

Telephone (412) 393-6000

May 14, 1993 ND3MNO:3452

Beaver Valley Power Station, Unit No. 1 Docket No. 50-334, Licensee No. DPR-66 LER 93-006-00

United States Nuclear Regulatory Commission Document Control Desk Washington, DC 20555

Gentlemen:

In accordance with Appendix A, Beaver Valley Technical Specifications, the following Licensee Event Report is submitted:

LER 93-006-00, 10 CFR 50.73.a.2.i.B, "Violations of Required Administrative Controls for High Radiation Areas."

Freeland

General Manager Nuclear Operations

DJM/sl

Attachment

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ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On April 15, 1993, with Unit One in Mode Six to support the ninth refueling outage, two events occurred involving inadequate attention to technical specification requirements for high radiation areas (>100 millirem per hour). In the first event, two operators entered a posted high radiation area without a radiation monitoring device which provides a continuous indication of the radiation dose rate in the area (a meter) as required by technical specification 6.12.1.a. In the second event, two operators entered a locked high radiation area, to perform valving, and left the barrier door open, violating technical specification 6.12.2. Each of the above events is a condition prohibited by technical specifications, and is reportable in accordance with 10CFR50.73.a.2.i.B. These events are recognized as violations of technical specifications and station radiological practices. Due to the specific circumstances, the radiological consequences were not significant. In the first event, the operators who entered the high radiation area without meters did not enter any other high radiation areas during their shift and neither operator received a dose in excess of 10 millirem during the course of work. In the second event, no unauthorized personnel gained access to high radiation area while the locked barrier door was open.

NRC FORM 366 (5-92)

REQUIRED NUMBER OF DIGITS/CHARACTERS FOR EACH BLOCK

BLOCK NUMBER	NUMBER OF DIGITS/CHARACTERS	TITLE					
1	UP TO 45	FACILITY NAME					
2	8 TOTAL 3 IN ADDITION TO 05000	DOCKET NUMBER					
3	VARIES	PAGE NUMBER					
4	UP TO 76	TITLE					
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9	1.	OPERATING MODE					
10	3	POWER LEVEL					
11	1 CHECK BOX THAT APPLIES	REQUIREMENTS OF 10 CFR					
12	UP TO 50 FOR NAME 14 FOR TELEPHONE	LICENSEE CONTACT					
13	CAUSE VARIES 2 FOR SYSTEM 4 FOR COMPONENT 4 FOR MANUFACTURER NPRDS VARIES	EACH COMPONENT FAILURE					
14	1 CHECK BOX THAT APPLIES	SUPPLEMENTAL REPORT EXPECTED					
15	6 TOTAL 2 PER BLOCK	EXPECTED SUBMISSION DATE					

NRC FORM 366A

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104 EXPIRES 5/31/95

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMFLY WITH THIS INFORMATION COLLECTION REQUEST 50.0 HRS FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBE 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1) DOCKET NUMBER (2)			LER NUMBER (6)	PAGE (3)	
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TEXT (It more space is required, use additional copies of NRC Form 365A), (17)

Description of Events:

On April 15, 1993, two events occurred involving inadequate attention to the technical specification requirements for high radiation areas (> 100 millirem per hour).

In the first event, at approximately 0145 hours, two operators were clearance tagging a sample valve in penetrations area "A." The area is posted as a high radiation area and is subject to the requirements of technical specification 6.12.1. This specification requires individuals entering a high radiation area to be equipped with a radiation monitoring device which provides a continuous indication of the radiation dose rate in the area (a dose rate meter). Operations personnel are trained and gualified to utilize dose rate meters without health physics support. The operators entered the area and placed the clearance tags without having in their possession the required dose rate meter. A Health Physics Quality Assessor entered the "A" penetrations area and discovered the operators performing the clearance tagging without a dose rate meter in their possession.

In the second event, at 1210 hours, two operators were performing clearance work in Reactor Coolant Pump "C" cubicle. They entered the cubicle and left the locked barrier door open while they performed their work. The open barrier door was discovered by health physics personnel who, upon seeing the open door, entered the cubicle and observed the two operators working in an area out of the direct line of sight of the barrier door. No other personnel were in the cubicle.

Cause of The Event

The first event was caused by the operators being inattentive to the technical specification requirements for entering a high radiation area. They were focused on the work at hand and did not give proper attention to administrative requirements requiring the use of dose rate meters. The second event was caused by an error in judgement on the part of the operators involved. The operators incorrectly determined that they could adequately control access from their work location within the cubicle. Due to the piping and shielding arrangement in the cubicle, they were unable to maintain adequate visual contact with the high radiation area access point once they reached the work location in the cubicle. NRC FORM 366A

U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER)

TEXT CONTINUATION

APPROVED BY OMB NO. 3150-0104 EXPIRES 5/31/95

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Corrective Actions

- Immediate: The operators involved in the events were counseled and disciplined.
- Long Term: Meter qualification privileges for all operations personnel at Unit 1 were revoked. Reinstatement required their review and understanding of technical specification 6.12, and the events of this report.

