

Commonwealth Edison Company
Quad Cities Generating Station
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March 3, 2000

SVP-00-046

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D.C. 20555

Quad Cities Nuclear Power Station, Units 1 and 2
Facility Operating License Nos. DPR-29 and DPR-30
NRC Docket Nos. 50-254 and 50-265

Enclosed is Licensee Event Report (LER) 254/00-001, 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)(iv). The licensee shall report any event or condition that resulted in manual or automatic actuation of any Engineered Safety Feature.

We are committing to the following actions:

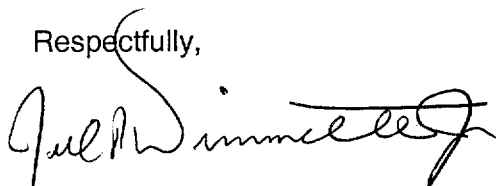
- (1) Skill based refresher training on finger block installation will be provided as part of the Human Performance Training Course.
- (2) Electrical Maintenance and Operations will investigate the possibility of using an alternate method of blocking HGA relay contacts to prevent inadvertent closure of contacts during logic testing.

Any other actions described in the submittal represent intended or planned actions by Commonwealth Edison (ComEd) Company. They are described for the NRC's information and are not regulatory commitments.

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Should you have any questions concerning this letter, please contact Mr. C.C. Peterson at (309) 654-2241, extension 3609.

Respectfully,

A handwritten signature in black ink, appearing to read "Joel P. Dimmette, Jr.", written in a cursive style.

Joel P. Dimmette, Jr.
Site Vice President
Quad Cities Nuclear Power Station

cc: Regional Administrator – NRC Region III
NRC Senior Resident Inspector – Quad Cities Nuclear Power Station

LICENSEE EVENT REPORT (LER)														Form Rev. 2.0											
Facility Name (1) Quad Cities Unit 1							Docket Number (2) 0 5 0 0 0 2 5 4							Page (3) 1 of 0 4											
Title (4) Inadvertent Start of the Shared Emergency Diesel Generator during Automatic Depressurization System Logic Testing																									
Event Date (5)			LER Number (6)				Report Date (7)			Other Facilities Involved (8)															
Month	Day	Year	Year	Sequential Number	Revision Number	Month	Day	Year	Docket Number(s)																
0	2	03	2000	001	00	03	03	2000	05000265																
OPERATING MODE (9) 1		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)																							
POWER LEVEL (10)	1	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)	X	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 Charles Peterson, Regulatory Affairs Manager, ext. 3609										TELEPHONE NUMBER 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	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX																
SUPPLEMENTAL REPORT EXPECTED (14)										Expected Submission Date (15)		Month	Day	Year											
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)										<input checked="" type="checkbox"/> NO															
ABSTRACT (Limit to 1400 spaces, i.e. approximately fifteen single-space typewritten lines) (16)																									

ABSTRACT:

On February 3, 2000, at 1021 hours, Unit 1 was in the Run Mode at 100% power and Unit 2 was in the Refuel Mode when an Electrical Maintenance (EM) worker inadvertently actuated a relay during the performance of an Automatic Depressurization System Logic Test. This caused the Shared Emergency Diesel Generator (EDG) to auto-start.

The root cause of this event was an ineffective work practice

Corrective actions will include skill based refresher training on finger block installation.

The safety significance of this event was minimal. In the event that either Unit EDG was needed they were operable.

There was a similar event in January 1998, (LER 1998-001.) However, the circumstances surrounding generation of the auto-start signals were not common between these two events.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

Form Rev. 2.0

FACILITY NAME (1) Quad Cities Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 2 5 4	LER NUMBER (6)			PAGE (3) 2 of 0 4
		Year	Sequential Number	Revision Number	
		2000	0 0 1	0 0	
TEXT Energy Industry Identification System (EIIIS) 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:

Inadvertent Start of the Shared Emergency Diesel Generator during Automatic Depressurization System Logic Testing

A. CONDITIONS PRIOR TO EVENT:

Unit:	1	Event Date:	February 3, 2000	Event Time:	1021 hours
Reactor Mode:	1	Mode Name:	Power Operation	Power Level:	100%

Unit:	2	Event Date:	February 3, 2000	Event Time:	1021 hours
Reactor Mode:	5	Mode Name:	Refueling	Power Level:	0%

This report was initiated by Licensee Event Report 254/00-001

Power Operation (1) – Mode switch in the Run position with average reactor coolant temperature at any temperature.

