

YANKEE ATOMIC ELECTRIC COMPANY

Telephone (413) 424-5261



Star Route, Rowe, Massachusetts 01367

October 25, 1989
BYR 89-157

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

Subject: Licensee Event Report No. 50-29/89-014

Technical Specification Violation Concerning Entry
Into High Radiation Area

Dear Sir:

In accordance with 10 CFR 50.73(a)(2)(i), the attached
Licensee Event Report is hereby submitted.

Very truly yours,

Timothy K. Henderson
Acting Plant Superintendent

DJK/pkg
ENCLOSURE

cc: [3] NSARC Chairman (YAEC)
[1] Institute of Nuclear Power Operations (INPO)
[1] USNRC, Region I
[1] Resident Inspector

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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) **Yankee Nuclear Power Station** DOCKET NUMBER (2) **0 5 0 0 0 1 0 2 1 9** PAGE (3) **1 OF 0 2**

TITLE (4)
Technical Specification Violation Concerning Entry Into High Radiation Area

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	5	8	9	8	9	0	1	4	0	0	1	0	2	5	8	9	0	5	0	0	0		

OPERATING MODE (9) **1**

POWER LEVEL (10) **11010**

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5 (Check one or more of the following) (11)

<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.406(c)	<input type="checkbox"/> 60.73(e)(2)(iv)	<input type="checkbox"/> 73.71(b)
<input type="checkbox"/> 20.406(e)(1)(i)	<input type="checkbox"/> 60.38(e)(1)	<input type="checkbox"/> 60.73(e)(2)(v)	<input type="checkbox"/> 73.71(c)
<input type="checkbox"/> 20.406(e)(1)(ii)	<input type="checkbox"/> 60.38(e)(2)	<input type="checkbox"/> 60.73(e)(2)(vi)	<input type="checkbox"/> OTHER (Specify in Abstract below and in Text, NRC Form 306A)
<input type="checkbox"/> 20.406(e)(1)(iii)	<input checked="" type="checkbox"/> 60.73(e)(2)(i)	<input type="checkbox"/> 60.73(e)(2)(vii)(A)	
<input type="checkbox"/> 20.406(e)(1)(iv)	<input type="checkbox"/> 60.73(e)(2)(ii)	<input type="checkbox"/> 60.73(e)(2)(vii)(B)	
<input type="checkbox"/> 20.406(e)(1)(v)	<input type="checkbox"/> 60.73(e)(2)(iii)	<input type="checkbox"/> 60.73(e)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME **Russell A. Mellor, Technical Director** TELEPHONE NUMBER **4113 41214-151211**

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRCDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRCDS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE) NO

EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR

ABSTRACT (Limit to 3400 spaces - i.e., approximately fifteen single-space typewritten lines) (16)

On September 25, 1989, at 0900 hours, while in Mode 1 at 100% power, a plant worker entered a High Radiation Area (HRA) in a pipe trench under the Primary Auxiliary Building cubicle corridor. The individual entered the pipe trench to perform a pre-work inspection for insulation removal and was not wearing an alarming dosimeter. An investigation was conducted and the determination was made that the conditions of entry did not comply with Technical Specification 6.12.b.

The root cause of this event was attributed to personnel error in that approved Radiation Protection (RP) procedures were not followed correctly. Immediate corrective action involved ordering the worker to exit the HRA. The worker was suspended for 3 days without pay for failing to comply with RP program requirements. This individual has been restricted from the plant radiation control area pending completion of an RP training course. Additional evaluations reveal no programmatic deficiencies in the General Employee Training and RP programs.

This event is considered an isolated occurrence; to confirm this, a Radiation Work Permit compliance observation program has been temporarily established. Unless this observation program identifies an adverse trend, no further corrective action is deemed necessary at this time. There was no adverse effect to the public health or safety.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) YANKEE NUCLEAR POWER STATION Rowe, MA. 01367	DOCKET NUMBER (2) 0 5 0 0 0 0 2 9	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
		8 9	0 1 4	0 0	0 2	OF 0 2

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

On September 25, 1989, at 0900 hours, while in Mode 1 at 100% power, a plant worker entered a High Radiation Area (HRA) in a pipe trench under the Primary Auxiliary Building cubicle corridor. The individual entered the pipe trench to perform a pre-work inspection for insulation removal and was not wearing an alarming dosimeter. An investigation was conducted and the determination was made that the conditions of entry did not comply with Technical Specification (TS) 6.12.b.

The root cause of this event was attributed to personnel error in that approved Radiation Protection (RP) procedures were not followed correctly. With the exception of wearing the proper protective clothing and a self reading pocket dosimeter, the worker did not comply with the remaining Radiation Work Permit (RWP) requirements. The RWP was not signed by the individual, an alarming dosimeter for entry into a HRA was not obtained, a breathing zone air (BZA) sampler was not obtained and RP was not notified prior to gaining access to the HRA.

Immediate corrective action involved ordering the worker to exit the HRA, return to the control point and leave the plant radiation control area (RCA). No unnecessary radiation exposure occurred, nor was there any spread of contamination; the individual received zero (0) mrem and was not contaminated. The worker was suspended for 3 days without pay for failing to comply with RP program requirements. This individual has been restricted from the plant RCA pending completion of an RP training course.

Additional plant evaluations have not revealed any programmatic deficiencies:

- o The TS requirements for entry into HRAs were found to be adequately presented in the RP portion of General Employee Training.
- o The plant procedure which describes RWPs and the specific RWP applicable to this event were both reviewed and found to be adequate and appropriate.

This event is considered an isolated occurrence; to confirm this, an RWP compliance observation program has been temporarily established. Unless this observation program identifies an adverse trend, no further corrective action is deemed necessary at this time.

There was no adverse effect to the public health or safety as a result of this event.