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ACCESSION NBR: 9004040128 DOC. DATE: 90/03/26 NOTARIZED: NO DOCKET #
 FACIL: STN-50-530 Palo Verde Nuclear Station, Unit 3, Arizona Publi. 05000530
 AUTH. NAME AUTHOR AFFILIATION
 BRADISH, T.R. Arizona Public Service Co. (formerly Arizona Nuclear Power
 LEVINE, J.M. Arizona Public Service Co. (formerly Arizona Nuclear Power
 RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 90-002-00: on 900222, locked high radiation area gate
 found open & unguarded.

DISTRIBUTION CODE: IE22T COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 10
 TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

NOTES: Standardized plant. 05000530

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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	DEDRO	1			1
	NRR/DET/ECMB 9H	1			1	NRR/DET/EMEB9H3	1			1
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	NRR/DREP/PRPB11	2			2	NRR/DST/SELB 8D	1			1
	NRR/DST/SICB 7E	1			1	NRR/DST/SPLB8D1	1			1
	NRR/DST/SRXB 8E	1			1	REG FILE 02	1			1
	RES/DSIR/EIB	1			1	RGNS FILE 01	1			1
EXTERNAL:	EG&G STUART, V.A	1			1	L ST LOBBY WARD	1			1
	LPDR	1			1	NRC PDR	1			1
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Arizona Public Service Company

PALO VERDE NUCLEAR GENERATING STATION

P.O. BOX 52034 • PHOENIX, ARIZONA 85072-2034

192-00639-JML/TRB/KR

March 26, 1990

JAMES M. LEVINE
VICE PRESIDENT
NUCLEAR PRODUCTION

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

Dear Sirs:

Subject: Palo Verde Nuclear Generating Station (PVNGS)
Unit 3
Docket No. STN 50-530 (License No. NPF-74)
Licensee Event Report 90-002-00
File: 90-020-404

Attached please find Licensee Event Report (LER) No. 90-002-00 prepared and submitted pursuant to 10CFR50.73. In accordance with 10CFR50.73(d), we are herewith forwarding a copy of the LER to the Regional Administrator of the Region V office.

If you have any questions, please contact T. R. Bradish, (Acting) Compliance Manager at (602) 393-2521.

Very truly yours,

James M. Levine

JML/TRB/KR/kj

Attachment

cc: W. F. Conway (all with attachment)
E. E. Van Brunt
J. B. Martin
D. H. Coe
T. L. Chan
A. C. Gehr
J. R. Newman
INPO Records Center

9004040128 900326
FDR ADCK 05000530
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LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 60.0 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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TITLE (4)
Locked High Radiation Area Gate Found Open and Unguarded

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)
02	22	90	90	002	00	03	26	90	N/A		0 5 0 0 0 0
									N/A		0 5 0 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) 0918	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(c)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)						
	<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)						
	<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)						
	<input type="checkbox"/> 20.405(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)							
	<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)							
<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(x)								

LICENSEE CONTACT FOR THIS LER (12)

NAME Thomas R. Bradish, (Acting) Compliance Manager	TELEPHONE NUMBER
	AREA CODE: 6 0 2 3 9 3 - 2 5 2 1

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDPS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDPS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

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

On February 22, 1990, at approximately 2205 MST, Palo Verde Unit 3 was in Mode 1 (POWER OPERATION) when a Unit 3 Radiation Protection Technician (RPT) discovered a Unit 3 Locked High Radiation Area (LHRA) gate open and unguarded. The LHRA key was in the gate lock.

The open and unguarded LHRA gate was contrary to the administrative requirements of Technical Specification 6.12.2. The apparent root cause for the LHRA gate being open was personnel error by Radiation Protection personnel who did not adequately follow approved procedures. This personnel error resulted in a loss of LHRA key control.

As immediate corrective action, Radiation Protection personnel verified the room to be unoccupied and secured the gate. The Radiation Protection personnel responsible for the loss of LHRA key control have received appropriate disciplinary action.

Previous similar events were reported in Unit 3 LER 88-005 and Unit 1 LER 89-021.

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.

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

I. DESCRIPTION OF WHAT OCCURRED:

A. Initial Conditions:

On February 22, 1990, Palo Verde Unit 3 was in Mode 1 (POWER OPERATION).

B. Reportable Event Description (Including Dates and Approximate Times of Major Occurrences):

Event Classification: Conditions prohibited by the plant's Technical Specifications (6.12.2) and Title 10 of the Code of Federal Regulations, Part 20, Standards for Protection Against Radiation, Section 20.203(c)(2).

