



Commonwealth Edison
LaSalle County Nuclear Station
2601 N. 21st. Rd.
Marseilles, Illinois 61341
Telephone 815/357-6761

December 11, 1992

Director of Nuclear Reactor Regulation
U.S. Nuclear Regulatory Commission
Mail Station P1-137
Washington, D.C. 20555

Dear Sir:

Licensee Event Report #92-014-00, Docket #050-373 is being submitted to your office in accordance with 10CFR50.73(a)(2)(i).

WR. Amf
for G. J. Diederich
Station Manager
LaSalle County Station

GJD/LMS/mkl

Enclosure

xc: Nuclear Licensing Administrator
NRC Resident Inspector
NRC Region III Administrator
INPO - Records Center
IDNS Resident Inspector

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PDR ADCK 05000373
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11

LICENSEE EVENT REPORT (LER)

Form Rev 2.0

Facility Name (1)

Docket Number (2)

Page (3)

LaSalle County Station Unit 1

0 | 5 | 0 | 0 | 0 | 3 | 7 | 3 | 1 | of | 0 | 5

Title (4)

High Radiation Area Boundary (Door) Violation Due To Personnel Error

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	1	1	1	9	2	9	2	---	0 1 4	0 0
1	1	1	1	9	2	1	2	1	1	9

OPERATING
MODE (9)

0

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(a)(1)(i)

20.405(a)(1)(ii)

20.405(a)(1)(iii)

20.405(a)(1)(iv)

20.405(a)(1)(v)

20.405(c)

50.36(c)(1)

50.36(c)(2)

50.73(a)(2)(i)

50.73(a)(2)(ii)

50.73(a)(2)(iii)

50.73(a)(2)(iv)

50.73(a)(2)(v)

50.73(a)(2)(vii)

50.73(a)(2)(viii)(A)

50.73(a)(2)(viii)(B)

50.73(a)(2)(x)

73.71(b)

73.71(c)

Other (Specify
in Abstract
below and in
Text)

LICENSEE CONTACT FOR THIS LER (12)

Name

TELEPHONE NUMBER

AREA CODE

Linda M. Shearer, Operating Staff, Extension 2803

8 | 1 | 5 | 3 | 5 | 7 | - | 6 | 7 | 6 | 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
A				N					

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)

Unit 1 was defueled for Refuel Outage L1R05.

On November 11, 1992, at 1730 hours the Reactor Building 673 elevation watertight door leading into the North East Corner Room (Low Pressure Core Spray / Reactor Core Isolation Cooling Room or LPCS/RCIC Room) was discovered tied open. The outer cage door was open with no posting on it. Because this area was a high radiation area, and no barricade was present, a violation of Tech Spec 6.1.1 was declared.

Investigation determined the cause to be personnel error and poor communication. A Non-licensed Operator tied open a watertight door, which was also a High Radiation Area barrier, while performing a Special Procedure (LLP).

Immediate Corrective Actions were the LPCS/RCIC cage doorway being barricaded by means of a rope with appropriate sign in order to comply with High Radiation Area access control rules.

Further Corrective Actions include: individuals involved will be counseled, Operating Department review of this event, Health Physics Department will walk down all unlocked high radiation area access points, and a review of secondary dosimetry.

This is reportable to the Nuclear Regulatory Commission pursuant to 10CFR50.73(a)(2)(i)(B) any condition prohibited by the plant's Technical Specifications.

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		Year	///	Sequential Number	///	Revision Number							
LaSalle County Station Unit 1	0 5 0 0 0 3 7 3	9 2	-	0 1 4	-	0 0	0 2	OF	0 5				
TEXT Energy Industry Identification System (EIIS) codes are identified in the text as [XX]													

PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor

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

A. CONDITION PRIOR TO EVENT

Unit(s): 1 Event Date: 11/11/92 Event Time: 1730 Hours

Reactor Mode(s): Defueled Mode(s) Name: Refuel Power Level(s): 0%

B. DESCRIPTION OF EVENT

Unit 1 was defueled for Refuel Outage L1R05.

On first shift November 1, 1992 a Non-licensed Operator (EA) was assigned to perform a special procedure, LLP-92-142, "Unit 1 Reactor Building Northeast Sump Discharge Diversion", as part of the effort to drain the Reactor Building Closed Cooling Water System (RBCCW) (WR) [CC] for an Out of Service (OOS).

A Shift Supervisor (SS), Station Control Room Engineer (SCRE), and Shift Engineer (SE) discussed the LLP. The Technical Specification issue and Fire Protection issues were reviewed concerning leaving the watertight door open. Low Pressure Core Spray (LPCS) (LP) [BM] was declared inoperable, and an appropriate Degraded Log Entry was made.

The EA called the SS and Nuclear Station Operator (NSO) to ask about leaving the watertight door open, as directed by the procedure. After discussion with the SS, the EA thought it was acceptable to tie the watertight door open, since the Reactor Core Isolation Cooling (RCIC) (RI) [BN] and LPCS Systems were OOS or inoperable already. The EA believed that the SS told him that he would take care of matters concerning the watertight door. No further details were discussed as to what specifically that meant. The SS meant he would take care of the LPCS inoperability and DEL entry. The SS was apparently not cognizant of the fact that by tying the watertight door open, the High Radiation Area barricade was being removed.

The EA continued with the procedure, tying the LPCS/RCIC Watertight Door open to allow routing a hose from the 1RE08 Reactor Building Northeast Drain Sump through the doorway. With the Watertight Door tied open, the radiation posting information was not obviously visible without actually entering the High Radiation Area.

