



VERMONT YANKEE NUCLEAR POWER CORPORATION

P. O. BOX 157
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VERNON, VERMONT 05354

January 23, 1991
VYV #91-018

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

REFERENCE: Operating License DPR-28
Docket No. 50-271
Reportable Occurrence No. LER 91-01

Dear Sirs:

As defined by 10 CFR 50.73, we are reporting the attached Reportable Occurrence as LER 91-01.

Very truly yours,

VERMONT YANKEE NUCLEAR POWER CORPORATION

Donald A. Reid
Plant Manager

cc: Regional Administrator
USNRC
Region I
475 Allendale Road
King of Prussia, PA 19406

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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-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3160-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20603.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) VERMONT YANKEE NUCLEAR POWER STATION						DOCKET NO. (2) 0 5 0 0 0 2 7 1				PAGE (3) 0 1 OF 0 3			
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TITLE (4) Entry Into A High Radiation Area By A Radiation Protection Technician Without A Dose Rate Monitoring Device Due To Personnel Error

EVENT DATE (5)			LER NUMBER (6)				REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)			
MONTH	DAY	YEAR	YEAR	SEQ. #	REV#	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NO. (S)		
0 1	0 4	9 1	9 1	- 0 0 1	- 0 0 0	0 1	2 3	9 1			0 5 0 0 0		
OPERATING MODE (9) N													

THIS REPORT IS SUBMITTED PURSUANT TO REQ'MTS OF 10CFR §: <input checked="" type="checkbox"/> ONE OR MORE (11)																																											
POWER LEVEL (10) 1 0 0		20.402(b)		20.405(a)(1)(i)		20.405(a)(1)(ii)		20.405(a)(1)(iii)		20.405(a)(1)(iv)		20.405(a)(1)(v)		20.405(c)		50.36(c)(1)		50.36(c)(2)		50.73(a)(2)(i)		50.73(a)(2)(ii)		50.73(a)(2)(iii)		50.73(a)(2)(iv)		50.73(a)(2)(v)		50.73(a)(2)(vii)		50.73(a)(2)(viii)(A)		50.73(a)(2)(viii)(B)		50.73(a)(2)(x)		73.71(b)		73.71(c)		OTHER:	

LICENSEE CONTACT FOR THIS LER (12)

NAME DONALD A. REID, PLANT MANAGER								TELEPHONE NO. 8 0 2 2 5 7 - 7 7 1 1							
AREA CODE				MO				DA				YR			

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

CAUSE	SYST	COMPNT	MFR	REPORTABLE TO NPRDS	CAUSE	SYST	COMPNT	MFR	REPORTABLE TO NPRDS
N/A					N/A				
N/A					N/A				

SUPPLEMENTAL REPORT EXPECTED (14)

<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO	EXPECTED SUBMISSION DATE (15)	MO	DA	YR
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ABSTRACT (Limit to 1400 spaces, i.e., approx. fifteen single-space typewritten lines) (16)

On January 4, 1991, at approximately 1115 hours, a Radiation Protection (RP) technician entered a posted High Radiation Area, the radioactive waste Cask Room, to check the condition of the resin and move a resin cask, without a dose rate monitoring device, as required by Technical Specification 6.5.B.1.

A RP Supervisor went to the Cask Room to check on the job progress, discovered the problem and immediately directed the technician to return to the step-off pad until a dose rate monitoring device could be obtained, as required. The general area dose rate during this event was less than 100 mr/hr.

The root cause of this event is personnel error. The technician failed to use a dose rate meter as required by procedures and Tech Specs when entering a High Radiation Area.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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UTILITY NAME (1)	DOCKET NO. (2)	LER NUMBER (6)			PAGE (3)
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TEXT (If more space is required, use additional NRC Form 366A) (17)

DESCRIPTION

On January 4, 1991, at approximately 1115 hours, a Radiation Protection (RP) Technician entered the radioactive waste Cask Room, a posted High Radiation Area, to check on the condition of the resin and move a resin cask prior to having it filled. The technician entered the Cask Room without a dose rate monitoring device as required by procedures and Technical Specifications 6.5.B.1. At approximately 1125 hours, a RP supervisor went to the Cask Room to monitor the work and immediately directed the technician to return to the step-off pad and wait there until a dose rate monitoring device could be obtained. During this time, the technician was not working on the top of the cask and the general area dose rate was less than 100 mr/hr and the dose rate where he was working was less than 50 mr/hr. While working in the area, without a dose rate monitoring device, his dose is estimated to be approximately 20 mr based on his dosimeter reading of 10 mr from the previous day and his dosimeter reading of 30 mr when he was required to return to the step-off pad.

The Cask Room area is posted as a High Radiation Area due to the potential radiation levels of the casks.

On January 7, 1991 the RP Supervisor brought this event to the attention of the RP Department Head. The department head took immediate action to initiate a RP incident report and to have the event reviewed to determine reportability. He also relieved the technician of his duties pending further investigation.

CAUSE OF EVENT

The root cause of this event is personnel error. Technical Specifications, procedures, and training clearly state that personnel shall have a dose rate monitoring device before entering a High Radiation Area. Further, the technician had previously completed this same job correctly the day before this incident.

ANALYSIS OF EVENT

The Cask Room is posted as a High Radiation Area due to the potential dose rates from the various radioactive waste casks. During this event, the general area dose rates were less than 100 mr/hr and the area in which the technician was working was less than 50 mr/hr. As the work required to move the cask took less than 20 minutes, the dose the technician received during the incident is within Vermont Yankee's administrative limits and below any 10 CFR limits. No overexposure occurred due to this event.

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

CORRECTIVE ACTIONS

The immediate corrective action was that a RP Supervisor had the technician return to the step-off pad and wait until he received a dose rate monitoring device.

Subsequent corrective actions as follows:

1. The technician that caused the incident was relieved of further RP duties.
2. The incident was discussed with all RP supervisors and in a department meeting with all RP personnel.
3. A RP Incident Report and a Corrective Action Report were initiated which will identify long term corrective actions and any possible contributing factors.
4. This event will be incorporated into the 1991 RP continuing training requirements.
5. All personnel who have access to the Radiation Control Area will receive training on this LER.

ADDITIONAL INFORMATION

No similar events have been reported to the Commission in the past five years.