On February 22, 1990, at approximately 2205 MST, a Unit 3 Radiation Protection Technician (RPT) (contractor, non-licensed) discovered a Unit 3 Locked High Radiation Area (LHRA) gate open and unguarded. The LHRA gate was located at the entrance to the Unit 3 Shutdown Cooling Heat Exchanger (HX)(BP) "A" Room on the 70 foot elevation of the Auxiliary Building (NF). The LHRA key was in the gate lock. The Shutdown Cooling Heat Exchanger Room "A" was posted as an LHRA. The posting on the exterior side of the gate met the requirements of the station posting procedure. In addition, the interior accessway was posted with an LHRA posting.

The open and unguarded LHRA gate was contrary to the administrative requirements of Technical Specification 6.12.2 and Title 10 of the Code of Federal Regulations, Part 20, "Standards for Protection Against Radiation," Section 20.203(c)(2).

Technical Specification 6.12.2 requires that areas accessible to personnel with radiation levels greater than 1000 mrem per hour to a major portion of the whole body shall be provided with locked doors to prevent unauthorized entry. The doors are to remain locked except during periods of access by personnel under an approved Radiation Exposure Permit (REP).

Prior to the event, on February 22, 1990, at approximately 1240 MST, contrary to an approved procedure, an RP Lead (utility, non-licensed) issued the LHRA key to the Shutdown Cooling Heat Exchanger "A" Room to himself. An LHRA Key Control Log entry was made by the same RP Lead. At approximately 1245 MST, the same RP Lead and a Senior RPT (utility, non-licensed) went to the 70 foot elevation of the Auxiliary Building to perform a pre-job survey in

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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-630), 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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the Shutdown Cooling Heat Exchanger "A" Room. Prior to entry, the RP Lead has stated, he unlocked the padlock with the LHRA key and removed the chain from the gate and relocked the padlock through the chain to an adjacent stair rail. After the RP Lead unlocked the gate with the same LHRA key, both the RP Lead and the Senior RPT entered the room and secured the gate behind them. At approximately 1310 MST, both the RP Lead and Senior RPT exited the room. The RP Lead has stated that he removed the padlock and chain from the stair rail, threaded the chain through the top door frame and the gate, pushed the gate shut, tightened the chain and locked the padlock. The Senior RPT left the area prior to witnessing the padlock being secured. The RP Lead has stated that he believed that upon returning to the Radiation Protection Island located at the 140 foot elevation of the Auxiliary Building, he placed the LHRA key on the Shift RP Lead's desk area. The RP Lead also stated that he did not recall anyone being at the desk at that time. At approximately 1410 MST, both the RP Lead and the Senior RPT indicated by signature on the associated REP LHRA Verification Sheet that they had performed the first and second verification ensuring that the Shutdown Cooling Heat Exchanger Room "A" gate was locked. An entry indicating the return of the LHRA key was not made in the LHRA Key Control Log.

At approximately 1336, 1536, 1616, 1816, and 1851 MST, firewatch personnel (contractor and utility, non-licensed) were in the 70 foot elevation of the Auxiliary Building passing by the Shutdown Cooling Heat Exchanger "A" Room. Statements from each person indicated that the gate was not seen open. However, none of the firewatch personnel physically verified that the gate was secured and locked.

At approximately 1840 MST, in preparation for the RP shift turnover, the Shift RP Lead (utility, non-licensed) noticed that the LHRA Key Control Log did not have an entry indicating that the key to the Shutdown Heat Exchanger Room "A" had been returned. After inspecting the LHRA key locker, he made an RP Log entry stating that the LHRA key was still signed out to the RP Lead.

At approximately 1900 MST, during the RP shift turnover, the oncoming or Night Shift RP Lead (utility, non-licensed) signed the RP Shift Turnover Checklist indicating that the RP Lead had the LHRA key and that all LHRA keys were accounted for. The Night Shift RP Lead attempted to contact the RP Lead at home to locate the LHRA key but had to leave a message for the RP Lead to return the call. In addition, the Night Shift RP Lead checked the LHRA

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ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 600 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-630), 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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dual verification documentation and observed that both the RP Lead and the Senior RP had signed that the Shutdown Cooling Heat Exchanger Room "A" gate was verified to be locked.

