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Quad Cities Nuclear Power Station
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RLB-92-144

July 1, 1992

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

Reference: Quad Cities Nuclear Power Station
Docket Number 50-265, DPR-30, Unit Two

Enclosed is Licensee Event Report (LER) 92-019, Revision 00, for Quad Cities Nuclear Power Station.

This report is submitted in accordance with the requirements of the Code of Federal Regulations, Title 10, Part 50.73(a)(2)(i)(B): The licensee shall report any operation or condition prohibited by the plant's Technical Specification.

Respectfully,

COMMONWEALTH EDISON COMPANY
QUAD CITIES NUCLEAR POWER STATION

R. L. Bax
Station Manager

RLB/TB/plm

Enclosure

cc: J. Schrage
T. Taylor
INPO Records Center
NRC Region III

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STMGR 390

LICENSEE EVENT REPORT (LER)

Form Rev 2.0

Facility Name (1)	Docket Number (2)	Page (3)
Quad Cities Unit Two	0 5 0 0 0 2 6 5	1 of 0 3

Title (4)

Locked High Radiation Door Lock Malfunctioned

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 Names	Docket Number(s)
										0 5 0 0 0
0 6	0 6	9 2	9 2	0 1 9	0 0	0 7	0 6	9 2		0 5 0 0 0

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)					
	4	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)		
POWER LEVEL (10)	0 5 5	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 (Specify in Abstract below and in Text)		
		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 NUMBER
	AREA CODE
Greg Powell, Health Physics, Ext. 2744	3 0 9 6 5 4 - 2 2 4 1

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)		Expected Submission Date (15)	Month	Day	Year
Yes (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

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

ABSTRACT:

On June 6, 1992 at 0545 hours, Unit Two was in the Run mode operating at 55 percent rated core thermal power. An Operator and Radiation Protection Technician discovered the door to a locked high radiation area was not secured. On May 15, 1992 the door was identified as being difficult to shut and lock. At this time the door still functioned. A Nuclear Work Request was written, but had not been acted on prior to this event.

The cause of this event was the door wedging in the door frame and not allowing the lock's striker mechanism to fully engage with the striker plate

Corrective action for this incident is to assign an individual at the malfunctioned door to a locked high radiation area to prevent inadvertent access until door is made fully functional.

This report is being submitted in accordance with 10CFR50.73(a)(2)(i)(B).

PLANT AND SYSTEM IDENTIFICATION:

General Electric - Boiling Water Reactor - 2511 MWt rated core thermal power.

EVENT IDENTIFICATION: Locked High Radiation Door Lock Malfunctioned.

A. CONDITIONS PRIOR TO EVENT:

Unit: Two Event Date: June 6, 1992 Event Time: 0545
Reactor Mode: 4 Mode Name: RUN Power Level: 55%

This report was initiated by Deviation Report D-4-2-93-092.

RUN Mode (4) - In this position the reactor system pressure is at or above 825 psig, and the reactor protection system is energized, with APRM protection and RBM interlocks in service (excluding the 15% high flux scram).

B. DESCRIPTION OF EVENT:

During an entry into Unit Two under the Main Condenser Hotwell on June 6, 1992, an Operator pushed on a locked high radiation door and it came open. A Radiation Protection Technician assigned to open the door and timekeep the operator, observed the failure of the locking mechanism. Prior to this event, the door was verified locked by a Radiation Protection Technician on June 1, 1992. On May 17, 1992 a Radiation Protection Technician identified that the door was difficult to shut and lock (door was secured prior to Technician leaving area). A Nuclear Work Request was written on that same day.

C. APPARENT CAUSE OF EVENT:

This event is being reported according to 10CFR50.73(a)(2)(i)(B), which requires the reporting of any event or condition that resulted in the nuclear plant being in a condition outside Technical Specifications. The cause of this event was the door wedging in the door frame and causing the lock's striker to only partly engage the striker plate. During weekly verification, the Radiation Protection Technician believed the door was locked because the knob would not turn and the door remained closed when pushed. If a person pushed hard enough on the door, the striker could disengage and come open without using a key.

D. SAFETY ANALYSIS OF EVENT:

The safety consequences of this event are minimal. Personnel are trained that entrance to a posted locked high radiation area requires a Radiation Protection Technician to be present. If an individual inadvertently entered the area, their electronic dosimeter would alarm because the dose rate setpoint would be exceeded (dose rate alarms for all general and most job specific RWPs are set below 1000 mRem/hr). Personnel are trained to leave an area if their dosimeter alarms and contact Radiation Protection.

E. CORRECTIVE ACTIONS:

The door was repaired by Mechanical Maintenance on June 6, 1992.

When a locking mechanism for a locked high radiation area entrance is not functioning properly, an individual will be assigned to prevent inadvertent access until the door is fully functional (NTS #2652009209201).

F. PREVIOUS EVENTS:

Previous events of high radiation area violations were documented as Radiation Occurrence Reports (RORS). In 1990, 1991, and early 1992, there were no RORs written due to lock malfunctions. As a result of a Technical Specification revision, the station is now required to write a Licensee Event Report when areas with whole body dose rates above 1000 mRem/hr are not secured as required by Technical Specifications.

G. COMPONENT FAILURE DATA:

The cause of the door wedging in the door frame and lock's striker only partly engaging the striker plate was the door hinges were sagging.