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Quad Cities Nuclear Power Station
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SVP-03-090

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

Quad Cities Nuclear Power Station, Unit 2
Facility Operating License No. DPR-30
NRC Docket No. 50-265

Subject: Licensee Event Report 265/03-003, "Low Pressure Coolant Injection Differential Pressure Instrument Inoperable due to Misposition of Instrument Valve"

Enclosed is Licensee Event Report (LER) 265/03-003, "Low Pressure Coolant Injection Differential Pressure Instrument Inoperable due to Misposition of Instrument Valve," for Quad Cities Nuclear Power Station, Unit 2.

This report is submitted in accordance with the requirements of the Code of Federal Regulations, Title 10, Part 50.73(a)(2)(i)(B), which requires reporting of any operation or condition which was prohibited by the plant's Technical Specifications.

Should you have any questions concerning this report, please contact Mr. W. J. Beck at (309) 227-2800.

Respectfully,



Timothy J. Tulon
Site Vice President
Quad Cities Nuclear Power Station

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

JE22

Estimated burden per response to comply with this mandatory information collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records Management Branch (T-6 E6), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by Internet e-mail to bjs1@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202 (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

LICENSEE EVENT REPORT (LER)

1. FACILITY NAME Quad Cities Nuclear Power Station Unit 2	2. DOCKET NUMBER 05000265	3. PAGE 1 of 3
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4. TITLE Low Pressure Coolant Injection Differential Pressure Instrument Inoperable due to Misposition of Instrument Valve

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MO	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO	MO	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
03	24	03	03	- 003 -	00	08	18	03	N/A	N/A
									FACILITY NAME	DOCKET NUMBER
									N/A	N/A

9. OPERATING MODE 1	11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply)				
	20.2201(b)	20.2203(a)(3)(ii)	50.73(a)(2)(ii)(B)	50.73(a)(2)(ix)(A)	
10. POWER LEVEL 100	20.2201(d)	20.2203(a)(4)	50.73(a)(2)(iii)	50.73(a)(2)(x)	
	20.2203(a)(1)	50.36(c)(1)(i)(A)	50.73(a)(2)(iv)(A)	73.71(a)(4)	
[REDACTED]	20.2203(a)(2)(i)	50.36(c)(1)(ii)(A)	50.73(a)(2)(v)(A)	73.71(a)(5)	
	20.2203(a)(2)(ii)	50.36(c)(2)	50.73(a)(2)(v)(B)		OTHER Specify in Abstract below or in NRC Form 366A
	20.2203(a)(2)(iii)	50.46(a)(3)(ii)	50.73(a)(2)(v)(C)		
	20.2203(a)(2)(iv)	50.73(a)(2)(i)(A)	50.73(a)(2)(v)(D)		
	20.2203(a)(2)(v)	X 50.73(a)(2)(i)(B)	50.73(a)(2)(vii)		
	20.2203(a)(2)(vi)	50.73(a)(2)(i)(C)	50.73(a)(2)(viii)(A)		
	20.2203(a)(3)(i)	50.73(a)(2)(ii)(A)	50.73(a)(2)(viii)(B)		

12. LICENSEE CONTACT FOR THIS LER

NAME Wally Beck, Regulatory Assurance Manager	TELEPHONE NUMBER (Include Area Code) (309) 227-2800
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13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

14. SUPPLEMENTAL REPORT EXPECTED				15. EXPECTED SUBMISSION DATE		
YES (If yes, complete EXPECTED SUBMISSION DATE)	X	NO		MONTH	DAY	YEAR

16. ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)

On June 20, 2003, a differential pressure instrument isolation valve was found isolated, rendering the instrument inoperable. The other three differential pressure switches that provide the one-out-of-two-twice logic to direct injection of the Low Pressure Coolant Injection system to the intact reactor recirculation pipe during a loss of coolant event were verified to be operable. The surveillance in progress was completed, the switch was tested satisfactorily and the manifold valves were returned to the in-service position.

A work history review identified that the valve was left closed following a March 24, 2003, surveillance. A search of the work history involving the individuals that performed the March 24, 2003, surveillance did not identify any discrepancies.

The safety significance of this event was minimal. The remaining three switches were operable and capable of providing the required logic signal. Therefore, there was no loss of safety function associated with this event.

The root cause for this event is a breakdown in the use of human performance tools. Corrective actions include a revision to Human Performance training and development of a human performance improvement program for the Instrument Maintenance Department.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Quad Cities Nuclear Power Station Unit 2	05000265				
		2003	003	00	3 of 3

(If more space is required, use additional copies of NRC Form 366A)(17)

C. CAUSE OF EVENT

The root cause for this event has been determined to be a breakdown in the use of human performance tools. Specifically, concurrent verification practices were not adequately utilized in this case.

D. SAFETY ANALYSIS

The safety significance of this event was minimal. The remaining three switches were operable and capable of providing the required logic signal. Therefore, there was no loss of safety function associated with this event.

E. CORRECTIVE ACTIONS

Immediate Actions

The instrument valves on all eight of the differential pressure switches on Unit 1 and Unit 2 were verified to be in the correct position.

All Instrument Maintenance crews were briefed on this issue as they came on shift.

Corrective Actions to be Completed

Instrument Maintenance Department (IMD) Management will review and revise the IMD Human Performance Training Program and Dynamic Learning Activities to include more stringent guidelines and more stringent pass/fail criteria.

IMD Management will conduct paired field observations and provide remediation to personnel upon discovery of inadequate performance in use of the human performance tools.

IMD Management will develop a Human Performance improvement plan to include IMD first-line supervisor performance.

F. PREVIOUS OCCURRENCES

No reportable events were identified during the last two years that involved a failure in the IMD to utilize human performance tools.

G. COMPONENT FAILURE DATA

There were no component failures associated with this event.