The EA routed the hose through the watertight door and under the cage wire door. The hose was secured per procedure and the cage door closed.

The SS reviewed the activities with the EA when he returned, but neither recognized that a High Radiation Area door was being left unbarricaded and unattended.

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

B. DESCRIPTION OF EVENT CONTINUED

On November 11, 1992, at 1730 hours the Reactor Building 673 elevation watertight door leading from the North East Corner Room (LPCS/RCIC Room) to the "raceway" was discovered tied open during monthly routine surveys by Radiation Protection Technicians (RPTs). The cage door was also found open with no posting information on it. If the cage door had been posted and closed it could have been considered an adequate barrier. Because this area was a High Radiation Area having no barricade with acceptable posting, a violation of Technical Specification 6.1.1 was declared. The SS was notified of the situation. An investigation was initiated.

C. APPARENT CAUSE OF EVENT

Investigation has determined the cause to be personnel error and poor communication. Contributing causal factors were:

1. In the past, the LPCS/RCIC area cage door had been used as the High Radiation barrier. It was always locked and posted. The watertight door has always been used as a method of flood protection in the corner room to protect equipment and maintain it as operable. In the past, the watertight door had not been used as a High Radiation barrier unless it was locked. Health Physics had moved the posting onto the front of the watertight door as a result of philosophy and procedure changes (LRP-1120-2) designed to make access to High Radiation Areas easier for the workers.

2. Failure to follow procedure contributed to leaving the area unbarricaded.

- a. The Operator failed to follow step D.3 of LLP-92-142, which states:

"Consult with the Radiation Protection Department prior to entering any Hi Radiation Areas. The RBEDT Tank Room contains unusually High levels of radiation."

It appears that the Operator glossed over this section of the procedure, partly because it was in the prerequisite (not a step of the body of the procedure), and partly because he wasn't going into the RBEDT Tank Room. He thought he didn't have to notify Radiation Protection Department because he had signed the Radiation Work Permit (RWP.)

- b. LRP-1120-2 provides directions that people should contact Radiation Protection whenever going into a High Radiation Area in order to determine if the conditions had changed since the last survey.
- c. The Operator failed to follow the RWP, which required him to contact Radiation Protection prior to entering High Radiation Areas as well as prior to entering contaminated areas allowed on the RWP.

D. SAFETY ANALYSIS OF EVENT

The safety significance of this event is minimal as it would not effect the safe shutdown of the plant.

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

D. SAFETY ANALYSIS OF EVENT CONTINUED

A watertight door which provides flood protection for the LPCS and RCIC pumps was open. The equipment had been appropriately declared inoperable prior to the watertight door being opened.

Personnel protection against radiation overexposure was reduced by the absence of a physical barrier however all unescorted individuals receive training on ALARA principles. In addition anyone working in the plant is required to review radiological survey maps associated with the RWP they working under. Accurate survey maps were available at all times.

E. CORRECTIVE ACTIONS

The LPCS/RCIC cage doorway was barricaded by means of a rope with signs in order to comply with High Radiation Area access control rules.

The Assistant Superintendent of Operating (ASO) or designee will counsel the EA and the SS involved regarding:

- The need for clear and specific communications, including repeating back information, especially when communicating by phone.
- The need to follow procedures will be reinforced, specifically addressing the fact that ALL parts of the procedure are to be followed, not just the body (section F).
- The need to read and follow the RWP instructions will be reviewed.
- New high radiation area rules being clearly understood. Action Item Record (AIR) 373-180-92-09101 will track completion of these items.

The Administrative Operating Engineer or his designee will review this event with the Operating Department during a review of other personnel errors. This will be completed before February 1, 1993. AIR 373-180-92-09102 will track completion of this review.

The Health Physics Department has walked down all unlocked High Radiation Area access points and verified that there are no other unbarricaded High Radiation Area access points in the plant.

Secondary dosimetry (Digi-doses) were reviewed for that period. It was determined that no one exceeded permitted doses as a result of this area being improperly barricaded.

The Administrative Operating Engineer has placed information about the new High Radiation Area access rules in his Daily Orders to enhance Shift Engineer emphasis of this change with each crew.

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F. PREVIOUS EVENTS

None.

G. COMPONENT FAILURE DATA

None.

EVENT SUMMARY AND CAUSE CODES

 DVR Number
 OL-1-22-091

<input type="checkbox"/> Lost generation	<input type="checkbox"/> Reactor trip	<input type="checkbox"/> NRC violation, level__
<input type="checkbox"/> Cost > \$25,000	<input type="checkbox"/> ESF actuation	<input type="checkbox"/> GSEP event, class__
<input type="checkbox"/> Hazard or Spill	<input type="checkbox"/> NRC reportable	<input type="checkbox"/> Tech Spec LCO
<input type="checkbox"/> Personnel injury	<input type="checkbox"/> LER	<input type="checkbox"/> Potential or future loss
<input type="checkbox"/> Component type	<input type="checkbox"/> PSE	<input type="checkbox"/> SALP functional area__
	<input type="checkbox"/> Failure mode	

Department		Department		Department	
X					
X					
X					

Licensed? L or blank		Type		Detail code	
Level		Department		Detail code	
A	W	IO	P	F	I
A	W	IO	P	M	Z
A					

Type		Detail Code		Department	
B					
B					
B					

Type	Detail code
C	

Type of deficiency	Detail code	Procedure type
D		
D		
D		

Type	Detail code	Department
E		
E		
E		