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LWP-97-042

April 23, 1997

United States Nuclear Regulatory Commission
Washington, DC 20555

Attention: Document Control Desk

Reference: Quad Cities Nuclear Power Station
Docket Number 50-254, DPR-24, Unit One

Enclosed is Licensee Event Report (LER) 97-007, Revision 00, for Quad Cities Nuclear Power Station.

This report is submitted in accordance with the requirements of the Code of Federal Regulations, Title 10, Part 50.73(a)(2)(iv). The licensee shall report any event or condition that resulted in manual or automatic actuation of any Engineered Safety Feature.

There are no commitments being made by this letter.

If there are any questions or comments concerning this letter, please refer them to Charles Peterson, Regulatory Affairs Manager at 309-654-2241, ext. 3609.

Respectfully,

COMMONWEALTH EDISON
QUAD CITIES NUCLEAR POWER STATION

L. W. Pearce
Station Manager

LWP/CP/plm

Enclosure

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION														Form Rev. 2.0	
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								Year		Sequential Number		Revision Number			
Quad Cities Unit One				0 5 0 0 0 2 5 4				9 7		- 0 0 7		- 0 0			
TEXT				Energy Industry Identification System (EIIS) codes are identified in the text as [XX]								2 OF 0 4			

PLANT AND SYSTEM IDENTIFICATION:

General Electric - Boiling Water Reactor - 2511 Mwt rated core thermal power.

EVENT IDENTIFICATION: Unit One Emergency Diesel Generator inadvertent start due to a personnel error while operating the control switch.

A. CONDITIONS PRIOR TO EVENT:

Unit: One Event Date: March 31, 1997 Event Time: 1231
Reactor Mode: 1 Mode Name: POWER OPERATION Power Level: 100%

This report was initiated by Licensee Event Report 254\97-007.

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

B. DESCRIPTION OF EVENT:

On 033197, at 1231 hours the Unit 1 Emergency Diesel Generator (DG)[EK] inadvertently started while the Unit 1 Nuclear Station Operator (NSO) was moving the control switch (C/S) from the AUTO position in preparation for a pre-start surveillance inspection of the engine. The inspection was to be performed prior to starting the Unit 1 DG for QCOS 6600-01, DG Monthly Load Test. Unit 1 was in Mode One at 100% power; the Unit 2 reactor was de-fueled and the 1/2 DG was operable.

The DG has a three position C/S with START at 50 degrees left of center (ten o'clock) position, STOP at the center (12 o'clock) position and AUTO at 47 degrees right of center (two o'clock) position. The C/S is designed with positioning cams which separate the 3 positions. To go from one position to another, pressure must be applied to the C/S to overcome resistance from a cam. Once the top of the cam is reached, the switch will move quickly into its new position.

The Unit 1 NSO briefed two Equipment Operators (EO) prior to performing QCOS 6600-01. When the EOs called from the DG room, the NSO prepared to place the Unit 1 DG C/S to STOP. The NSO asked an extra NSO to peer check his moving of the Unit 1 DG C/S from the AUTO position to the STOP position. The correct switch and position it was to be placed in, were confirmed.

At 1231 hours, the NSO turned the Unit 1 DG C/S to the left from the AUTO position and the DIESEL GEN #1 / AUTO START / AUTO START BLOCK annunciator was received as expected. The extra NSO looked away from the C/S to verify the expected alarm tile had illuminated prior to acknowledging the annunciator. At this time it was observed by personnel in the Unit 1 DG Room and the Control Room that the DG had started. The NSO immediately turned the C/S to the right, back to the AUTO position. Per Unit Supervisor direction, the NSO then placed the C/S to STOP.

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Following a normal 11 minute cooldown, the Unit 1 DG stopped. The control switch was left in the STOP position under direction by the Unit Supervisor and subsequently placed in quarantine. The Unit 1 DG was declared inoperable at 1231 hours and a seven day Limiting Condition for Operation (LCO) was entered. At 1428 hours, a four hour Emergency Notification System (ENS) phone call was made due to an unplanned manual actuation of an engineered safety feature (ESF).

C. APPARENT CAUSE OF EVENT:

The most probable cause of this event is personnel error by the NSO. Testing indicates that the C/S functions properly. A personnel statement from the NSO involved stated that the C/S did travel beyond the STOP position some distance, but he was unsure of the magnitude. If the C/S was moved far enough, the start contacts would close, causing the DG to start. The annunciator sequence of events recorder data supports this conclusion.

During remediation, the NSO involved in this event was observed using an inadequate grasp of the C/S handle when manipulating the switch. This method of turning the three position C/S may have been responsible for the mispositioning.

D. SAFETY ANALYSIS OF EVENT:

The Unit 1 DG was declared inoperable on 033197 at 1231 hours and a seven day Limiting Condition for Operation (LCO) was entered. The DG was declared operable on 040397 at 2100 hours.

At the time of the event, the Unit 1 DG C/S was to be taken to the STOP position in preparation for inspection of the engine prior to a scheduled monthly operability surveillance as required by Technical Specification 4.9.A.2. Actions specified in the DG outage report and Technical Specification 3.9.A for inoperability of one DG had been satisfactorily completed prior to moving the C/S. Within 24 hours of the entry into the LCO, the Unit 1/2 DG was started to demonstrate operability due to the inability to immediately eliminate a common mode failure.

Following determination of the root cause of the event, it was determined that no common mode failure existed. The Unit 1 DG was available for operation if an accident or transient condition occurred. The Unit 1 Station Blackout (SBO) DG, Unit 2 SBO DG, and Unit 1/2 DG remained operable for the entire duration of the investigation. Based on this, the safety significance of this event was minimal. At no time during the event was the health and safety of the public or Control Room personnel jeopardized.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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E. CORRECTIVE ACTIONS:

The NSO has been removed from all licensed duties until he has completed the remediation plan that was developed for him.

Observation of a sampling of NSOs revealed a common weakness in the method of operating a three position C/S. The Shift Operations Superintendent has provided direction to the NSOs on the proper method to be used to manipulate a pistol grip C/S.

F. PREVIOUS EVENTS:

A review of previous LERs at Quad Cities Station since 010195 revealed one previous event due to an inadequate work practice. LER 2-95-002 reported the unplanned start of the Unit 2 DG caused by opening a 4KV bus potential fuse drawer prior to the independent verification being performed.

G. COMPONENT FAILURE DATA:

There was no equipment failure associated with this event. Extensive testing of the DG C/S after this event revealed proper operation for this type of switch.