At approximately 2045 MST, an Auxiliary Operator (utility, non-licensed) passed by the Shutdown Heat Exchanger "A" gate. The Auxiliary Operator has stated that if the LHRA key was hanging from the gate lock, he believed he would have noticed the key. Although he did not physically inspect the gate, he has stated that he believed the gate was properly secured and locked.

At approximately 2200 MST, the RP Lead returned the Night Shift RP Lead's call and stated that he did not have the LHRA key. The Night Shift RP Lead sent an RPT (contractor, non-licensed) to the Unit 3 Shutdown Cooling Heat Exchanger "A" Room to search for the missing LHRA key. At approximately 2205 MST, the RPT discovered the Shutdown Cooling Heat Exchanger "A" Room gate open and unguarded. The missing LHRA key was in the gate lock. The chain was found threaded through the top door frame secured by the padlock. The RPT verified the room to be unoccupied and secured the gate. The gate was verified to be shut and locked by a second RPT (utility, non-licensed) at approximately 2210 MST. At approximately 2330 MST, an RPT (utility, non-licensed) completed a verification survey of the room. No unexpected radiation levels were recorded.

- C. Status of structures, systems, or components that were inoperable at the start of the event that contributed to the event:

Not applicable - no structures, systems, or components were inoperable at the start of the event which contributed to this event.

- D. Cause of each component or system failure, if known:

Not applicable - no component or system failures were involved.

- E. Failure mode, mechanism, and effect of each failed component, if known:

Not applicable - no component failures were involved.

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

F. For failures of components with multiple functions, list of systems or secondary functions that were also affected:

Not applicable - no component failures were involved.

G. For a failure that rendered a train of a safety system inoperable, estimated time elapsed from the discovery of the failure until the train was returned to service:

Not applicable - no failures were involved which rendered a train of a safety system inoperable.

H. Method of discovery of each component or system failure or procedural error:

Not applicable - there have been no component or system failures or procedural errors identified.

I. Cause of event

The apparent root cause for the LHRA gate being open was personnel errors (SALP Cause Code A) by Radiation Protection personnel who did not adequately follow approved procedures. These personnel errors resulted in a loss of LHRA key control. There were no unusual characteristics of the work location that directly contributed to the error.

Contrary to approved procedures,

1. the Shift RP Lead did not maintain control of the key to the LHRA key locker, the LHRA keys nor the LHRA Key Control Log, and the RP Lead issued the LHRA key to himself,
2. an inadequate dual verification of an LHRA gate closure was performed by the Senior RPT,
3. the RP Lead did not return the key to the Shift RP Lead, and
4. the RP Lead did not maintain control of the LHRA key.

In addition, both Shift RP Leads had assumed that the RP Lead took the LHRA key home. As a result, the LHRA key was not determined to be lost until the telephone discussion at approximately 2200 MST. This assumption resulted in a failure to immediately and

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thoroughly investigate the loss of control of the LHRA key when it was discovered missing from the LHRA key locker.

Because the Auxiliary Operator believed the gate was properly secured and locked at approximately 2045 MST, Security personnel (utility, non-licensed) were requested to conduct interviews with the personnel who had access to the Unit 3 Radiologically Controlled Area (RCA) during the period from 2045 to 2200 MST. The interviews did not conclusively identify any individual(s) as responsible for having opened the gate. However, the Security investigation did conclude that, had the LHRA key been properly controlled, the padlock and chain utilized on the gate would have effectively prevented an intentional, unauthorized opening.

The documentation that supports the administrative control of LHRA access requirements (e.g., LHRA Key Control Log and Radiation Exposure Permit Sign-In Sheets) indicates that no authorized entries were made into the affected area from the time that RP Lead stated that the door was locked to the time the door was found open. In addition, an evaluation has been performed of the existing LHRA administrative controls including procedures, posting, training, and work practices that control access to the LHRAs. The administrative controls, with exception of the work practices, were found to adequately control entry to LHRAs.

J. Safety System Response:

Not applicable - there were no safety system responses and none were necessary.

K. Failed Component Information:

Not applicable - no component failures were involved.

II. ASSESSMENT OF THE SAFETY CONSEQUENCES AND IMPLICATIONS OF THIS EVENT:

There exists no direct evidence that an unauthorized entry into an LHRA was made. Information available does not indicate that unauthorized access into the LHRA occurred and no unexpected radiation exposures have been recorded for personnel in the Unit 3 RCA during the period for which the gate may have been open and unguarded.

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There were no safety consequences or implications resulting from this event as this event had no impact on the safe operation of the plant or the health and safety of the public.

