AC Ferm	LICENSEE EVENT REPORT (LER)											U.S. NUCLEAR REGULATORY COMMISSION APPROVED ONS NO. 3150-0104 EXPIRES: \$/31.85						
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							ICENSEE	CONTACT	FOR THIS	LER (12)				TELEPHO				
William Eisele, Health Physicist, Extension 666												1,5	3,5	7 1 -	,6,7	16,1		
		_			COMPLETS	ONE LINE FOR	EACH C	OMPONEN	T FAILURE	DESCRIBE	IN THIS RE	PORT (13)						
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RACT (Limit to 1400 spaces, i.e., approximately titisen unque-space typewritten lines) (16)

Door 213 controlling access to area behind the Unit 2 Turbine Shield Walls (High Radiation Area) was found to be open. This door is the Southeast entrance wire mesh gate. This loss of positive control is contrary to Technical Specification 6.1.1. and 10 CFR 20.203. The gate was secured at 1724 hours at the time of discovery.

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TEXT IN more space is required, use additional NAC Form 386A's/ (17)

1. EVENT DESCRIPTION

On May 21, 1984, at 1724 hours, while conducting plant rounds, a Health Physicist found Door 213 to be open. Door 213 is a wire mesh gate, and is the southeast entrance to the area behind the Unit 2 Turbine Shield Walls. The area behind these walls was posted as a High Radiation Area at the time of the event. During this time period, Unit 2 was at 37% power. This loss of positive control over access into this High Radiation Area is contrary to Technical Specification 6.1.1. and 10 CFR 20.203.

11. CAUSE

The cause of this event is personnel error. Two Maintenan a Mechanics opened the gate to carry lumber into the Unit 2 Turbine area at 1715 hours. Neither individual apparently ensured that the gate closed and locked after passing through the entrance.

III. PROBABLE CONSEQUENCES OF THE OCCURRENCE

The door was only open for 9 minutes without positive control. To date, no individual at LaSalle County Station has received a whole body or extremity dose equivalent in excess of the regulatory limits specified in 10 CFR 20.101 as a result of this occurrence. The Direct Reading Dosimeter Log indicates that the highest dose equivalent recorded for the day in question was 44 mrem, which is less than the allowable daily administrative limit of 50 mrem. The impact of this event is therefore considered to be minimal in terms of dose equivalent to station personnel.

IV. CORRECTIVE ACTION

When the door was found to be open, it was promptly closed and secured. Security was contacted to determine what individuals had passed through the door. It was determined that High Radiation Key Card 9002 had been punched into the card reader controlling access through Door 213. This key card was traced to the two Maintenance Mechanics discussed previously.

V. PREVIOUS OCCURRENCES

While these have been previous unsecured high radiation doors, the only LER was 373/84-25-00.

VI. NAME AND TELEPHONE NUMBER OF PREPARER

W.F. Eisele, (815) 357-6761, Extension 666.



June 7, 1984

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

Dear Sir:

Reportable Occurrence Report #84-022-00, Docket #050-374 is being submitted to your office in accordance with 10CFR 50.73.

G.J. Diederich Superintendent

LaSalle County Station

GJD/MLD/ph

Enclosure

cc: NRC, Regional Director INPO-Records Center File/NRC

TEZZ