



Commonwealth Edison

Quad Cities Nuclear Power Station
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STM-94-002

October 28, 1994

U.S. Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

Reference: Quad Cities Nuclear Power Station
Docket Number 50-254, DPR-29, Unit One

Enclosed is Licensee Event Report (LER) 94-011, Revision 00, for Quad Cities Nuclear Power Plant Station.

This report is submitted in accordance with the requirements of the Code of Federal Regulations, Title 10, Part 50.73(a)(2)(v)(A). 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 shutdown the reactor and maintain it in a safe shutdown condition.

The following commitments are being made by this letter:

- The Maintenance Staff procedure group along with the Mechanics in the MMD shall review the discrepancies noted during this investigation, with respect to QCMM 300-34, revising and clarifying the procedure as appropriate. The deficiencies found during the task analysis did not cause the event, but need to be reviewed to provide clear and accurate work instructions to MMD personnel for HCU maintenance activities.

The above procedure review will investigate the feasibility of splitting procedure QCMM 300-34 into separate maintenance steps due to the large number of different maintenance activities involved with it. The procedure is currently cumbersome and confusing to the MMD personnel that are required to perform the maintenance activities. The procedure will be revised and used for any scheduled HCU maintenance which occurs after November 8, 1994.

- The SED shall reevaluate the Post Maintenance Test/Verification requirements for HCU maintenance activities, with respect to testing the operability of the HCU trains prior the beginning of cycle startup activities. This evaluation will be done prior to Unit-2 coming off line for Q2R13.
- The MMD and Training Department shall develop a initial training class, and a refresher training class, to instruct appropriate personnel on HCU maintenance activities. The training class will utilize hands-on training, an HCU mockup, and will follow the HCU maintenance procedure. All MMD personnel will receive HCU maintenance training in 1995 during continuing training cycles.

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Page 2

- The MMD and Training Department shall develop a training class to instruct appropriate maintenance personnel on Temporary Alterations. The training class will discuss the definition of a Temporary Alteration, it's uses, documentation requirements, and will review this report. The class presentation package will be developed, and started on 01/01/95 in the MMD continuing training cycle.

If there are any questions or comments concerning this letter, please refer them to Nick Chrissotimos, Regulatory Assurance Administrator at 309-654-2241, ext. 3100.

Respectfully,

COMMONWEALTH EDISON COMPANY
QUAD CITIES NUCLEAR POWER STATION

D. B. Clark Jr

E. S. Kraft, Jr.
Site Vice President
and Acting Station Manager

ESK/TB/plm
Enclosure

cc: J. Schrage
C. Miller
INPO Records Center
NRC Region III

**Licensee Event Report
Reviewer Assignment Form**

Revised 08/10/94

LER # 254\94-011

Date: August 29, 1994

Subject: During scram timing, control rod drive L-11 failed to scram due to pipe
plug inserted into solenoid valve due to personnel not adhering to procedure.

Signatures of reviewers indicating review and approval of item:

Systems Eng. Supv:	<u><i>[Signature]</i></u>	<u>10/21/94</u>	<u><i>[Signature]</i></u>	<u>10/21/94</u>
		Date		Date
Operating Eng.:	<u><i>Alex L. Misch</i></u>	<u>10/21/94</u>	<u><i>David E. Schumacher</i></u>	<u>10/21/94</u>
		Date		Date
Technical Supt.:	<u><i>Paul C. Att</i></u>	<u>10-27-94</u>	<u> </u>	<u> </u>
		Date		Date
	<u><i>[Signature]</i></u>	<u>10-27-94</u>	<u> </u>	<u> </u>
		Date		Date

Approved: *D. B. Leach* 10-28-94
PORC Chairman Date
(If not Station Manager)

Approved: *D. B. Leach* 10-28-94
Station Manager Date

LICENSEE EVENT REPORT (LER)

Form Rev. 2.0

Facility Name (1) Quad Cities Unit One										Docket Number (2) 0 5 0 0 0 2 5 4										Page (3) 1 of 0 9																													
Title (4) During Scram Timing, Control Rod Drive L-11 Failed To Scram Due To Pipe Plug Inserted Into Solenoid Valve Due To Personnel Not Adhering To Procedure																																																	
Event Date (5) Month: 0 8 Day: 2 Year: 9 4										LER Number (6) Sequential Number: 0 1 1 Revision Number: 0 0										Report Date (7) Month: 1 Day: 0 Year: 2 8 9 4										Other Facilities Involved (8) Docket Number(s) 0 5 0 0 0 0 0 0																			
OPERATING MODE (9) 04										THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)																																							
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LICENSEE CONTACT FOR THIS LER (12)																																																	
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ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)																																																	

ABSTRACT:

At 1935 on 08/29/94, Unit-1 was in the run mode when Control Rod Drive (CRD) L-11 failed to scram when given a signal.

