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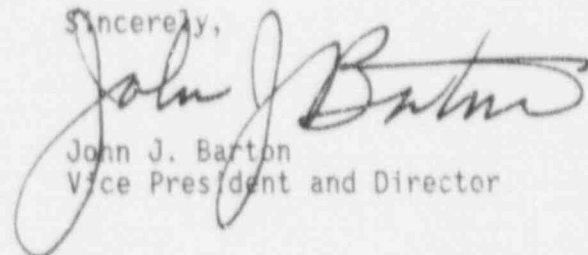
U.S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555

Dear Sir:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Voluntary Licensee Event Report

This letter forwards one (1) copy of Voluntary Report No. 91-003. This event has been determined to be not reportable as defined in the USNRC regulations.

Sincerely,



John J. Barton
Vice President and Director

JJB\TB:jc
Enclosure

cc: Administrator, Region 1
Senior NRC Resident Inspector
Oyster Creek NRC Project Manager

(LER-COVLTRS)

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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Oyster Creek, Unit 1 DOCKET NUMBER (2) 0 1 5 1 0 1 0 1 2 1 9 PAGE (3) 1 OF 1 5

TITLE (4) Tech. spec Violation Due to Unlocked High Radiation Area Caused by Personnel Error

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 NAME	DOCKET NUMBER (8)	
06	13	91	91	003	00	08	01	91		0 1 5 1 0 1 0 1	
										0 1 5 1 0 1 0 1	

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

OPERATING MODE (9)	20.402(b)	20.408(a)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10) <u>0100</u>	20.408(a)(1)(ii)	50.73(a)(1)	50.73(a)(2)(v)	73.71(a)
	20.408(a)(1)(iv)	50.73(a)(2)	50.73(a)(2)(vi)	<input checked="" type="checkbox"/> OTHER (Specify in Abstract below and in Text, NRC Form 205A)
	20.408(a)(1)(vi)	50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	Voluntary Report
	20.408(a)(1)(vii)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
	20.408(a)(1)(viii)	50.73(a)(2)(iii)	50.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME Paul Cervenka TELEPHONE NUMBER 609 971 4894

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

CAUSE	SYSTEM	COMPONENT	MANUFAC. TUNER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFAC. TUNER	REPORTABLE TO NRC

SUPPLEMENTAL REPORT EXPECTED (14) YES (If yes, complete EXPECTED SUBMISSION DATE) NO

EXPECTED SUBMISSION DATE (15) MONTH DAY YEAR

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

An area designated as a locked high radiation area was found unlocked. This condition is prohibited by Plant Technical Specification 6.13.2 and is being reported voluntarily. A critique of this event was conducted and concluded that procedure controls, General Employee Training, and Radiation Control Technician Training with respect to High Radiation Areas are all adequate and did not contribute to this event. This event was caused by several personnel errors all of which were contrary to an approved plant procedure. During the past two years at least ten thousand entries have been made to locked high radiation areas without incident. The personnel directly responsible for this event were contractor personnel and were determined to be negligent in performing their duties.

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TEXT (if more space is required, use additional NRC Form 205A's) (17)

Date of Occurrence

The date of occurrence was June 13, 1991 at approximately 1600 hours.

Identification of Occurrence

An area designated as a locked high radiation area was found unlocked.

This condition is prohibited by Plant Technical Specification 6.13.2 and is reported voluntarily.

Conditions Prior to Occurrence

The reactor was shutdown for an extended period of time for the 13R Refueling Outage.

Description of Occurrence

On June 13, 1991 at approximately 1600 hours a contractor Quality Assurance (QA) inspector was assigned to inspect pipe hangers in the cleanup system (E11S-CE) heat exchanger room, a locked high radiation area. After contacting and discussing the activity with the area Radiation Control Technician (RCT), the RCT decided to obtain the key to the lock for the inspector, since the inspector was already donning protective clothing. The area RCT gave the key to the inspector. The inspector then unlocked the gate and then returned the key to the RCT who remained in the immediate area. The gate was of a chain link design using a chain and padlock as the locking device. When the inspector completed his work he exited the area and pulled the gate closed. The RCT believed the gate was locked, he was unaware that a chain and lock was required to lock the gate. The following day, June 14 at approximately 0900 hours the QA inspector notified a different RCT that he may not have locked the gate upon exiting the high radiation area the previous day. The gate was immediately checked and found to be unlocked.

Cause of Occurrence

A critique of this event was conducted and concluded that procedure controls, General Employee Training, and Radiation Control Technician Training with respect to High Radiation Areas are all adequate and did not contribute to this event.

This event was caused by several personnel errors all of which were contrary to an approved plant procedure. The errors and procedural requirements are discussed below.

