

1. The VHRA key was improperly issued. The VHRA key is normally issued with a checklist that prompts the technician to check that the required controls are in place. No checklist was used in this instance. The procedure requires that each issuance of a VHRA key be logged. No log entry was made in this case. A high level of work activity in the C&RP foreman office area at the time of the VHRA key issuance contributed to the informality of this key issuance.

2. The C&RP technician who was sent to unlock the VHRA door had received training on posting requirements, but did not have significant experience in implementing the training, nor had the technician been examined on his knowledge in this area by C&RP supervision.

3. The VHRA entry did not receive proper attention by the C&RP foreman because entry through VHRA doors is routine. These areas are frequently entered because most VHRAs are enclosed in much larger locked radiation areas, and access to these low radiation areas is frequently required.

IV. Analysis of Event

It was determined that there was no significant radiation exposure associated with this event because:

A. A review of dosimetry records for the period revealed no abnormally high radiation doses that could be attributed to an entry into a VHRA with dose rates that would be received in such an area.

B. The areas were posted with warning signs indicating VHRA.

C. Due to the configuration of the facility (see attached floor plan) the areas are not easily accessible. Control had been established at the door to the radwaste cask storage area in the unlikely event that an individual might take a ladder and gain access to the VHRA on either side of the 8 or 12 foot wall.

D. The painter working in the area indicated that he did not enter the VHRA.

Therefore, no adverse safety consequences or implications resulted from this event.

V. Corrective Actions:

A. The C&RP foremen were counseled by C&RP supervision regarding the need to exercise caution and the importance of formality in communications when issuing VHRA keys. Memos were issued to emphasize this and a policy to reduce unnecessary traffic in the foreman's office as well.

B. A policy was established and implemented to provide an additional foreman or engineer in the foreman's office during periods of high work activity.

C. Procedure RCP G-130, "Control of Access for Radiation Protection Purposes," will be revised:

(1) The foreman will be required to obtain the concurrence of the Senior Radiation Protection Engineer or General Foreman before ordering the compensating action, such as the installation of flashing yellow lights when he believe it is necessary to unlock a VHRA and establish compensating actions.

(2) The qualification of C&RP technicans required to check out VHRA keys will be addressed.

1751S

(3) VHRA keys for areas defined in plant procedures as being potentially debilitating will be segregated into a separate locked box. The concurrence of the senior radiation protection engineer prior to issuance of the special VHRA keys will be required.

E. A radiological occurrence report covering this event was reviewed with all C&RP personnel. This report will also be included in quarterly C&RP technicans training. Also, the policy of issuing VHRA keys to qualified C&RP technicans was reviewed with all C&RP personnel.

F. PG&E will undertake a long term evaluation of the portions of all VHRA boundaries to determine if the existing locked barricades are in optimum locations.

VI. Additional Information

A. Failed components:

None

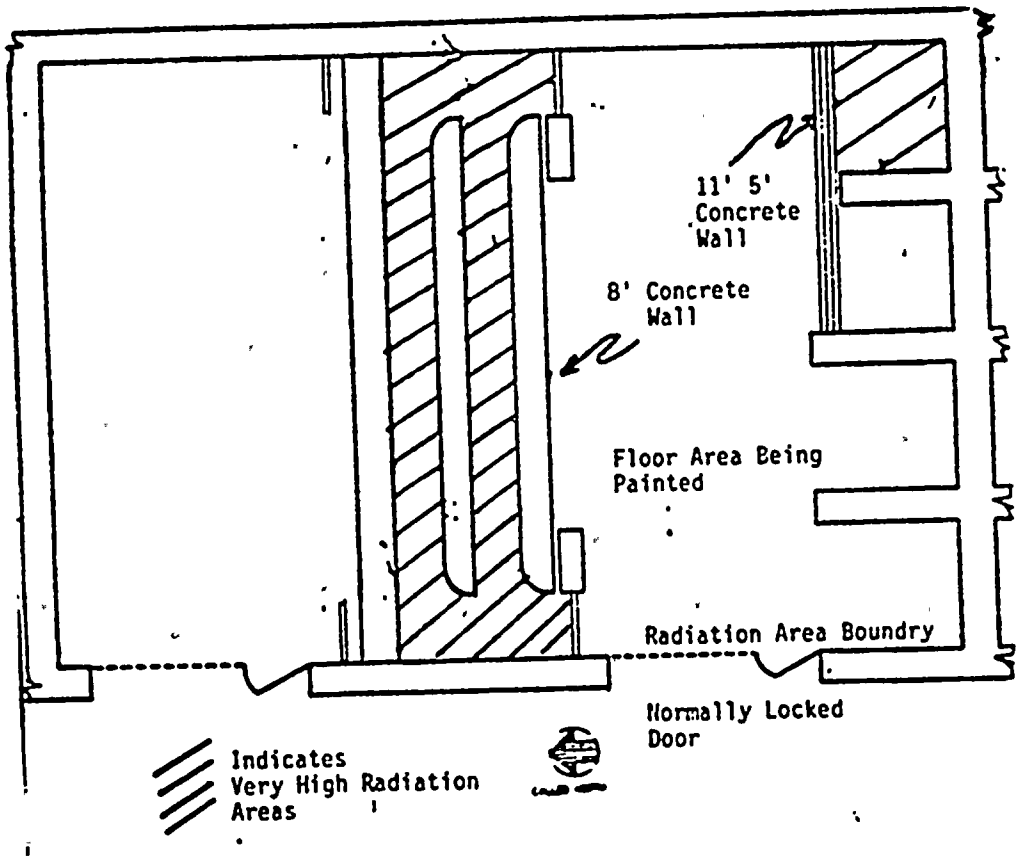
B. Previous LERs on similar events:

None

1751S

ATTACHMENT

FLOOR PLAN OF RADWASTE CASK STORAGE AREA



PACIFIC GAS AND ELECTRIC COMPANY

PG&E 77 BEALE STREET • SAN FRANCISCO, CALIFORNIA 94106 • (415) 781-4211 • TWX 910-372-6587

JAMES D. SHIFFER
VICE PRESIDENT
NUCLEAR POWER GENERATION

October 26, 1987

PGandE Letter No.: DCL-87-254

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

Re: Docket No. 50-275, OL-DPR-80
Docket No. 50-323, OL-DPR-82
Diablo Canyon Units 1 and 2
Licensee Event Report 1-87-015-00
Failure to Meet the Requirements of Technical Specification 6.12, High Radiation Area, When an Area Was Left Unlocked

Gentlemen:

Pursuant to 10 CFR 50.73(a)(2)(i)(B), PGandE is submitting the enclosed Licensee Event Report concerning the failure to meet the requirements of Technical Specification 6.12, High Radiation Area, when an area was left unlocked. This event has in no way affected the public's health and safety.

Kindly acknowledge receipt of this material on the enclosed copy of this letter and return it in the enclosed addressed envelope.

Sincerely,

William S. Kaefer for
J. D. Shiffer

Enclosure

cc J. B. Martin
P. P. Narbut
B. Norton
M. M. Mendonca
B. H. Vogler
CPUC
Diablo Distribution
INPO

1751S/0051K/RHM/1811
DCO-87-TC-N107

IE22
1/1