The root cause of the event was due to Mechanical Maintenance Department (MMD) personnel not adhering to procedure during maintenance activities on the Hydraulic Control Unit (HCU) scram valves. The MMD personnel performed an informal work practice associated with installing a pipe plug in the HCU Scram Solenoid Pilot Valve exhaust port.

Contributing causes and factors for this event were maintenance procedure deficiencies, a lack of communication between the Work Planners and maintenance personnel, and a lack initial training on HCU scram valve maintenance activities.

Immediate corrective actions included CRD insertion to position 00, and inspections for similar obstructions.

Corrective actions to be completed include HCU maintenance procedure review and enhancement, reevaluation of the HCU Post Maintenance Test/Verification, and reevaluation of the MMD training on HCUs (which will include refresher training). Additional training will be developed for Temporary Alterations specific to MMD applications.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

Form Rev. 2.0

FACILITY NAME (1) Quad Cities Unit One	DOCKET NUMBER (2) 0 5 0 0 0 2 5 4	LER NUMBER (6)						PAGE (3) 2 OF 0 9
		Year		Sequential Number		Revision Number		
		9 4	-	0 1 1	-	0 0		

TEXT Energy Industry Identification System (EIS) 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: During scram timing, control rod drive L-11 failed to scram due to pipe plug inserted into solenoid valve due to personnel not adhering to procedure.

A. CONDITIONS PRIOR TO EVENT:

Unit: One	Event Date: August 29, 1994	Event Time: 1935
Reactor Mode: 04	Mode Name: RUN	Power Level: 021

This report was initiated by Licensee Event Report 254\94-011.

RUN (4) - In this position the reactor system pressure is at or above 825 psig, and the reactor protection system is energized, with APRM protection and RBM interlocks in service (excluding the 15% high flux scram).

B. DESCRIPTION OF EVENTS:

At 1935 on 08/29/94, Unit-1 was in the run mode at 21% rated core thermal power. While performing hot scram timing, the Operations Department noted that Control Rod Drive (CRD) [AA] L-11 failed to scram when the test switch was placed in the full up position. The scram light did not illuminate on the full core display, and no air vented from the 1-305-126 or 127 scram valves for Hydraulic Control Unit (HCU) 42-43.

An Operator, involved with the testing, visually checked the Scram Solenoids Pilot Valves (SSPV) [SOL] 1-305-117 and 118 for HCU 42-43, and noted a pipe plug inserted in the assembly exhaust port. No other abnormalities were noted.

Immediate corrective actions involved notifying the Unit Supervisor, the Shift Engineer (SE) and a Qualified Nuclear Engineer (QNE).

CRD L-11 was inserted to position 00, and electrically disarmed. The SE quarantined HCU 42-43, and positioned a security guard to monitor the area. All Nuclear Work Request (NWR) work packages associated with maintenance during the most recent unit refuel outage (Q1R13) were also quarantined for investigation.

The SE conducted an interview with the Mechanical Maintenance Department (MMD) mechanic who signed the NWR work package (Q11247) that rebuilt the HCU 42-43 scram valves during the Q1R13 outage.

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 One				0 5 0 0 0 2 5 4				9 4 -		0 1 1 -		0 0			
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TEXT Energy Industry Identification System (EIS) codes are identified in the text as [XX]

All Unit-1 and Unit-2 CRD HCU's were inspected for similar SSPV exhaust line obstructions. Both units had the backup scram valves and alternate rod insertion valves checked for abnormalities. No abnormalities were noted.

NWR Q17794 was initiated to remove the SSPV exhaust port plug. Problem Identification Form (PIF) 94-2147 was generated to investigate the event.

Previous to this event, CRD R-7 also failed to scram during hot scram timing at 1645 hours on 8/29/94. The Operations Department generated PIF 94-2146 to document the event, and the implications of 2 CRD's failing to scram are covered in the Safety Analysis section of this report.

On 09/13/94, the MMD personnel involved with the NWR Q11247 were removed from regular duties and became involved in the investigation. The involved personnel were coached on procedure adherence by the MMD Master.

