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Nuclear

May 28, 2004

SVP-04-056

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 Desket No. 50.265

NRC Docket No. 50-265

Subject:

Licensee Event Report 265/04-003, "Unit Trip from Turbine Trip during Thrust

**Bearing Wear Detector Testing**"

Enclosed is Licensee Event Report (LER) 265/04-003, "Unit Trip from Turbine Trip during Thrust Bearing Wear Detector Testing," 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)(iv)(A), which requires reporting of any event or condition that resulted in manual or automatic actuation of the reactor protection system.

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

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NRC FORM 366 U.S. NUCLEAR REGULATORY COMMISSION LICENSEE EVENT REPORT (LER)																	
1. FACILITY NAME							2. DOCKET NUMBER 3						3. PAGE				
Quad Cities Nuclear Power Station Unit 2								05000265					1 of 3				
4. TITLE	Unit Trip	from Tu	rbine	Trip	during Th	rust l	Bearin	g Wea	ar Detect	or '	Testing						
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16. ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)

On March 30, 2004, at 0740 hours, during testing of the Thrust Bearing Wear Detector (TBWD), the main turbine tripped and a Reactor Protection System trip signal was received from the closure of the main turbine stop valves. All control rods fully inserted, and the unit was taken to shutdown.

The cause of this event was the inappropriate use of a surveillance procedure with a known single-point vulnerability, in lieu of a calibration procedure. This was caused by an implementation practice that did not require performance of all three TBWD calibration procedures following turbine maintenance.

The safety significance of this event was minimal. All plant systems operated as designed to shut the unit down.

Corrective actions include the revision of the operations turbine test of the TBWD to provide a positive means of inhibiting a turbine trip during TBWD testing, a review of the implementation of Instrument Maintenance procedures for other situations in which the procedures are used interactively with procedures from another department, and the revision of the work frequency codes that determine when the local adjustment procedures are performed such that the procedures are appropriately performed at the end of an outage.

#### NRC FORM 366A **U.S. NUCLEAR REGULATORY COMMISSION** (7-2001) LICENSEE EVENT REPORT (LER) **TEXT CONTINUATION** LER NUMBER (6) PAGE (3) FACILITY NAME (1) DOCKET NUMBER (2) YEAR SEQUENTIAL REVISION NUMBER NUMBER Quad Cities Nuclear Power Station Unit 2 05000265 2004 003 2 of 3

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

# PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor, 2957 Megawatts Thermal Rated Core Power

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

### EVENT IDENTIFICATION

Unit Trip from Turbine Trip during Thrust Bearing Wear Detector Testing

### A. CONDITION PRIOR TO EVENT

Unit: 2 Reactor Mode: 1 Event Date: March 30, 2004

Event Time: 0740 hours

Mode Name: Power Operation Power Level: 072%

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

### B. DESCRIPTION OF EVENT

On March 30, 2004, at 0740 hours, during testing of the Thrust Bearing Wear Detector (TBWD) [DET], the main turbine [TA] tripped and a Reactor Protection System [JC] trip signal was received from the closure of the main turbine stop valves. All control rods fully inserted, and the unit was taken to shutdown.

## C. CAUSE OF EVENT

The cause of this event was the inappropriate use of a surveillance procedure, with a known single-point vulnerability, in lieu of a calibration procedure.

There are three procedures that adjust the TBWD. These are the TBWD local initial adjustment, the TBWD local intermediate adjustment, and the TBWD local final adjustment. Over the years, it has become accepted practice that the initial adjustment is not necessary, since the intermediate adjustment checks the same parameters. However, the intermediate adjustment does not have direction to balance the TBWD, but to check that it is within certain criteria. Also, the intermediate adjustment is performed with the turbine on the turning gear, instead of at 25% power as recommended by the vendor manual.

Also, it has become practice to use the results of the normal weekly turbine test, which tests the TBWD, to determine whether the local final adjustment needs to be performed. This is to save the dose involved in making the local adjustment. However, the normal weekly operations test of the TBWD does not positively remove the turbine trip during the test, but relies on test logic to inhibit the trip. This had previously been identified as a potential source of a plant trip from a single failure. The local adjustment procedure provides steps for electrically bypassing the TBWD trip.

NRC FORM 366A (7-2001)

### U.S. NUCLEAR REGULATORY COMMISSION

# LICENSEE EVENT REPORT (LER)

TEXT CONTINUATION

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Between the initial setup of the TBWD and the time of the unit trip, the turbine rotor [TRB] had axially shifted, due to run-in, temperature changes, and dynamic loading, causing the TBWD to be significantly out of adjustment. As a result, the displacement of the TBWD housing (used to simulate movement of the TBWD in response to bearing wear) caused the TBWD to initiate a main turbine trip when the test button was pushed during the operations weekly turbine test. The switches designed to inhibit the turbine trip during this test were operable; however, due to the degree to which the TBWD was out of adjustment, the turbine trip occurred early in the test such that the inhibit switches had not actuated.

### D. SAFETY ANALYSIS

The safety significance of this event was minimal. All plant systems operated as designed to shut the unit down. There were no safety system functional failures associated with this event.

### E. CORRECTIVE ACTIONS

# Completed Corrective Actions

The operations turbine test of the TBWD was revised to provide a positive means (lead lift) of inhibiting a turbine trip during TBWD testing.

All TBWD testing was suspended pending further review of the testing process.

# Corrective Actions to be Completed

The implementation of Instrument Maintenance (IM) procedures will be reviewed for other situations in which the procedures are used interactively with procedures from another department to ensure the IM procedure is being properly implemented.

The work frequency codes that determine when the local adjustment procedures are performed will be revised such that the procedures are appropriately performed at the end of an outage.

Modifications will be installed to provide a positive means (e.g., a manual test circuit bypass switch) to prevent trips during TBWD testing.

### F. PREVIOUS OCCURRENCES

No previous occurrences were identified at Quad Cities Nuclear Power Station involving a scram during performance of the TBWD surveillance.

### G. COMPONENT FAILURE DATA

There were no component failures associated with this event.