

CONTROL BLOCK:

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 (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

09		SYSTEM CODE S D		11	CAUSE CODE A		12	CAUSE SUBCODE A		13	COMPONENT CODE Z Z Z Z Z Z Z						14	COMP. SUBCODE Z		15	VALVE SUBCODE Z		16												
7	8	9	10		11		12										19				20														
17		LER/RO REPORT NUMBER		EVENT YEAR 8 3		21	22	SEQUENTIAL REPORT NO. 0 2 2		24	26	OCCURRENCE CODE /		27	REPORT TYPE 0 1		28	29	REPORT TYPE T		30	REVISION NO. 0		32											
ACTION TAKEN X		18	FUTURE ACTION G		19	EFFECT ON PLANT Z		20	SHUTDOWN METHOD Z		21	HOURS 0 0 0 0						22	ATTACHMENT SUBMITTED Y		23	NPRD-4 FORM SUB N		24	PRIME COMP. SUPPLIER Z		25	COMPONENT MANUFACTURER Z 9 9 9						26	47
33			34			35			36																										

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

7		8		9		FACILITY STATUS [1][5] [H] (28)		% POWER [0][0][0] (29)		OTHER STATUS NA (30)		METHOD OF DISCOVERY [B] (31)		DISCOVERY DESCRIPTION Routine Operations Inspections (32)		80	
7		8		9		ACTIVITY CONTENT RELEASED OF RELEASE [1][6] [Z] (33) [Z] (34)		AMOUNT OF ACTIVITY NA (35)				LOCATION OF RELEASE NA (36)				80	
7		8		9		PERSONNEL EXPOSURES NUMBER [1][7] [0][0][0] (37)		TYPE [Z] (38)		DESCRIPTION NA (39)						80	
7		8		9		PERSONNEL INJURIES NUMBER [1][8] [0][0][0] (40)		DESCRIPTION NA (41)								80	
7		8		9		LOSS OF OR DAMAGE TO FACILITY TYPE [1][9] [Z] (42)		DESCRIPTION NA (43)								80	
7		8		9		PUBLICITY ISSUED [2][0] [N] (44)		DESCRIPTION NA (45)								80	

PHONE 309-654-2241, ext 183

- I. LER NUMBER: LER/RO 83-22/01T-0
- II. LICENSEE NAME: Commonwealth Edison Company
Quad-Cities Nuclear Power Station
- III. FACILITY NAME: Unit Two
- IV. DOCKET NUMBER: 050-265
- V. EVENT DESCRIPTION:

At 1330 hours, on November 15, 1983, while performing routine plant inspections, both interlock doors to the Unit Two Main Steam Isolation Valve (MSIV) room were found to be open while the room was part of Secondary Containment at the time. This situation resulted in Secondary Containment integrity being in a degraded mode delineated by Technical Specification 3.7.C.1. The ventilation and floor drain penetrations were isolated immediately; thus, making the MSIV room part of the Turbine Building and restoring Secondary Containment integrity. Unit Two was shutdown for refueling and no fuel was in the Reactor vessel. Unit One was operating at approximately 99 percent of rated thermal power.

VI. PROBABLE CONSEQUENCES OF THE OCCURRENCE:

The MSIV room can be isolated from Secondary Containment by plugging the floor drain and securing hatches located on the Reactor Building ventilation dampers entering the room. Normal operating practice is to maintain a negative differential pressure between the Reactor Building and the outside, and between the Turbine Building and outside. Both Standby Gas Treatment trains were operable throughout the event and would have auto-started in the event of an auto-initiation signal. Any release to the environment occurring during this incident would have been treated in the Standby Gas Treatment System and/or discharged at an elevated release point.

VII. CAUSE:

On November 9, 1983, the MSIV room was changed to part of the Reactor Building so that water could be drained from piping located in the room. On November 15, Maintenance personnel were found working in the room with both interlock doors propped open. These individuals had been told on November 10 that the room was part of the Turbine Building by a Shift Engineer. This individual had missed the log entry which explained the change in status. Thus, the root cause of this incident is personnel error.

VII. CAUSE: (Continued)

A contributing cause was inadequate procedures. There were no procedures which explained the necessary actions to make the MSIV room part of the Reactor Building or Turbine Building. Also, there was no definite mechanisms set-up to alert personnel at the MSIV room of the status of the room.

VIII. CORRECTIVE ACTION:

The Shift Engineer responsible for allowing the door interlocks to be defeated has been counseled by the Station Superintendent and will be assigned a special project to investigate plant activities that could have a similar potential for error.

A procedure will be written which will provide the necessary instructions and precautions to properly change the condition of the MSIV room. This procedure will also explain the use of signs to identify the exact status of the room. The signs will be posted on the entrance door to the Unit One and Unit Two MSIV rooms. This same system of signs will be used in the Shift Engineer's office to provide better administrative controls.



Commonwealth Edison

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DmB

NJK-83-436

November 28, 1983

J. Keppler, Regional Administrator
Office of Inspection and Enforcement
Region III
U. S. Nuclear Regulatory Commission
799 Roosevelt Road
Glen Ellyn, IL 60137

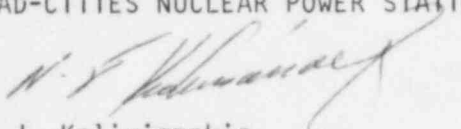
Reference: Quad-Cities Nuclear Power Station
Docket Number 50-265, DPR-30, Unit Two
Appendix A, Section 3.7.C.1

Enclosed please find Reportable Occurrence Report Number RO 83-22/01T-0 for Quad-Cities Nuclear Power Station. This occurrence was previously reported to Region III, Office of Inspection and Enforcement by telephone on November 15, 1983, and telecopy on November 16, 1983.

This report is submitted to you in accordance with the requirements of Technical Specification 6.6.B.1.f, a personnel error procedural inadequacy which could prevent, by itself, the fulfillment of the functional requirements of a system used to cope with accidents analyzed in the SAR.

Respectfully,

COMMONWEALTH EDISON COMPANY
QUAD-CITIES NUCLEAR POWER STATION


N. J. Kalivianakis
Station Superintendent

NJK:DGC/bb

Enclosure

cc B. Rybak
A. Morrongiello
INPO Records Center

DEC - 1 1983

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