The MMD discussed this event as a group in tailgate meetings between 09/13/94 and 09/20/94, emphasizing the need for procedure adherence and the safety significance of this event.

At 1226, on 9/29/94, the station made a 4 hour phone call to the NRC to document this event.

C. CAUSE OF THE EVENT:

This event is being reported in accordance with 10CFR50.73(a)(2)(v)(A); 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 shut down the reactor and maintain it in a safe shutdown condition.

The following is a summary of conclusions and Causal Factors (C/F) relating to problems which may have influenced human performance and/or contributed to equipment malfunctions.

The failure of the CRD L-11 to scram, during hot scram timing, was caused by a 1/2 inch pipe plug inserted into the SSPV 117 and 118 exhaust port. Because the exhaust port for the SSPV was plugged, the instrument air could not be vented to cause isolation of the 126 and 127 scram valves. Because air could not be vented from the HCU 42-43 normally closed scram valves, the CRD would not move when given a full up signal. The backup scram valves would not have operated CRD L-11, on a full scram signal, because of the pipe plug in the SSPV exhaust port.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

Form Rev. 2.0

FACILITY NAME (1) Quad Cities Unit One	DOCKET NUMBER (2) 0 5 0 0 0 2 5 4	LER NUMBER (6)			PAGE (3)		
		Year		Sequential Number		Revision Number	
		9 4	-	0 1 1	-	0 0	4 OF 0 9

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

C/F: Written Communication
 Work Practice
 Work Organization
 Training/Qualification
 Managerial Methods
 Maintenance/Testing

1. The root cause for the pipe plug installed in the HCU 42-43, 117 and 118 SSPV exhaust port, was due to MMD personnel not adhering to the procedure QCMM 300-34, "CRD HCU Scram Inlet and Outlet Valves Overhaul and Inspection", while performing maintenance activities during Q1R13. A pipe plug was installed in the SSPV exhaust port during maintenance activities on the HCU 126 and 127 scram valves under NWR Q11247. The procedure QCMM 300-34 does not direct use of a pipe plug, nor would a pipe plug be required if the procedure was followed correctly. Management expectations with respect to procedure adherence is discussed at length in QCAP 1100-12, "Procedure Use and Adherence". If the MMD personnel had adhered to the procedure, they would have stopped when encountering a discrepancy, and notified their supervisor.
2. An informal work practice associated with MMD maintenance activities on the HCU scram valves during Q1R13, under NWR Q11247 inserted the pipe plug in the SSPV exhaust port. The informal work practice involved deviating from the procedure that governs maintenance on the HCU scram valves (QCMM 300-34) without notification to appropriate supervision. The deviation from the procedure resulted in performing the steps of the procedure out of order, and blocking an exhaust port in order to pressurize the SSPV pneumatic piping while applying air to the top of the diaphragm of the 127 valve.
3. Deficiencies with the procedure that controls MMD maintenance activities to the CRD HCU's (QCMM 300-34) led to internal factors that contributed to MMD personnel not following it correctly. Steps were found inaccurate, out of sequence, confusing, and not designed for less practiced users.
4. A lack of communication between the Work Planners and MMD personnel could have contributed to the event because the Work Analyst did not question the need for a pipe plug that was listed in the work package tool list. The work package associated with NWR Q11247 had a tool list that included the usage of a 1/2 inch pipe plug for the HCU 127 scram valve relief. The Work Analyst did not question the need for a pipe plug in the tool list, did not question the statement "for 127 valve relief", and did not notify MMD.
5. A contributing factor to the pipe plug being installed in the SSPV exhaust port was a lack of initial training on HCU scram valve maintenance activities.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

Form Rev. 2.0

FACILITY NAME (1) Quad Cities Unit One	DOCKET NUMBER (2) 0 5 0 0 0 2 5 4	LER NUMBER (6)						PAGE (3) 5 OF 0 9
		Year		Sequential Number		Revision Number		
		9 4	-	0 1 1	-	0 0		

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

D. SAFETY ANALYSIS:

During startup testing after Q1R13 it was noted that CRD's L-11 and R-7 failed to scram during hot scram testing. CRD's D-10 and E-11 scram times were slower than average, failing the Technical Specification scram insertion time requirement for 2 by 2 array rod groups. The core average scram insertion times were adequate per Technical Specifications.

The site requested that Nuclear Fuel Services (NFS) provide a shutdown evaluation for the Q1R13 core for 3 different reactor scram scenarios.

