



Commonwealth Edison

Quad Cities Nuclear Power Station
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RLB-92-255

December 10, 1992

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

Reference: Quad Cities Nuclear Power Station
Docket Number 50-254, DPR-29, Unit One

Enclosed is Licensee Event Report (LER) 92-029, 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)(1)(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

230042

STMGR 502

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LICENSEE EVENT REPORT (LER)

Form Rev 2.0

Facility Name (1) Quad Cities Unit One	Docket Number (2) 0 5 0 0 0 2 5 4	Page (3) 1 of 0 3
Title (4) High Radiation Area Posting Concealed from View And Barrier Eliminated		

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)
1 0	2 9	9 2	9 2	0 2 9	0 0	1 2	1 5	9 2		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9) 2

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

POWER LEVEL (10) 0 0 0	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
	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
Greg Powell, Health Physics Ext. 2744	AREA CODE 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	MANUFAC-TURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)

Yes (If yes, complete EXPECTED SUBMISSION DATE) X | NO

Expected Submission Date (15)	Month	Day	Year

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

ABSTRACT:

On 10-29-92, a Radiation Protection Supervisor found the Unit One Regen Room door propped open. The Regen Room is controlled as a High Radiation Area. The posting identifying the room as a High Radiation Area is on the outside of the door. By the door being propped open, the posting was concealed from view and the barrier to enter the room was eliminated.

The cause of this incident was workers neglecting to close the door after entering or exiting the High Radiation area with equipment.

Corrective action for this incident was to close the door. Signs were posted on all unlocked High Radiation Area doors or gates stating that the door must be closed after entry and exit. Stanchion mounted swing gates have been ordered for placement at specific High Radiation Area entrances. These swing gates will provide an additional barrier and posting to these High Radiation Areas.

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

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION							Form Rev 2.0		
FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)				Page (3)			
		Year	///	Sequential Number	///	Revision Number			
Quad Cities Unit One	0 5 0 0 0 2 5 4	9 2	-	0 2 9	-	0 0	0 2	OF	0 3

TEXT Energy Industry Identification System (EIIS) codes are identified in the text as [XX]

PLANT AND SYSTEM IDENTIFICATION:

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

EVENT IDENTIFICATION: High Radiation Area Posting concealed from view and barrier eliminated.

A. CONDITIONS PRIOR TO EVENT:

Unit: One	Event Date: October 29, 1992	Event Time: 1720
Reactor Mode: 2	Mode Name: REFUEL	Power Level: 0%

This report was initiated by Deviation Report D-4-1-92-140.

REFUEL Mode (2) - In this position interlocks are established so that one control rod only may be withdrawn when flux amplifiers are set at the proper sensitivity level and the refueling crane is not over the reactor. Also, the trip from the turbine control valves, turbine stop valves, main steam isolation valves, and condenser vacuum are bypassed. If the refueling crane is over the reactor, all rods must be fully inserted and none can be withdrawn.

B. DESCRIPTION OF EVENT:

On 10-29-92, a Radiation Protection Supervisor found the Unit One Regen Room door propped open. Unit One was in a Refuel Outage and the Regen Room was being controlled as a High Radiation Area. The posting identifying the room as a High Radiation Area is on the outside of the door. By the door being propped open, the posting was concealed from view and the barrier to enter the room was eliminated. Radiation Protection Supervisor contacted another Radiation Protection Supervisor to send a Radiation Protection Technician to the Regen Room. The Radiation Protection Supervisor maintained control of the area while he waited for the Radiation Protection Technician. The Radiation Protection Technician entered the Regen Room to see if any workers were in the area. The room was unoccupied. The Radiation Protection Technician removed the spool piece used to prop the door open and closed the door.

This incident was not determined to be a Licensee Event Report (LER) until November 17, 1992. The delay in determining if this event was a LER was due to conversation between the Station, Corporate Licensing and the NRC on whether this incident required an LER to be written.

C. APPARENT CAUSE OF EVENT:

This event is being reported according to 10CFR 50.73 (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.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

Form Rev 2.0

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Quad Cities Unit One	0 5 0 0 0 2 5 4	9 2	-	0 2 9	-	0 0	0 3	OF	0 3	
TEXT Energy Industry Identification System (EIIIS) codes are identified in the text as [XX]										

The cause of this event was workers neglecting to close the door to the Regen Room after propping it open for easy access or exit with equipment.

D. SAFETY ANALYSIS OF EVENT:

The safety consequences of this event are minimal. All personnel that enter the Radiological Controlled Area of the plant are required to wear an electronic dosimeter. If an individual inadvertently entered the area, the electronic dosimeter would provide a read out of the exposure accumulated and would alarm at a pre-set accumulated exposure level of 90 mRem.

E. CORRECTIVE ACTIONS:

The door to the Unit One Regen Room was closed. An investigation of the incident did not reveal who left the door propped open. Additional signs were placed on all unlocked High Radiation Area doors and gates. These signs informed individuals that the door or gate must be closed after entry or exit. Stanchion mounted swing gates have been ordered for placement at specific (frequently used) High Radiation Area entrances. These swing gates will provide an additional barrier and posting to these High Radiation Areas (NTS# 2542009214001).

F. PREVIOUS EVENTS:

LER 2-92-019 Locked High Radiation area locking mechanism malfunction.

LER 2-92-022 Opening in wall allowing access into a Locked High Radiation area.

G. COMPONENT FAILURE DATA:

None.