III. CORRECTIVE ACTION:

A. Immediate:

As immediate corrective action, Radiation Protection personnel verified the room to be unoccupied and secured the gate in accordance with an approved procedure. The gate was verified to be shut and locked at approximately 2210 MST. The dosimetry records were checked for personnel who had access to the Unit 3 RCA during the period for which the gate may have been open and unguarded. No unexpected radiation exposures had been recorded.

A Night Order was issued in all three units to restate management's expectations concerning the compliance with procedures that control access to LHRAs.

A memo to all RP personnel, detailing management's expectations concerning work practices that control access to LHRA's has been written by the Site Radiation Protection Manager (RPM).

B. Action to Prevent Recurrence:

The Radiation Protection personnel responsible for the loss of LHRA key control have received appropriate disciplinary action.

Each Unit RPM will personally instruct their respective RP personnel on the content of the Site RPM's memo referenced above. This instructive session will be completed by March 29, 1990.

Additionally, Unit RP personnel will be required to read the Incident Investigation Report pertaining to this event, the License Event Report (Unit 3 LER 90-002) and the two procedures that control LHRA keys and access to the LHRAs. This action will be completed by April 15, 1990.

Applicable Radiation Protection procedures will be revised to include a review by RP supervision of the LHRA Key Control Log to further ensure compliance by RP personnel with the administrative controls for LHRA keys. This action will be completed by April 15, 1990.



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These actions to prevent recurrence and the actions in Section V are intended to reduce the probability of personnel error by Radiation Protection personnel who are responsible for LHRA key control. Subsequently, when the LHRA keys are properly controlled, authorized entries into LHRAs will be adequately controlled, and the opportunities for individual(s) to intentionally open an LHRA door or gate without proper authorization are significantly reduced.

IV. PREVIOUS SIMILAR EVENTS:

A previous similar event was reported in Unit 3 LER 88-005. As reported previously, a maintenance technician entered an LHRA using a screwdriver to unlock the door and gain access into the area. The root cause was a cognitive personnel error on the part of the maintenance technician. The technician received appropriate disciplinary action and additional training. Plant personnel were informed of the event and other actions were taken to improve the Radiation Protection program. Additionally, locking mechanisms on the LHRA doors and gates were evaluated. A special locking mechanism was to be installed on LHRA doors and gates that were expected to require locking as LHRAs. It was determined that these special locking mechanisms would provide adequate protection against defeat by unauthorized personnel. These corrective action recommendations were intended to reduce the probability of personnel error and unauthorized, intentional opening events.

Another previous similar event was reported in Unit 1 LER 89-021. As reported previously, two LHRA gates, one in Unit 3 and the other in Unit 1 were discovered open and unguarded within four days of each other. The root cause of the unauthorized, open LHRA gates was that the gates were intentionally forced open by unknown individuals. The special locking mechanisms are to be installed on doors and gates which are currently posted as LHRAs thirty days following delivery of the required parts. As an interim measure, separate chains and padlocks have been utilized on the LHRA cage-type gates and anti-pick plates have been installed on the hollow metal LHRA doors to provide increased protection against unauthorized access to the LHRAs in Units 1, 2, and 3. In addition, applicable Radiation Protection procedures were revised to include enhancements (e.g., dual verification of LHRA door closure upon exit) to reduce the probability of personnel error.

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Personnel errors that are the result of not adequately following approved procedures or mental lapses or that are the result of poor judgement are not normally correctable with revised procedures or additional training. Therefore, the corrective actions for the previous events would not have prevented this event.

V. ADDITIONAL INFORMATION:

As part of the corrective actions identified in a previous similar event, special locking mechanisms are to be installed on LHRA doors and gates that are expected to require locking as LHRAs. These special locking mechanisms will provide adequate protection against defeat by unauthorized personnel and are intended to reduce the probability of personnel error and subsequent unauthorized, intentional opening events.

As of March 26, 1990, the current LHRA doors and gates have been prepared for installation of the special locking mechanisms (SLM) and the SLMs have been installed on the currently posted LHRA doors and gates as follows:

ITEM	UNIT 1	UNIT 2	UNIT 3	TOTAL
Wire Mesh Gates and Hollow Metal Doors				
Current LHRA Doors/Gates	14	14	7	35
LHRAs with SLM Installed	13	14	6	33

Installation of the special locking mechanisms on the remaining hollow metal doors and wire mesh gates that are expected to require locking as LHRAs is expected to be completed by June 1, 1990.