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ACCESSION NBR: 9108150097 DOC. DATE: 91/08/12 NOTARIZED: NO DOCKET #
 FACIL: 50-388 Susquehanna Steam Electric Station, Unit 2, Pennsylvania 05000388
 AUTH. NAME AUTHOR AFFILIATION
 METER, J. J. Pennsylvania Power & Light Co.
 STANLEY, H. G. Pennsylvania Power & Light Co.
 RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 91-011-00: on on 910626, discovered high radiation door in closed position w/locking mechanism improperly seated in striker plate. Caused by personnel error & inadequate condition of door. Door repaired. W/910812 ltr.

DISTRIBUTION CODE: IE22T COPIES RECEIVED: LTR 1 ENCL 1 SIZE: S
 TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

NOTES: LPDR 1 cy Transcripts. 05000388

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INTERNAL:	ACNW		2	2		ACRS		2	2
	AEOD/DOA		1	1		AEOD/DSP/TPAB		1	1
	AEOD/ROAB/DSP		2	2		NRR/DET/ECMB 9H		1	1
	NRR/DET/EMEB 7E		1	1		NRR/DLPQ/LHFB10		1	1
	NRR/DLPQ/LPEB10		1	1		NRR/DOEA/OEAB		1	1
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	NRR/DST/SRXB 8E		1	1		REG FILE 02		1	1
	RES/DSIR/EIB		1	1		RGNT FILE 01		1	1
EXTERNAL:	EG&G BRYCE, J.H		3	3		L ST LOBBY WARD		1	1
	NRC PDR		1	1		NSIC MURPHY, G.A		1	1
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Pennsylvania Power & Light Company

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August 12, 1991

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

SUSQUEHANNA STEAM ELECTRIC STATION
LICENSEE EVENT REPORT 91-011-00
FILE R41-2
PLAS -495

Docket No. 50-388
License No. NPF-22

Attached is Licensee Event Report 91-011-00. The event was determined reportable per 10CFR50.73(a)(2)(i)(C) in that a condition prohibited by Technical Specifications existed when an unauthorized entry to an area greater than or equal to 1000 mrem/hr was possible.

H.G. Stanley
Superintendent of Plant - Susquehanna

JJM/mjm

cc: Mr. T. T. Martin
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LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1) **Susquehanna Steam Electric Station - Unit 2** DOCKET NUMBER (2) **0 5 0 0 0 3 8 8** PAGE (3) **1 OF 0 4**

TITLE (4) **High Radiation Area Door Found Unsecured**

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	6	2	5	9	1	9	1	1		0 5 0 0 0
				0	1	1	0	0	0 8 1 2 9 1	0 5 0 0 0

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

POWER LEVEL (10) 1 0 0	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
	20.405(a)(1)(i)	50.38(c)(1)	50.73(a)(2)(v)	73.71(c)
	20.405(a)(1)(ii)	50.38(c)(2)	50.73(a)(2)(vi)	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)(vii)(B)	
	20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME **J.J. Meter - Engineer II** TELEPHONE NUMBER **7 1 7 5 4 2 - 1 8 7 3**

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) NO X

EXPECTED SUBMISSION DATE (15) MONTH DAY YEAR

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

On June 26, 1991 two plant Engineers and a Health Physics Technician discovered a high radiation area door in the closed position with the locking mechanism not properly seated in the striker plate. An event review team evaluated the event and determined the condition was prohibited by Technical Specification 6.12.2 and was reportable per 10CFR50.73(a)(2)(i)(c). The event was caused by both personnel error and less than adequate physical condition of the door. Use of the high radiation area door in question was inadvertently omitted from a station key usage log. This omission prevented the required independent verification of the door being closed and secured. Additionally, physical inadequacies of the door assembly could have given a false sense of a secured door when it was checked closed after it was used. Immediate corrective actions included closing and independently verifying the door to be locked. All remaining high radiation area doors were then verified to be locked and latched. Maintenance was performed on the high radiation area door in question. Long term corrective actions include inspecting, and repairing as necessary, all Technical Specification 6.12.2 doors and providing Health Physics Technicians with training emphasizing self-verification and reporting of damaged doors. There were no safety consequences or compromises to the health and safety of the public.