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TEXT IF MORE SPACE IS REQUIRED, USE PREVIOUS EDITION OF NRC Form 496A (4/77)

Procedure 9300-ADM-4110.06 "Control of Locked High Radiation Areas" requires that the Shift Radiation Control Technician who issues the high radiation area key to an individual must ensure that the individual is briefed on instructions and responsibilities associated with signing out the key. The shift Radiation Control Technician that issued the key was an in house technician and did not perform this briefing. He felt it was not necessary because the individual signing out the key was a qualified Radiation Control Technician. The procedure does not provide for any exceptions for this briefing, therefore this briefing should have been performed. This error did not cause the event but may have contributed to it.

The above procedure also specifies the individual who signs out the key is the responsible individual to ensure the gate is locked closed after exiting the area. When the key is returned this individual is required to sign a form that reads "I have physically challenged the latching mechanism (push, pull, twist, etc.) in order to fully ascertain that a locked condition has been established/maintained". The contractor Radiation Control Technician who signed out the key, signed this form even though he did not perform the action. The RCT remained at the step off pad while the QA inspector was in the high radiation area. When the QA inspector left the area he pulled the gate closed. The RCT assumed that this action locked the gate. He was not aware that a chain and padlock was required to properly secure the gate.

The above procedure also specifies that the responsible individual who signs out the key is also responsible to get another individual to independently verify the high radiation area gate is locked. The RCT that signed out the key requested a firewatch individual in the area to sign the verification form. The firewatch individual signed the form which contained the statement "I have physically challenged the latching mechanism (push, pull, twist, etc.) in order to fully ascertain that a locked condition has been established/maintained". The firewatch did not check and verify the status of the cleanup heat exchanger area door. The firewatch individual indicated, subsequent to signing the form, he did check the status of the gate to the general cleanup area which is a locked chain link gate, however this is not the control to the locked high radiation area.

To ensure that the provisions of this procedure are properly implemented the procedure also requires that the Radiation Controls Department, on a daily basis, verify the integrity of all locked high radiation areas for which keys have been issued. Shortly after 2030 hours on 6/13/91 another contractor Radiation Control Technician assumed responsibility for the area involved. This technician indicated he donned gloves and booties, entered the contaminated area and checked the status of the cleanup heat exchanger room gate as part of his routine activities for assuming his post. Later when reviewing the high radiation key log he realized that the Cleanup System Heat Exchanger room was entered during the day. He initialed the log indicating he had checked the gate based upon his actions at 2030 hours. Based upon the gate being found unlocked the following morning, it appears doubtful that the check of the gate was performed in accordance with established and proceduralized door status and integrity guidelines.

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TEXT IF MORE SPACE IS REQUIRED, USE ADDITIONAL NRC Form 365A's (17)

Other than the radiation control technician who issued the key, all other personnel involved in this event were contractor personnel.

Analysis of Occurrence and Safety Assessment

Areas are designated and controlled as locked high radiation areas to prevent unauthorized entry. By controlling access to these areas the Radiation Control Department can ensure that all personnel are briefed on conditions, work activities are properly planned, and all possible precautions are taken to minimize radiation dose to individuals that have the need to enter the area.

The locked high radiation area in question is the Cleanup System Heat Exchanger room. The general radiation fields in this area are several hundred millirads per hour. Access to the general area immediately outside of the heat exchanger room is also a limited access area and normally kept locked although not controlled as a locked high radiation area. The Cleanup System Heat Exchanger room is clearly marked a locked high radiation area. In this case the gate permitting entry to the heat exchanger room was not locked for a period of approximately 18 hours. Because access is limited to the general area and the entry is clearly labeled as a locked high radiation area, it is highly improbable that personnel would enter this area without Radiation Control Department permission. Based upon the above, the significance of this event is minimal.

Corrective Actions

Immediate corrective action upon discovering the door was unlocked was to search the Cleanup System Heat Exchanger room to ensure no one was inside and then lock the gate and independently verify it was locked in accordance with procedures.

This is the first instance of a locked high radiation area found unlocked in approximately two years. During this 1 year period at least ten thousand entries have been made to locked high radiation areas without incident. The personnel directly responsible for this event were contractor personnel and were determined to be negligent in performing their duties. Appropriate disciplinary action has been taken with regard to personnel involved in this incident.

Procedure controls and training have been reviewed and have been determined to be adequate. This Licensee Event Report will be added as required reading for the Radiation Control Technician Qualification program to ensure that all RCT's are sensitive to the controls, procedures and expectations in this area.

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TEXT (If more space is required, use additional NRC Form 3866's) (17)

Similar Events

- LER 87-036 High Radiation Area Technical Specification Violation due to Personnel Error and Procedural Non-Compliance.
- LER 87-031 Violation High Radiation Area Technical Specifications Caused by Personnel Error During Response to Fire Alarm.