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Quad Cities Generating Station
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ComEd

February 23, 2000

SVP-00-037

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 Docket No. 50-265

Enclosed is Licensee Event Report (LER) 265/00-002, 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)(i)(B). The licensee shall report any operation or condition prohibited by the Plant's Technical Specifications.

We are committing to the following action:

A process will be put in place to identify selected equipment being credited to maintain Shutdown Safety levels. The purpose of this action is to limit access to the plant areas containing that equipment during outage periods.

Any other actions described in the submittal represent intended or planned actions by Commonwealth Edison (ComEd) Company. They are described for the NRC's information and are not regulatory commitments.

Should you have any questions concerning this letter, please contact Mr. C.C. Peterson at (309) 654-2241, extension 3609.

Respectfully,

Joel P. Dimmette, Jr.
Site Vice President
Quad Cities Nuclear Power Station

cc: Regional Administrator – NRC Region III
NRC Senior Resident Inspector – Quad Cities Nuclear Power Station

IE22

LICENSEE EVENT REPORT (LER) Form Rev. 2.0

Facility Name (1)	Docket Number (2)	Page (3)
Quad Cities Unit 2	0 5 0 0 0 2 6 5	1 of 0 5

Title (4)
Emergency Diesel Generator Inoperable due to Inadvertent Movement of Ventilation Fan Power Select Switch

Event Date (5)			LER Number (6)			Report Date (7)			Other Facilities Involved (8) Docket Number(s)								
Month	Day	Year	Year	Sequential Number	Revision Number	Month	Day	Year	Facility Names	0	5	0	0	0			
0 1	2 8	2000	2000	0 0 2	0 0	0 2	2 3	2000		0	5	0	0	0			

OPERATING MODE (9)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)					
5						

POWER LEVEL (10)																	
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	TELEPHONE NUMBER AREA CODE
Charles Peterson, Regulatory Affairs Manager, ext. 3609	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 EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

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

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

ABSTRACT:

On January 28, 2000, at approximately 0015 hours, Unit 2 was in Mode 5 with Core Alterations in progress, when the Unit 2 Emergency Diesel Generator (EDG) ventilation fan power supply selector switch was determined to be in the alternate feed position. The power supply was immediately changed to normal feed at 0030 hours. The switch was apparently moved out of the normal position by either Security guards sitting in the room or contractor personnel who were using the room as a place to change clothes. The cause of this event was inadequate communication of the expectation for workers to stay out of areas unless assigned duties placed them there. Immediate corrective actions were to place the switch in the correct position and to communicate the expectation to the affected work groups that access to plant areas is only on an as-needed basis. Long term corrective actions include providing training on the expectations for accessing plant areas and providing additional postings for equipment being relied upon for maintaining shutdown safety or meeting Technical Specification (TS) requirements during outages. Station procedures direct that the EDG be declared inoperable when the vent fan power select switch is in the alternate feed position. Because Core Alterations were in progress and the Unit ½ EDG was inoperable to Unit Two due to planned maintenance, the Technical Specifications were not met.

With the vent fan power select switch in the alternate position, the power for the vent fan would be supplied by a Unit 1 safety bus. The Unit 1 EDG was operable throughout the time frame that the switch could have been mispositioned. Therefore, the safety significance of this event was minimal.

PLANT AND SYSTEM IDENTIFICATION:
General Electric - Boiling Water Reactor - 2511 MWt rated core thermal power.

EVENT IDENTIFICATION:
Emergency Diesel Generator Inoperable due to Inadvertent Movement of Ventilation Fan Power Select Switch

A. CONDITIONS PRIOR TO EVENT:

Unit:	2	Event Date:	January 28, 2000	Event Time:	0015 hours
Reactor Mode:	5	Mode Name:	Refueling	Power Level:	0%

This report was initiated by Licensee Event Report 265/00-002

Refueling (5) - Mode switch in the Shutdown or Refueling position with average reactor coolant temperature ≤ 140 degrees F and fuel in the reactor vessel with one or more vessel head closure bolts less than fully tensioned or with the head removed.

