New Hompshire Yankee

Ted C. Feigenbaum President and Chief Executive Officer

NYN- 90190

October 26, 1990

United States Nuclear Regulatory Commission Washington, D.C. 20555

Attention: Document Control Desk

References: Facility Operating License No. NPF-86, Docket No. 50-443

Subject: Licensee Event Report (LER) No. 90-023-00: Noncompliance with Technical Specifications - Unsecured High Radiation Area.

Gentlemen:

Enclosed please find Licensee Event Report (LER) No. 90-023-00 for Seabrook Station. This submittal documents an event which occurred on September 27, 1990 and is being reported pursuant to 10CFR 50.73(a)(2)(i).

Should you require further information regarding this matter, please contact Mr. Allen L. Legendre, Lead Engineer - Compliance, at (603) 474-9521, extension 2373.

Very truly yours,

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Ted C. Feigenbaum

Enclosures: NRC Forms 366, 366A

TCF:WJT/dma

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New Hampshire Yankee Division of Public Service Company of New Hampshire P.O. Box 300 • Seabrook, NH 03874 • Telephone (603) 474-9521 United States Nuclear Regulatory Commission Attention: Document Control Desk

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cc: Mr. Thomas T. Martin Regional Administrator United States Nuclear Regulatory Commission Region 1 475 Allendale Road King of Prussia, PA 19406

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Mr. Noel Dudley NRC Senior Resident Inspector P.O. Box 1149 Seabrook, NH 03874

INPO Records Center 1100 Circle 75 Parkway Atlanta, GA 30339

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On September 27, 1990 at 4:07 p.m. EDT, while in MODE 1, it was discovered that a door to a locked high radiation area, the "Demin Alley", located in the Primary Auxiliary Building, was unlocked and had been unlocked for approximately five hours. This event occurred contrary to Seabrook Station Technical Specification 6.11.2.

On September 27, 1990 at 11:08 a.m., a Health Physics foreman entered the Demin Alley through door P203. Upon closure, however, the door latch did not completely engage and the door was consequently left unlocked. Additionally, the foreman involved failed to check the door to ensure that it was properly locked prior to exiting the area.

The root cause has been attributed to personnel error.

The Health Physics foreman was counselled and received disciplinary action. Additional corrective actions include: (1) the installation of a padlock mechanism on current locked high radiation doors, except for the containment personnel hatch controls and areas inside containment; (2) removal of key card access authorization to locked high radiation areas for all personnel; (3) new procedural requirements which includes a double verification sign-off that the locked high radiation area door is indeed locked; and (4) a requirement that a person with the work party remain outside the locked high radiation area door to ensure proper access controls. A meeting was held with Health Physics personnel to discuss the event and the new procedure requirements.

There were no adverse safety consequences as a result of this event.

This is the third event of this type involving an unsecured high radiation area door.

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On September 27, 1990 at 4:07 p.m. EDT, it was discovered that door P203 which leads to the "Demin Alley" in the primary auxiliary building, was unlocked and had been unlocked for approximately five hours. This occurred contrary to Seabrook Station Technical Specification 6.11.2. This Technical Specification requires that High Radiation Areas, with radiation levels greater than 1,000 mR/hour at 18 inches from the radiation source, which are accessible to personnel be locked to prevent unauthorized entry.

BACKGROUND

On September 27, 1990 at 11:08 a.m., a Health Physics foreman entered the Demin Alley through door P203 (one of three access doors) for routine inspections. Upon closure, however, the door latch did not completely engage and the door was consequently left unlocked. Additionally, the foreman involved failed to check the door to ensure that it was properly locked prior to exiting the area.

ROOT CAUSE

The root cause of this event has been determined to be personnel error. The Health Physics foreman should have checked the door to ensure that it was properly locked after entering and prior to exiting the area.

CORRECTIVE ACTIONS

On September 27, 1990 at 4:07 p.m., a Health Physics Technician, while conducting his daily Locked High Radiation Area Surveillance, discovered the door unlocked. He immediately locked and secured the door, thereby reestablishing compliance with Technical Specification 6.11.2.

In addition to the corrective actions identified in LERs 90-013-00 and 90-020-00, the following corrective actions were expedited to preclude recurrence of this type of event:

- Key card access authorization to locked high radiation areas was removed for all personnel.
- 2. A procedure was developed and approved on September 28, 1990 specifying the new requirements for access to locked high radiation areas. These requirements include:
 - Personnel requiring access must obtain a controlled key from the Health Physics control point.
 - An individual will be posted at the locked high radiation area entrance to ensure proper access and egress controls are maintained. Upon final egress from the locked high radiation area, an independent verification will be performed and both personnel will sign a form indicating the door has been properly locked and verified closed.

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CORRECTIVE ACTIONS (Continued)

- 3. A meeting was held on September 28 and October 1, 1990 with Health Physics personnel to discuss the event and the new procedural requirements.
- 4. A design change to install a padlock mechanism on current locked high radiation area doors, except for the containment personnel hatch controls and areas inside containment, has been completed. The addition of this second lock is expected to provide increased awareness to personnel operating these doors.
- 5. The individual involved with the event was counselled and received disciplinary action.

SAFETY CONSEQUENCES

There were no adverse safety consequences as a result of this event. Although the door was unlocked, a review of computer door alarms indicated no unauthorized access was attempted. An intrusion alarm would have actuated at the Health Physics control point if access to the area was attempted. Additionally, the general area dose rate was determined to be in the range of 2 to 10 millirem per hour during the time that the Demin Alley was unlocked, with maximum dose rates in individual shielded cubicles up to 16.5 rem per hour.

PLANT CONDITIONS

At the time of this event, the plant was in MODE 1, Power Operations, at 92% power with a Reactor Coolant System [AB] temperature of 585 degrees Fahrenheit and pressure of 2,235 psig.

This is the third event of this type involving an unsecured high radiation area. The previous events were reported by LER 90-013-00 and LER 90-020-00.