The first scenario assumes all rods inserted except for CRD's L-11 and R-7 which remain at position 48. Assuming cold (68 degree F) and xenon free conditions, the computer code (PANACEA) calculated an uncorrected eigenvalue of 0.992. The core would remain subcritical with control rods L-11 and R-7 at position 48 with all other rods inserted.

The second scenario assumes all rods inserted except for CRD's L-11, R-7, and M-11 (additional failure of the strongest rod) which remain at position 48. The temperature corrected (460 degree F), xenon free Core Monitoring Code Predictor case calculated an eigenvalue of 0.978. The CRD's L-11 and R-7 were initially withdrawn at approximately 529 degree F. The core would remain subcritical under these conditions.

The third scenario assumes all rods inserted except for CRD's L-11, R-7, and M-11 which remain at position 48. Assuming cold (68 degree F) and clean (xenon free) conditions, PANACEA calculated an uncorrected eigenvalue of 1.013. Under these conditions the core would be supercritical.

CRD R-7 would have inserted in approximately 40 seconds due to actuation of the backup scram valves. Since CRD's L-11 and R-7 were not withdrawn until the reactor moderator temperature was approximately 529 degrees F, ample time would have existed for the operator to manually insert the withdrawn control rods prior to reaching a temperature which could have resulted in achieving criticality.

The safety significance of this event was minimal because the core would have remained subcritical assuming failure of the strongest rod M-11 with L-11 and R-7 at 48 with the moderator temperature greater than 460 degrees F. Additionally no credit was taken for xenon which would have provided additional margin for remaining subcritical. If a reactor scram would have occurred, ample time would have been available for the operator to take corrective actions and insert the withdrawn rods. The 2 CRD's with slow scram times (D-10 and E-11) would not adversely impact the ability to maintain the core subcritical.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

Form Rev. 2.0

FACILITY NAME (1) Quad Cities Unit One	DOCKET NUMBER (2) 0 5 0 0 0 2 5 4	LER NUMBER (6)						PAGE (3) 6 OF 0 9
		Year		Sequential Number		Revision Number		
		9 4	-	0 1 1	-	0 0		

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

E. CORRECTIVE ACTIONS:

The immediate corrective action involved a visual inspection of the HCU 42-43 (CRD L-11). The Operator noted a pipe plug inserted in the SSPV assembly exhaust port.

The Operations Department performed further inspections of all HCU's on Unit-1 and Unit-2 for similar SSPV exhaust port blockage. Both units had their Backup Scram Valves and Alternate Rod Insertion valves inspected for abnormalities. No additional abnormalities were noted.

CRD L-11 and R-7 were fully inserted to position 00, taken out of service and electrically disarmed to prevent withdrawal of the CRD.

The HCU 42-43 was quarantined by the SE, and a security guard posted to monitor the HCU area.

All NWR packages that involved maintenance during Q1R13 on HCU 42-43 were quarantined.

All personnel were interviewed that were involved with maintenance on HCU 42-43 during Q1R13, under NWR Q11247.

On 09/01/94, the Senior Work Analyst placed administrative controls on all CRD work as an interim measure to prevent recurrence of the event.

On 09/13/94, the MMD personnel involved with the NWR Q11247 were removed from regular duties and became involved in the investigation. The involved personnel were coached on procedure adherence by the MMD Master.

The MMD held tailgate meetings between 9/13/94 and 9/20/94 that discussed the need for procedure adherence, and the safety significance of this event.

The MMD Training Coordinator has initiated Training Department requests for classes on HCU maintenance activities, and Temporary Alterations.

At 1226, on 9/29/94, the station made a 4 hour phone call to the NRC to document this event.

On 10/04/94 the MMD held a 4 hour stand down to perform a Safety Culture Workshop. The workshop emphasized to all department personnel the importance of Self-Check and included a hand out of the Self Check procedure (QCAP 2300-28), and the Procedure Use and Adherence procedure (QCAP 1100-12).

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

Form Rev. 2.0

FACILITY NAME (1) Quad Cities Unit One	DOCKET NUMBER (2) 0 5 0 0 0 2 5 4	LER NUMBER (6)						PAGE (3)	
		Year		Sequential Number		Revision Number			
		9 4	-	0 1 1	-	0 0			
TEXT Energy Industry Identification System (EIIIS) codes are identified in the text as [XX]									

On 10/25/94 MMD again tailgated this event with the department. The causes associated with installing a pipe plug during maintenance activities on the scram valve, and the fact that the pipe plug involved installing a Temporary Alteration, was covered. Procedure adherence, the need for personnel to note discrepancies to their appropriate supervision, and the roles of the Work Planners and maintenance personnel, were also discussed.

