

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 4
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Title (4)
Electrical distribution weekly surveillance did not document voltage verification in accordance with Technical Specification 4.9.E. due to an inadequate procedure.

Event Date (5)			LER Number (6)			Report Date (7)			Other Facilities Involved (8)								
Month	Day	Year	Year	Sequential Number	Revision Number	Month	Day	Year	Facility Names	Docket Number(s)							
0	9	2	7	9	6	9	6	0	1	4	0	0	1	0	2	5	4

OPERATING MODE (9) 1		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)									
POWER LEVEL (10) 1 0 0		20.402(b)		20.405(c)		50.73(a)(2)(iv)		73.71(b)			
		20.405(a)(1)(i)		50.36(c)(1)		50.73(a)(2)(v)		73.71(c)			
		20.405(a)(1)(ii)		50.36(c)(2)		50.73(a)(2)(vii)		Other (Specify in Abstract below and in Text)			
		20.405(a)(1)(iii)	X	50.73(a)(2)(i)		50.73(a)(2)(viii)(A)					
		20.405(a)(1)(iv)		50.73(a)(2)(ii)		50.73(a)(2)(viii)(B)					
		20.405(a)(1)(v)		50.73(a)(2)(iii)		50.73(a)(2)(x)					

LICENSEE CONTACT FOR THIS LER (12)									
NAME Charles Peterson, Regulatory Affairs Manager, ext. 3602						TELEPHONE NUMBER AREA CODE 3 0 9 6 5 4 - 2 2 4 1			

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)									
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)						Expected Submission Date (15)	Month	Day	Year
YES (If yes, complete EXPECTED SUBMISSION DATE)						X NO			

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

ABSTRACT:

On 9/27/96 at 0000 hours, Unit 1 and Unit 2 were in Power Operation mode at 100 percent power when a Technical Specification (TS) required surveillance became overdue for both Units. QCOS 0005-06, Weekly Electrical Distribution Breaker and Voltage Verification, is required to be performed weekly in accordance with TS 4.9.E and had last been performed on 9/19/96 for both Units. On 9/26/96, Nuclear Station Operators performed QCOS 0005-06 for both Units, but the surveillance procedure did not have operators document verification of proper voltages in accordance with TS 4.9.E, a requirement implemented with the Upgraded TS on 9/23/96. On 10/02/96 at 2000 hours, a Unit Supervisor reviewing the 9/26/96 copies of QCOS 0005-06 identified there was no documentation that proper voltages had been verified. A 24 hour Limiting Condition for Operation (LCO) for completion of the surveillance was entered for both Units in accordance with TS 4.0.C. A revision to QCOS 0005-06 was expedited, and on 10/03/96 at 1923 hours, the revised QCOS 0005-06 was successfully performed and TS 4.0.C LCO was exited for both Units.

The root cause of this event is an inadequate procedure. Corrective actions include procedure revision, counselling of personnel involved with the review and approval of the procedure, and briefing all Operations personnel on the event.

The safety significance of this event is minimal as the affected busses and motor control centers were verified as energized and an abnormal voltage would have been identified by operators during rounds or through Control Room alarms.

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TEXT Energy Industry Identification System (EIIIS) 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: Electrical distribution weekly surveillance did not document voltage verification in accordance with Technical Specification 4.9.E due to an inadequate procedure.

A. CONDITIONS PRIOR TO EVENT:

Unit: One Event Date: September 27, 1996 Event Time: 0000
 Reactor Mode: 1 Mode Name: POWER OPERATION Power Level: 100%

Unit: Two Event Date: September 27, 1996 Event Time: 0000
 Reactor Mode: 1 Mode Name: POWER OPERATION Power Level: 100%

This report was initiated by Licensee Event Report LER254\96-014.

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

B. DESCRIPTION OF EVENT:

On 4/25/96, a new procedure, QCOS 0005-06, Weekly Electrical Distribution Breaker and Voltage Verification was developed by a Senior Reactor Operator in preparation for implementing the Upgraded Technical Specifications (TSUP). This procedure was reviewed for technical accuracy by a Shift Engineer and the Operations TSUP Coordinator prior to approval by the Administrative Operating Engineer. On 9/17/96, revision 0 of QCOS 0005-06 was issued prior to implementing the TS. The purpose of this procedure was in part "to verify the onsite distribution system [EB, ED, EJ] is in the correct breaker [BKR] alignment with proper voltages on essential busses [BU] and motor control centers [MCC], as required by Technical Specifications (TS)." A typical step from revision 0 of this surveillance was to "verify Bus 13-1 (23-1) energized from Bus 13 (23)" without specifying adequate voltage to be checked. TS section 4.9.E states: "Each of the required power distribution system divisions shall be determined energized at least once per 7 days by verifying correct breaker alignment and voltage on the busses/MCCs/panels."