Refueling (5) - Mode switch in the Shutdown or Refueling position with average reactor coolant temperature \leq 140 degrees F and fuel in the reactor vessel with one or more vessel head closure bolts less than fully tensioned or with the head removed.

B. DESCRIPTION OF EVENT:

On February 3, 2000, Automatic Depressurization System (ADS) logic testing was being performed on Unit 2 in accordance with QCOS 0203-06, Revision 6, "Automatic Blowdown Logic Test."

This procedure is performed once every 18 months to meet the requirements of Technical Specifications Surveillance Requirements Sections 4.6.F.1.a and b. This procedure describes that inadvertent equipment actuation may occur during performance of the procedure. During performance of this procedure an Electrician under the supervision of an Operating Supervisor removed and installed electrical jumpers, fuses [FU], and contact blocks to test the individual annunciators [ANN], relays [RLY], and valves [V] without actual initiation of the system. Phone communications were established between the Unit 2 Control Room, Auxiliary Electric Room, and Panel 2202-32, located on the second floor of the Reactor Building.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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Quad Cities Unit 1	0 5 0 0 0 2 5 4	2000	0 0 1	0 0	3 of 0 4
TEXT Energy Industry Identification System (EIS) codes are identified in the text as [XX]					

As directed by the Operations Supervisor in the Auxiliary Electrical Room, the Electrician was attempting to place a finger block (an insulator to prevent electrical current from being passed when the contact is closed) between contacts 1 and 7 of relay 2-1430-127A at panel 902-32-3W. The 2-1430-127A relay is at approximately knee level in the panel and has a wire run directly above. This makes installation of the finger block difficult. The Operations Supervisor heard the 2-1430-108A relay energize and instructed the Electrician to stop. The Operations Supervisor immediately contacted the Control Room to determine if an inadvertent start had taken place. The Control Room Personnel reported the Shared Unit Emergency Diesel Generator (EDG) [EK] had started and the test was stopped.

A debrief of this event was held with the personnel involved with the test, the Unit Supervisor, Shift Manager, Operations Supervisor and Senior Outage Control Center management personnel. After discussing the event and identifying lessons learned, a Problem Identification Form was generated and permission was given to resume the ADS logic testing.

Once the Shared Unit EDG was shut down, the Operations Supervisor in charge of the test verified conditions existed to restart the procedure. The same Electrician successfully installed the finger block and the testing was completed without further incident.

C. CAUSE OF THE EVENT:

The root cause for this event was an ineffective work practice for blocking fingers on HGA relays.

HGA relays have a limited clearance around their operating contacts making installation of finger blocks difficult. The Operations Supervisor and the Electrician were both aware of the potential difficulty in installing the finger block on the 2-1430-127A relay.

D. SAFETY ANALYSIS:

The safety significance of this event was minimal. Both the Unit 1 and Unit 2 Emergency Diesel Generators were operable throughout this event if needed. The Shared Diesel was also available to supply power for either Unit.

E. CORRECTIVE ACTIONS:

Corrective Actions Completed:

A crew briefing was held to emphasize the importance of being diligent while installing finger blocks during logic testing.

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 1	0 5 0 0 0 2 5 4	2000	

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

Corrective Action to be Completed:

- (1) Skill based refresher training on finger block installation will be provided as part of the Human Performance Training Course.
- (2) Electrical Maintenance and Operations will investigate the possibility of using an alternate method of blocking HGA relay contacts to prevent inadvertent closure of contacts during logic testing.

F. PREVIOUS OCCURRENCES:

A review of previous LERs and Operating Experience for the past two years identified one similar event..

On January 5, 1998, (LER 98-001) the Unit 1 EDG was inadvertently sent an auto start signal during the performance of QCTS 0300-05 when an Electrician accidentally bumped the 1-1403-127A relay while replacing a relay cover. This event is similar; however, the circumstances were different. Corrective actions from this past event were adequate and would not have prevented this event.

G. COMPONENT FAILURE DATA:

There were no component failures associated with this event.