Commonwealth Edison Company Quad Cities Generating Station 22710 206th Avenue North Cordova, IL 61242-9740 Tel 309-654-2241



March 8, 2000

SVP-00-048

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

> Quad Cities Nuclear Power Station, Unit 2 Facility Operating License Nos. DPR-30 NRC Docket Nos. 50-265

Subject:

High Pressure Coolant Injection Failure to Start during Low Pressure

Testing Due to Incomplete Maintenance Activities

Enclosed is Licensee Event Report (LER) 265/00-005, 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)(v)(D). The licensee shall report any event or condition that alone could have prevented the fulfillment of the safety function of structures or systems that are needed to mitigate the consequences of an accident.

We are committing to the following action:

A supplemental LER will be submitted after completion of the root cause determination.

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,

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

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ABSTRACT:

On February 11, 2000, at 0258 hours, Unit 2 was in the Startup mode (Mode 2) with reactor vessel pressure between 150 and 180 psig, when the High Pressure Coolant Injection (HPCI) pump failed to start during startup surveillance testing. The surveillance was terminated, the system was restored to the standby lineup, and reactor pressure was reduced below 150 psig to place the reactor in a condition where HPCI was not required to be operable.

An investigation determined that work performed on the HPCI system during the refueling outage was not complete and the work package had been closed out in error. The maintenance was subsequently completed and the startup was recommenced.

When the HPCI discharge piping was vented in preparation for retesting of HPCI, air in the discharge piping exceeded procedural acceptance criteria. This indicated that a satisfactory vent had not been obtained on the discharge piping prior to the first test. The discharge piping was subsequently filled and vented, reactor vessel pressure was increased to between 150 and 180 psig, and HPCI was successfully tested.

The determination of the root causes associated with the failure to complete the maintenance and the apparent failure to obtain a satisfactory vent of the discharge line prior to the first HPCI test is not complete. A supplemental LER will be submitted after completion of the root cause determination.

The safety significance of this event was minimal. The reactor vessel pressure was at less than 180 psig, and the automatic depressurization system and all low-pressure emergency core cooling systems were operable.

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PLANT AND SYSTEM IDENTIFICATION:

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

EVENT IDENTIFICATION:

High Pressure Coolant Injection Failure to Start during Low Pressure Testing Due to Incomplete Maintenance Activities

A. CONDITIONS PRIOR TO EVENT:

Unit:	2	Event Date:	February 11, 2000	Event Time:	0258 hours
Reactor Mode:	2	Mode Name:	Startup	Power Level:	4%

This report was initiated by Licensee Event Report 265/00-005

Startup (2) - Mode switch in Startup/Hot Standby position with average reactor coolant temperature at any temperature.

B. <u>DESCRIPTION OF EVENT:</u>

On February 11, 2000, at 0258 hours, Unit 2 was in the Startup mode (Mode 2) with reactor vessel pressure between 150 and 180 psig. When the High Pressure Coolant Injection (HPCI) [BJ] motor speed changer was taken to the high speed stop as part of operability testing required by Technical Specifications surveillance requirement 4.5.A.3.b.1, the HPCI turbine [TRB] failed to operate. The surveillance was terminated and the system was restored to the standby lineup. At 0341 hours reactor pressure was reduced below 150 psig to place the reactor in a condition where HPCI was not required to be operable.

An investigation determined that a work package for work performed on the HPCI system during the refueling outage had been closed out in error. An adjustment still needed to be made on the Interlock Dump Valve [V] to make HPCI operable. These actions were completed and the startup was recommenced.

In preparation for re-testing HPCI, the HPCI discharge piping was vented. During this venting, air was seen to exit the vent line for greater than 10 seconds. This exceeded procedural acceptance criteria. The discharge piping was filled and vented, reactor vessel pressure was increased to between 150 and 180 psig, and HPCI was successfully tested.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION															Form Rev. 2.0				
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C. <u>CAUSE OF THE EVENT:</u>

The determination of the root causes associated with the failure to complete the maintenance and the apparent failure to properly vent the discharge line prior to the first HPCI test is not complete. A supplemental LER will be submitted after completion of the root cause determination.

D. SAFETY ANALYSIS:

During the time that HPCI was inoperable, the reactor vessel pressure was at less than 180 psig. The automatic depressurization system and all low-pressure emergency core cooling systems (ECCS) [B] were operable. At that reactor vessel pressure, low-pressure ECCS pumps [P] could inject into the vessel. Also, there is very little driving pressure for a pipe break and the resulting leakage. Therefore, the safety significance of this event was minimal.

E. CORRECTIVE ACTIONS:

Corrective Actions Completed:

The maintenance was completed, the discharge piping was filled and vented, and HPCI was successfully tested.

Corrective Actions to be Completed:

Corrective actions will be developed as part of the determination of the root cause. A supplemental LER will be submitted after completion of the root cause determination.

F. PREVIOUS OCCURRENCES:

Previous occurrences will be assessed as part of the root cause determination.

G. <u>COMPONENT FAILURE DATA:</u>

Component failure data, if required, will be presented in the supplemental LER.