B. DESCRIPTION OF EVENT:

On January 28, 2000, at approximately 0015 hours, Unit 2 was in Mode 5 with Core Alterations in progress. While on rounds, the Unit 2 Equipment Operator (EO) questioned the position of the Unit 2 Emergency Diesel Generator (EDG) [EK] Ventilation Fan [FAN] Power supply switch [HS] located on the 2251-2-37 panel in the Unit 2 EDG room. The EO noted that the amber HVAC SUPPLY FAN ALT FEED INDICATION LIGHT [IL] was not lit and noticed that the selector switch position seemed misaligned. A Senior Reactor Operator (SRO) was dispatched to help, and verified that the fan switch position was indeterminate. Permission was received to start the vent fan and when the fan was started the amber light came on identifying the vent fan was aligned to the alternate feed. As soon as it was determined that the vent fan was on alternate feed the fan was secured and power returned to the normal feed at 0030 hours.

Security roving watches had been using this room as a low dose area to stop in while on rounds. The operators noted that the chair they had been using was located immediately below the switch. The switch is approximately 4 ft above floor level. The Security watch supervisor interviewed the roving guards that were in and out of this location from January 27, 2000, at 1850 hours until the time of discovery. The guards stated they did not touch or inadvertently move this switch. They noted other personnel entering the area when they were in the room but saw no one manipulate a component until the operators arrived to investigate. A Security roving watch reported that a group of 15 to 20 contractors were using the U2 EDG room to change clothes, instead of the hallway as appropriate. The Security watch noted that the personnel changing clothes were leaning against the walls and doors for balance and that an inadvertent movement of machinery was possible due to the crowded conditions. Personnel had been using this room to change clothing when colder temperatures made the EDG room a more comfortable location.

Station procedures direct that the EDG be declared inoperable when the vent fan power select switch is in the alternate feed position. Because Core Alterations were in progress and the Unit ½ EDG was inoperable to Unit 2 due to planned maintenance, the Technical Specifications were not met.

An Equipment Part Number (EPN) search was performed of the Out-of-Service (OOS) database. It was determined that the switch has not been taken OOS for over two years. A search of procedures was performed and the switch is only manipulated in two procedures. The last documented manipulation of this switch on the Unit 2 EDG was July 21, 1999 in accordance with QCOP 6600-01, "DIESEL GENERATOR 1(2) PREPARATION FOR STANDBY OPERATION".

C. CAUSE OF THE EVENT:

The root cause for the inadvertent movement of the switch by security or contractor personnel was inadequate communication of expectations. Personnel used the EDG room as a convenience as the Station did not effectively communicate the expectation that such use was inappropriate. There were no postings, training, or guidance provided to contractors that communicated this expectation. This expectation is particularly important during Unit outages where significant numbers of less experienced personnel are in the plant.

D. SAFETY ANALYSIS:

The safety significance of this event was minimal. With the vent fan power select switch in the alternate position, the power for the vent fan would be supplied by a Unit 1 safety bus. If any loss of power were to occur that affected only Unit 2, the Unit 1 safety bus would be powered by off-site power. If the loss of power were to affect both units, the Unit 1 EDG would supply power to the safety bus. In either case, the vent fan would have power. The Unit 1 EDG was operable throughout the time frame that the switch was most likely mispositioned (i.e., from the start of the Unit 2 refueling outage until discovery of the switch misposition). There was no Safety System Functional Failure as part of this event.

E. CORRECTIVE ACTIONS:

Corrective Actions Completed:

The Control Room verified that the fan switches were in the correct position on both units and walked down the other panels in the emergency diesel generator rooms. No other discrepancies were found.

The Security Department head directed security guards to remove the chairs from the EDG rooms and not to congregate in these areas. Security distributed a memo to the guards identifying approved in-plant waiting areas.

Construction Supervisor has provided information concerning lessons learned from this event and appropriate areas for changing clothing to contractor personnel during tailgate sessions.

Corrective Actions to be Completed:

A process will be put in place to identify selected equipment being credited to maintain Shutdown Safety levels. The purpose of this action is to limit access to the plant areas containing that equipment during outage periods.

F. PREVIOUS OCCURRENCES:

A review was performed of Licensee Event Reports over the last two years that were caused by inadvertent movement of switches / components by personnel who were not directly involved with working on the equipment. No events were identified.

G. COMPONENT FAILURE DATA:

There were no component failures associated with this event.