This event was also reviewed by the Unit 2 operations personnel that are trained and qualified to utilize dose rate meters.

Previous Similar Events

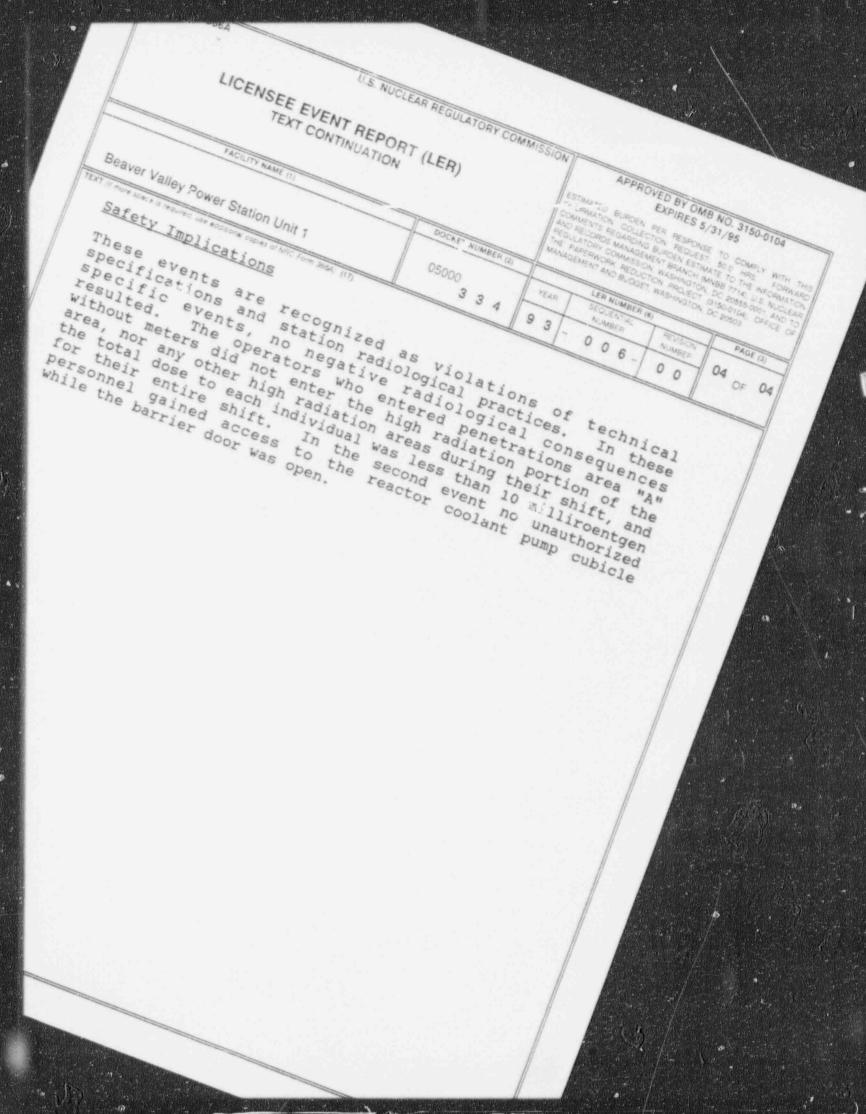
A review of station documents revealed two previous similar events:

- Unit 1 LER 92-006 documented an event in which the East Valve Trench Area barrier door was discovered to be open during a routine radiation barrier check. This event was caused by a failure to properly verify that the door was locked upon exit from the area.
- Unit 1 LER 89-014 documented an event in which the East Valve Trench Area barrier door was found open due to a faulty locking mechanism.

Reportability

The two events described in this report each resulted in a condition prohibited by technical specification 6.12. As such, they are being reported in accordance with 10CFR50.73.a.2.i.B.

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NRC FORM 366A

U.S. NUCLEAR REGULATORY COMMISSION

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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Safety Implications

These events are recognized as violations of technical specifications and station radiological practices. In these specific events, no negative radiological consequences resulted. The operators who entered penetrations area "A" without meters did not enter the high radiation portion of the area, nor any other high radiation areas during their shift, and the total dose to each individual was less than 10 milliroentgen for their entire shift. In the second event no unauthorized personnel gained access to the reactor coolant pump cubicle while the barrier door was open.