There is a Level 2 investigation in progress that will review the results of this event (and other recent events) to determine common causal factor and inappropriate action relationships. The investigation will provide recommendations for additional corrective actions if warranted. The team will expand the scope of it's investigation to include other issues that have potential impact on unit startup and continued error free operations.

Remaining corrective actions are as follows.

1. The Maintenance Staff procedure group along with the Mechanics in the MMD shall review the discrepancies noted during this investigation, with respect to QCMM 300-34, revising and clarifying the procedure as appropriate. The deficiencies found during the task analysis did not cause the event, but need to be reviewed to provide clear and accurate work instructions to MMD personnel for HCU maintenance activities.

The above procedure review will investigate the feasibility of splitting procedure QCMM 300-34 into separate maintenance steps due to the large number of different maintenance activities involved with it. The procedure is currently cumbersome and confusing to the MMD personnel that are required to perform the maintenance activities. The procedure will be revised and used for any scheduled HCU maintenance which occurs after November 8, 1994.
(NTS 2541809401101)

2. The SED shall reevaluate the Post Maintenance Test/Verification requirements for HCU maintenance activities, with respect to testing the operability of the HCU trains prior the beginning of cycle startup activities. This evaluation will be done prior to Unit-2 coming off line for Q2R13. (NTS 2541809401102)
3. The MMD and Training Department shall develop a initial training class, and a refresher training class, to instruct appropriate personnel on HCU maintenance activities. The training class will utilize hands-on training, an HCU mockup, and will follow the HCU maintenance procedure. All MMD personnel will receive HCU maintenance training in 1995 during continuing training cycles.
(NTS 2541809401103)

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

Form Rev. 2.0

FACILITY NAME (1) Quad Cities Unit One	DOCKET NUMBER (2) 0 5 0 0 0 2 5 4	LER NUMBER (6)						PAGE (3) 8 OF 0 9
		Year		Sequential Number		Revision Number		
		9 4	-	0 1 1	-	0 0		

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4. The MMD and Training Department shall develop a training class to instruct appropriate maintenance personnel on Temporary Alterations. The training class will discuss the definition of a Temporary Alteration, it's uses, documentation requirements, and will review this report. The class presentation package will be developed, and started on 01/01/95 in the MMD continuing training cycle. (NTS 2541809401104)

F. PREVIOUS EVENTS:

A Quad Cities Station, and nationwide, search of the Nuclear Plant Reliability Data System (NPRDS) search was performed resulting in no records indicating a failure of a CRD associated with SSPV exhaust port blockage.

The Nuclear Tracking System (NTS) database was reviewed for similar events involving plugged HCU SSPV exhaust ports. There was no LER identified that was similar to this event.

Additional searches of the NTS database for events involving Quad Cities departmental procedure adherence events (with respect to documents not followed correctly), indicated 5 LER investigations from January 1993 to July of 1994. A summary of the events, involving the Operations Department (OP) and the Electrical Maintenance Department (EMD), are included below.

NTS #	Dept.	Description
2541809302000	OP	1B recirculation pump was shutdown with the 1-202-5B valve opened causing shut down cooling to short cycle due to inadequate work practices, written communication, managerial and supervisory methods, and training.
2541809301400	OP	IRM #11 and APRM #3 were both bypassed without a 1/2 scram being inserted due to personnel error.
2541809301800	OP	APRM #4 was bypassed while IRM #16 was in bypass due to a personnel error.
2651809400200	OP	Control rod was mispositioned during scram testing due to inappropriate work practices, management/supervisory and verbal communications.
2651809400700	EMF	2B RHR room air handling unit was found inoperable. The 1/2 EDG had been inoperable during the same period due to inadequate written communication, training/qualification and work practices.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

Form Rev. 2.0

FACILITY NAME (1) Quad Cities Unit One	DOCKET NUMBER (2) 0 5 0 0 0 2 5 4	LER NUMBER (6)						PAGE (3) 9 OF 0 9
		Year		Sequential Number		Revision Number		
		9 4	-	0 1 1	-	0 0		

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

Regulatory Assurance performed a review of the PIF database to determine where the majority of the station's problems have occurred, and to attempt determination of future problem areas. A report was completed September 23, 1994, and submitted to the Quad Cities Station Manager. Procedure adherence, and documents not followed correctly have been incorporated into this report.

G. COMPONENT FAILURE DATA:

There was no component failure associated with this event.