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On 9/19/96, QCOS 0005-06 was being performed for the first time on both Units. A Nuclear Station Operator (NSO) contacted the Operations TS Coordinator and questioned if the surveillance adequately addressed TSUP 4.9.E if the proper voltages were not verified and documented. The Operations TSUP Coordinator recommended that the NSO could verify that there were no undervoltage alarms present on the 901-8 and 902-8 Control Room electrical distribution panels and document the verification in the comments section of QCOS 0005-06 if he was concerned with the adequacy of the procedure. The Operations TSUP Coordinator stated he would ensure that the procedure concern would be resolved prior to performing the surveillances again (the following week). QCOS 0005-06 was completed for both Units and included comments that no alarms were present. The Operations TSUP Coordinator failed to follow through to ensure the procedure concern was resolved as requested.

On 9/23/96, the TSUP was implemented. On 9/26/96, QCOS 0005-06 was performed again for both Units. The NSO's verified the associated busses were energized in accordance with the procedure but no one recognized that the procedure did not meet the TS 4.9.E requirement to document the verification of proper voltage. The surveillances were completed and no comments were documented.

On 10/02/96 at 2000 hours, an operator was reviewing documentation for the 9/26/96 performances of QCOS 0005-06 for both Units and noted there was no documentation of proper voltage verification as required by TS 4.9.E. The Unit Supervisor verified no undervoltage annunciator alarms present on the 901-8 and 902-8 Control Room electrical distribution panels. A 24 hour Limiting Condition for Operation (LCO) for completion of the surveillance was entered effective at 2000 hours in accordance with TS 4.0.C. The Operations TSUP Coordinator was contacted and a revision to QCOS 0005-06 was expedited to ensure the verification of proper voltages was documented. On 10/03/96 at 1923 hours, the revised QCOS 0005-06 was successfully performed and TS 4.0.C LCO was exited for both Units.

C. APPARENT CAUSE OF EVENT:

The root cause of this event was the inadequate review and approval of QCOS 0005-06 which did not recognize that TS 4.9.E required verifications were not documented by the procedure. The individuals involved with reviewing and approving the procedure considered the term "verify energized" to encompass and fully satisfy the Technical Specification. All other new or modified surveillances applicable to Power Operation have been performed and no other TSUP surveillance problems have been identified.

A contributing cause of this event was ineffective tracking of an identified problem. The procedural discrepancy was recognized and addressed on 9/19/96 prior to the implementation of the TSUP requirement on 9/23/96, but the necessary changes were not tracked and completed as the Operations TSUP Coordinator perceived the change as a clarification rather than a correction.

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D. SAFETY ANALYSIS OF EVENT:

The safety significance of this event is minimal. The affected busses and motor control centers were verified as energized on 9/26/96 and although the proper voltages verifications were not documented, an abnormal voltage would have been identified by operators during rounds or through Control Room alarms.

E. CORRECTIVE ACTIONS:

Corrective Actions Completed:

1. QCOS 0005-06 has been revised to ensure the verification of proper voltages is documented.
2. The affected Operations personnel were counselled on the failure to identify the procedural inadequacy during the review for procedure approval.

Corrective Actions To Be Completed:

1. All Operations personnel will be briefed on this event by 12/15/96, reinforcing the expectation to initiate procedure changes when needed. (NTS# 2541809601401 - Operations).

F. PREVIOUS EVENTS:

A search for LERs in the last 2 years involving missed Technical Specification surveillances revealed the following events:

254/94-14, Fire system surveillance went past their critical due date without the systems being declared inoperable and compensatory actions put in place due to inadequate training and written communication.

254/95-06, The RPS EPA relays had not been tested prior to the mode switch being moved to Refuel due to an inadequate written communication.

254/96-19, Main steam line radiation monitor functional test not performed within frequency established for Technical Specifications when in Refueling mode due to incomplete documentation of a Technical Specification interpretation.

G. COMPONENT FAILURE DATA:

Not applicable.