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LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1) Unit 2 Susquehanna Steam Electric Station	DOCKET NUMBER (2) 0 5 0 0 0 3 8 8	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
		9 1 -	0 1 1 -	0 0	0 2	OF 0 4

TEXT (If more space is required, use additional NRC Form 368A's) (17)

DESCRIPTION OF EVENT

At 1540 hours on June 26, 1991 with Unit 2 operating at 100% power, two Engineers (one utility, one non-utility) and a Health Physics Technician (utility) were preparing to perform helium in-leakage testing in the Unit 2 condenser bay. One of the Engineers, after dressing in protective clothing, leaned against a door (#142) to the condenser bay while waiting for the technician to complete dressing. The door, which controlled access to a high radiation area, opened without using a key. The Technician investigated the discovery and found the locking mechanism in the locked position and determined that the latch apparently had not completely engaged in the striker plate of the door jamb. The Technician informed his Supervisor (utility) who determined that the condition did not prevent unauthorized entry to an area where dose rates are greater than or equal 1000 mrem/hr and a Significant Operating Occurrence Report was generated. Following completion of the event investigation, it was determined that this condition was prohibited by Technical Specification 6.12.2 and reportable per 10CFR50.73(a)(2)(i)(c).

CAUSE OF EVENT

An event review team was established to evaluate the event for causal factors. From this evaluation, it was determined the following events occurred:

<u>Date</u>	<u>Time</u>	<u>Event/Action</u>
5/11/91		Key #305 to condenser bay door #142 (Unit #2 elevation 676') was signed out. Door was independently verified to be closed.
6/22/91		Weekly High Radiation area doors were confirmed to be properly locked.
6/25/91	Approx. 2115	A Health Physics Technician (#1) (utility) signed out key #312 to enter the condenser bay at elevation 656'. Work activities required the Technician to proceed to elevation 676' in the condenser bay. After work was complete, the Technician exited the condenser bay via door #142. The Technician firmly believes that door #142 was closed and secured. The Technician, however did not reflect his exit through door #142 in the high radiation area door key log. Since door #142 was not documented as being used, no independent verification of being locked was performed as required by procedure.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

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		9 1	0 1 1	0 0	0 3	OF 0 4

TEXT (If more space is required, use additional NRC Form 386A's) (17)

<u>Date</u>	<u>Time</u>	<u>Event/Action</u>
6/26/91	1530	A different Health Physics Technician (#2) signed out key #305 for door #142. The door was found unlatched when an Engineer leaned against the door.

Based on a cause and effect analysis performed on the event, the causal factors were related to both personnel error and the physical condition of the door being less than adequate. Personnel error involved Technician (#1) not performing adequate self verification that door #142 was locked and failure to identify use of door #142 in the high radiation area key log. This omission resulted in no independent verification of door closure and locked condition following its use which is required by procedure. Therefore, the unlatched condition went undetected until the following day. The less than adequate physical condition of door #142 also contributed to the event. The door closure mechanism did not provide enough force to close and/or latch door #142. In addition, the door weather stripping was damaged and became trapped between the door and the jamb. The resulting wedging of the weather strip could have given a false sense of a secured door when the door was checked closed and locked.

CORRECTIVE ACTIONS

Upon discovery of the open door, Technician (#2) immediately notified Supervision of the condition. The door was secured and verified to be locked and latched after the entry. All remaining high radiation area doors were verified to be locked and latched. Technicians involved with the event were interviewed and made aware of the conclusions. Maintenance was performed on the weather stripping on door #142 and the closure device was replaced. Rivets on the door edge were filed down to prevent contact with the jamb when closing.

Health Physics Technicians will receive training emphasizing self verification and reporting of damaged doors. All other Technical Specification 6.12.2 related doors will be inspected and repaired as necessary. These Technical Specification 6.12.2 related doors will also be reinspected after the next refueling outage, and then the results of the inspection will be evaluated to determine if a preventative maintenance program is necessary.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 500 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1) Unit 2 Susquehanna Steam Electric Station	DOCKET NUMBER (2) 0 5 0 0 0 3 8 8	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
		9 1	0 1 1	0 0	0 4	OF 0 4

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

REPORTABILITY/ANALYSIS

This event was determined to be reportable under 10CFR50.73(a)(2)(i)(C) in that a condition prohibited by Technician Specification 6.12.2 existed when an unauthorized entry to an area greater than or equal to 1000 mrem/hr was possible.

In accordance with the guidance provided in NUREG 1022 Supplement 1 item 15.4 and 10CFR50.4(d) the required submission date for this report was determined to be August 19, 1991. The door was not properly locked on June 25, 1991. It was discovered accessible on June 26, 1991. An investigation of the circumstances was completed on July 19, 1991 at which time the event was determined to be reportable.

Since Technical Specification 6.12.2 is an administrative control to protect site personnel from unplanned exposure, there were no safety consequences or compromises to the health and safety of the public. An investigation was performed to determine if any unauthorized entries occurred during the period between June 25, 1991 and June 26, 1991. None were found.

ADDITIONAL INFORMATION

A review of past Licensee Event Reports (LER's) for the station identified one previous event where unauthorized access to an area greater than or equal to 1000 mrem/hr was possible. Details of that event are described in Unit 1 LER 90-012 (Docket No. 50-387/License No. NPF-14).