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July 10, 1992 ND3MNO:3329

Beaver Valley Power Station, Unit No. 1 Docket No. 50-334, License No. DPR-66

LER 92-006-00

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 92-006-00. 10 CFR 50.73.a.2.i.B, "Unlocked High Radiation Area Door".

Very truly yours,

T. P. Noonan

General Manager Nuclear Operations

DJM/sl

Attachment

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July 10, 1992 ·ND3MND:3329 Page two cc: Mr. T. T. Martin, Regional Administrator United States Nuclear Regulatory Commission Region 1 475 Allendale Rond King of Prussia, PA 19406 C. A. Roteck, Ohio Edison 76 S. Main Street Akron, OH 44308 Mr. A. DeAgazio, BVPS Licensing Project Manager United States Nuclear Regulatory Commission Washington, DC 20555 Larry Rossbach, Nuclear Regulatory Commission, BVPS Senior Resident Inspector Larry Beck Centerior Energy 6200 Oak Tree Blvd. Independence, Ohio 44101-4661 INPO Records Center Suite 1500 1100 Circle 75 Parkway Atlanta, GA 30339

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LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THE INFORMATION COLLECTION REQUEST 50.0 HRS FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORD AND REPORTS MANAGEMENT BRANCH (F.530), U.S. NUCLEAR COLLATORY COMMISSION, WASHINGTON, DC 20856. A. D. T. THE FAPERWORK REDULTION FROJECT (3150-0104). OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20523.

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or. 6/13/92 at 0212 hours, with the Unit in Operating Mode 1 at 100% power, a routine radiation barrier check discovered the north barrier door to the East Valve Trench. Area was unlocked and approximately 4 inches ajar. This door had last been varified locked at 1731 on 6/12/92. The East Valve Trench Area is a high radiation area located within the Primary Auxiliary Building with radiation fields greater than 1000 mrem/hour. Technical Specification 6.2.12 requires that such areas have locked doors to prevent unauthorized entry. This event is being reported in accordance with 10CFR50.73.a.2.i.B. as a condition prohibited by Technical Specifications. There were no adverse safety implications as a resul' f this event. A search of the area revealed no unauthorized personnel. An exposure summary was developed for all individuals in the Primary Auxiliary Building during this time period and no unusual exposures were identified.

RETIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST BOD HRS FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P\$30. U.S. NUCLEAR REGULATORY COMMISSION WASHINGTON, DC 20858, AND TO THE PARFAWORK REDUCTION PROJECT ("180-0104) OFFICE OF MAN. GEMENT AND 8. DGET, WASHINGTON, DC 20803.

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DESCRIPTION OF EVERT:

On 6/13/92 at 0212 hours, the north barrier door to the East Valve Trench Area was found unlocked and approximately 4 inches ajar. This door has a locking mechanism integral to the door and also has a padlock which locks a hasp on the door. Each shift a radiation technician performs a physical check of all the locked radiation barriers to ensure they are locked. This barrier was last verified locked at 1721 hours on 6/12/92. The East Valve Trench Area is a high radiation area with radiation fields greater than 1000 mrem/hour in some places. The area contains piping and valves for primary plant demineralizers and the solid waste system, which accounts for the high radiation fields experienced. Technical Specification 6.2.12 requires that such areas have locked doors to prevent unauthorized entry. This event is being reported in accordance with 10CFR50.73.a.2.i.B, as a condition prohibited by Technical Specifications.

CAUSE OF EVENT:

The event was caused by a failure to properly verify that the high radiation area barrier door was locked upon exit from the area. Investigation of the event and interviews with personnel who had signed out high radiation barrier keys on 6/12/92 and 6/13/92 were unable to determine precisely when the door had been left unlocked.

CORRECTIVE ACTIONS:

The following corrective actions have been taken as a result of this event:

Immediate:

- 1. The area was immediately searched to ensure that no unauthorized individuals were in the area. No individuals were in the area. The doo. was secured and locked.
- The padlock and door locking mechanism were checked and found to be in proper working condition.

TEXT CONTINUATION

ESTIMATED JURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION PROJECT 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN E. "MATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (PARI). U.S. NUCLEAR REGULATORY COMMISSION. WASHINGTON, DC 2019.5. AND TO THE PAPERWORK REDUCTION PROJECT (3/80-01). OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 2019.3.

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- 3. Since the East Valve Trench Area is within the Primary Auxiliary Building (PAB), an exposure summary was developed on all personnel who had entered the PAB during the time period in question. It revealed that no individual received an unusual exposure. The maximum exposure received by any individual was 5 millirem.
- 4. A letter was issued within the Radiation Control Department delineating the specific requirements for physically checking the padlocks installed on designated high radiation area barrier doors (in addition to the installed door locking device).

Long term:

- A letter of counselling will be issued to all individuals who had high radiation area barrier keys on the days in question.
- A letter discussing this incident will be issued to all individuals who are authorized to sign out high radiation area barrie, keys.
- 3. The form for performing the barrier check will be revised to include the requirement to physically check the padlocks installed on designated high radiation area larrier doors in addition to the installed door locking device.
- 4. This event and its significance will be discussed in the Radiological Operations Personnel Continuous Operator Retraining Program. Emphasis will be placed on the importance of verifying proper locking of radiation barriers following exit from an area and on specification requirements.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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PREVIOUS OCCURRENCES:

A review of station documents revealed one previous similar event:

Beaver Valley Unit 1 LER 89-01 documented an event in which the East Valve Trench Area barrier door was found open. In that event the cause was a faulty locking mechanism.

REPORTABILITY:

This written report is being submitted in accordance with 10CFR50.73.a.2.i.b, as a condition in violation of Technical Specifications.

SAFETY IMPLICATIONS:

There were no safety implications as a result of this event. The area was searched and no unauthorized personnel were discovered in the East Valve Trench Area. An exposure summary developed on all personnel in the Unit One Primary Auxiliary Building during the time period in question showed that no unusual exposures were identified. The maximum exporte received by any individual was 5 millirem.