

# LICENSEE EVENT REPORT

CONTROL BLOCK:

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 1 L Q A D 2 2 0 0 0 - 0 0 0 - 0 0 0 3 4 1 1 1 1 4 5  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

CON'T  
01 1 L Q A D 2 2 0 0 0 - 0 0 0 - 0 0 0 3 4 1 1 1 1 4 5  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)  
01 2 After discovering the 1/2 Diesel Generator was inoperable due to failure of the 1/2  
01 3 Diesel Generator Cooling Water Pump, the surveillance for ECCS was performed on the  
01 4 incorrect bus. The probable consequences were minimal. All outside transmission  
01 5 lines were available and the Unit 1 Diesel Generator was always available and could  
01 6 have supplied emergency power to Unit 2 via the 14-1:24-1 bus tie.  
01 7  
01 8  
01 9

SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP. SUBCODE VALVE SUBCODE  
01 9 E E 11 A 12 A 13 E N G I N E 14 Z 15 Z 16  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)  
1 0 The cause of this occurrence is designated as personnel error. All operating  
1 1 personnel were reminded of the importance of proper testing. The Diesel Generator  
1 2 outage checklist is to be revised to clarify which systems should be tested for any  
1 3 one diesel generator being inoperable.  
1 4

FACILITY STATUS % POWER OTHER STATUS METHOD OF DISCOVERY DISCOVERY DESCRIPTION  
1 5 E 28 0 8 3 29 NA B 31 Routine Surveillance 32  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

NAME OF PREPARER Daryl Clark  
PHONE 309-654-2241, ext. 170  
8106090 533

- I. LER NUMBER: LER/RO 80-28/03L-0
- II. LICENSEE NAME: Commonwealth Edison Company  
Quad-Cities Nuclear Power Station
- III. FACILITY NAME: Unit Two
- IV. DOCKET NUMBER: 050-265
- V. EVENT DESCRIPTION:

On October 23, 1980, after discovering that the 1/2 Diesel Generator was inoperable due to the 1/2 Diesel Generator Cooling Water Pump failure, the surveillance testing required for an inoperable Diesel Generator was performed. Unit One was shutdown for refueling at the time; thus, surveillance was only required for Unit Two. The required surveillance was performed immediately on the low pressure coolant injection systems and the containment cooling mode of RHR which is supplied from 4KV Bus 23-1, whose emergency power supply is the 1/2 Diesel Generator. The following day, while preparing to perform the surveillance for the second day of the diesel outage, it was discovered that the previous surveillance had been performed on the incorrect bus. The surveillance should have been performed on the pumps supplied by 4KV Bus 24-1, which is supplied by the Unit Two Diesel Generator. This was contrary to the surveillance requirements for an inoperable Diesel Generator as specified in Technical Specification 4.9.E. The Unit Two Diesel Generator had been tested satisfactorily on the first day. The testing for the second day was performed immediately on the correct pumps and 4KV Bus.

VI. PROBABLE CONSEQUENCES OF THE OCCURRENCE:

The probable consequences of this occurrence were minimal. All outside transmission lines were available through the duration of the occurrence. Thus the normal power supply to the emergency buses and systems was always available. Although Unit One was shutdown for refueling, the Unit One Diesel Generator was operable and could have supplied emergency power to Unit Two via the 14-1:24-1 Bus tie.

VII. CAUSE:

The cause of this occurrence is designated as personnel error. Procedure inadequacy has been designated to be a contributing cause. The Diesel Generator outage surveillance checksheet did not clearly specify which emergency bus was to be tested when a Diesel Generator was inoperable.

VIII. CORRECTIVE ACTION:

All operating personnel were reminded of the importance of proper testing and operation of the proper equipment as specified in Technical Specifications. To prevent a recurrence, the Diesel Generator outage surveillance form is to be revised to clarify which system should be tested for any one Diesel Generator being inoperable.