VERMONT YANKEE NUCLEAR POWER CORPORATION

P. O. BOX 157
GOVERNOR HUNT ROAD
VERNON, VERMONT 05354

December 5, 1990
VYV #90-384

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 90-16

Dear Sirs:

As defined by 10 CFR 50.73, we are reporting the attached Reportable Occurrence as LER 90-16.

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

IE 22
1/1

NRC Form 366 (6-89) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMS NO.3150-0104
EXPIRES 4/30/92
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)	DOCKET NO. (2)	PAGE (3)
VERMONT YANKEE NUCLEAR POWER STATION	0 5 0 0 0 2 7 1	0 1 OF 0 3

TITLE (4) FAILURE TO LOCK DRYWELL OUTER ACCESS AIR LOCK DOOR DUE TO AN INCOMPLETE PROCEDURE

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 5 0 0 0
1 1	0 8	9 0	9 0	- 0 1 6	- 0 0	1 2	0 5	9 0		0 5 0 0 0

OPERATING MODE (9): N	THIS REPORT IS SUBMITTED PURSUANT TO REQ'MTS OF 10CFR §: ✓ ONE OR MORE (11)			
	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10): 1 0 0	20.405(a)(1)(I)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
	20.405(a)(1)(II)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER:
	20.405(a)(1)(III)	X 50.73(a)(2)(I)	50.73(a)(2)(viii)(A)	
	20.405(a)(1)(iv)	50.73(a)(2)(II)	50.73(a)(2)(viii)(B)	
	20.405(a)(1)(v)	50.73(a)(2)(III)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

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

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
NA					NA				
NA					NA				

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MO	DA	YR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

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

Vermont Yankee Technical Specification 6.5.B.1 requires that high radiation areas in which the radiation intensity is greater than 1000mr/hr shall have locked doors to prevent unauthorized entry and have the keys controlled by the duty Shift Supervisor and/or the Plant Health Physicist.

On 11/08/90, with the reactor at 100% power, a Radiation Protection Assistant making his rounds discovered that the Drywell (EIIS=VSL) airlock (EIIS=AL) outer door (EIIS=[ ) was closed but not locked. The Drywell, at 100% power, is by definition a "locked high radiation area". The plant had just experienced a refueling outage and had started up on October 14, 1990.

Both airlock doors had been closed and the inner door was secured by strongbacks, which essentially made the door impassable except by deliberate actions.

The outer door was immediately chained and locked by Radiation Protection Personnel.

The root cause of this event is attributable to an incomplete procedure.

DESCRIPTION

Vermont Yankee Technical Specification 6.5.B.1 requires that high radiation areas in which the radiation intensity is greater than 1000mr/hr shall have locked doors to prevent unauthorized entry, and have the keys maintained under the administrative control of the Shift Supervisor on duty and/or the Plant Health Physicist.

On 11/08/90, with the reactor at 100% power, the Drywell airlock outer door was found to be closed but not locked. The Drywell, at 100% power, is by definition a "locked high radiation area". The plant had recently experienced a refueling outage and had started up on October 14, 1990.

On 10/13/90, following the outage, the Drywell checkpoint watch was secured. At that time, no general areas of the Drywell exceeded 1000mr/hr therefore, the door was not required to be locked.

On 10/15/90, following the "hot closeout" inspection, Maintenance workers installed the strongbacks on the inner Drywell door and closed the outer door. At that time, power level was low, approximately 54 MWth (3%), and dose rates were assumed to be less than 1000mr/hr; below the level that required the area to be locked.

Between 10/15/90 and 11/08/90, reactor power was increased to 100% and the dose rates exceeded those that require the door to be locked. Although the Drywell outer door was not physically locked, entry was ocked by the installation of the strongbacks on the inner Drywell door. The outer door was properly posted at all times.

On 11/08/90, immediately following the discovery of the event, the outer Drywell door was chained and locked in the closed position.

CAUSE OF EVENT

The root cause of this event is attributable to an incomplete procedure. The Drywell procedure OP 2115 "Primary Containment" contains an Appendix titled "Drywell Closeout Inspection". While this procedure has a checkoff to ensure that the air lock doors are shut and interlocked, there is no checkoff to ensure that the outer door is locked.

ANALYSIS OF EVENT

Although the outer door to the Drywell was not physically secured with a lock as required where area dose rates exceed 1000mr/hr, the inner door was secured by the installation of strongbacks. These would have prevented any entry, as their unauthorized removal would require special tools and could not have been done accidentally.

Additionally, the outer Drywell door was properly posted with a standard High Radiation Area sign.

During the time that the Drywell door was not physically locked, there were no adverse effects to plant personnel or to the public.

CORRECTIVE ACTIONS

The following corrective action was completed:

1) The Drywell outer door was immediately chained and locked shut.

The following corrective actions will be completed:

1) OP 2115, "Primary Containment", Appendix A, will be revised to include a checkoff to ensure that the Radiation Protection Department chains and locks shut the outer Drywell door. This checkoff will require the signature of the Radiation Protection Technician who completes the task.

ADDITIONAL INFORMATION

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