

Exelon Generation Company, LLC
Quad Cities Nuclear Power Station
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November 29, 2002

SVP-02-094

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

Subject: Licensee Event Report 265/02-005, "Failure of Low Pressure Coolant Injection Logic Test due to a Detached Wire"

Enclosed is Licensee Event Report (LER) 265/02-005, "Failure of Low Pressure Coolant Injection Logic Test due to a Detached Wire," for Quad Cities Nuclear Power Station, Unit 2.

This report is submitted in accordance with the requirements of the Code of Federal Regulations, Title 10, Part 50.73(a)(2)(v)(B), which requires reporting of any event or condition that could have prevented the fulfillment of the safety function of structures or systems that are needed to remove residual heat, and Part 50.73(a)(2)(i)(B), which requires reporting of any operation or condition which was prohibited by the plant's Technical Specifications.

We are committing to the following actions:

A detailed inspection of all fuse block compression fitting control wiring in the Control Room, Auxiliary Electric Room and Emergency Diesel Generator Rooms will be performed.

Expectations will be established and implemented concerning the performance of inspections for electrical components and equipment to ensure they remain intact following work activities.

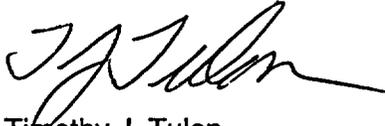
Any other actions described in the submittal represent intended or planned actions by Exelon Generation Company (EGC), LLC. They are described for the NRC's information and are not regulatory commitments.

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Should you have any questions concerning this report, please contact Mr. W. J. Beck at (309) 227-2800.

Respectfully,



Timothy J. Tulon
Site Vice President
Quad Cities Nuclear Power Station

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

NRC FORM 366 (7-2001)	U.S. NUCLEAR REGULATORY COMMISSION	APPROVED BY OMB NO. 3150-0104 EXPIRES 7-31-2004 Estimated burden per response to comply with this mandatory information collection request 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records Management Branch (T-6 E6), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to bjs1@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202 (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection
LICENSEE EVENT REPORT (LER)		

1. FACILITY NAME Quad Cities Nuclear Power Station Unit 2	2. DOCKET NUMBER 05000265	3. PAGE 1 of 4
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4. TITLE Failure of Low Pressure Coolant Injection Logic Test due to a Detached Wire

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MO	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO	MO	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
10	07	02	02	- 005	- 00	11	29	02	N/A	N/A
									FACILITY NAME	DOCKET NUMBER
									N/A	N/A

9. OPERATING MODE	1	11 THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check all that apply)			
		20.2201(b)	20.2203(a)(3)(ii)	50.73(a)(2)(ii)(B)	50.73(a)(2)(ix)(A)
10. POWER LEVEL	097	20.2201(d)	20.2203(a)(4)	50.73(a)(2)(iii)	50.73(a)(2)(x)
		20.2203(a)(1)	50.36(c)(1)(i)(A)	50.73(a)(2)(iv)(A)	73.71(a)(4)
		20.2203(a)(2)(i)	50.36(c)(1)(ii)(A)	50.73(a)(2)(v)(A)	73.71(a)(5)
		20.2203(a)(2)(ii)	50.36(c)(2)	<input checked="" type="checkbox"/> 50.73(a)(2)(v)(B)	OTHER Specify in Abstract below or in NRC Form 366A
		20.2203(a)(2)(iii)	50.46(a)(3)(ii)	50.73(a)(2)(v)(C)	
		20.2203(a)(2)(iv)	50.73(a)(2)(i)(A)	50.73(a)(2)(v)(D)	
		20.2203(a)(2)(v)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)(B)	50.73(a)(2)(vii)	
		20.2203(a)(2)(vi)	50.73(a)(2)(i)(C)	50.73(a)(2)(viii)(A)	
		20.2203(a)(3)(i)	50.73(a)(2)(ii)(A)	50.73(a)(2)(viii)(B)	

12. LICENSEE CONTACT FOR THIS LER

NAME Wally Beck, Regulatory Assurance Manager	TELEPHONE NUMBER (Include Area Code) (309) 227-2800
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13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

14. SUPPLEMENTAL REPORT EXPECTED				15. EXPECTED SUBMISSION DATE		
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)		<input checked="" type="checkbox"/> NO				

16. ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)

On October 7, 2002, at 1044 hours, a detached wire was found in a panel in the auxiliary equipment room as the result of a logic test failure. With the wire detached, one division of the Low Pressure Coolant Injection (LPCI) system would not have automatically started, and the flow from the other division may have been diverted from the reactor vessel. All pumps and valves could have been operated manually from the control room control panels and plant operators would have been able to restore required flow to the vessel.

The detached wire was determined to be due to poor installation of the wiring and a lack of formal expectations concerning the inspection of equipment disturbed during work activities. Corrective actions include attaching the wire correctly and establishing and implementing expectations concerning the performance of inspections for electrical components and equipment following work activities.

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
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(If more space is required, use additional copies of NRC Form 366A)(17)

wires were loosened during the movement of the fuse block, but still made contact.

Additionally, it was determined that problems with indication lights [IL] encountered during a surveillance test performed in March 2002, were caused by the detached lead. During the March 2002 surveillance, the indicating lights were noted to flicker and then extinguish. This indicates that the loose connection that existed prior to March 2002 became detached at that time. The indicating lights were not a part of the acceptance criteria for the March 2002 surveillance. A work order initiated at that time to address the problem was prioritized based on the erroneous assumption that the failure of the lights was not associated with a loss of any RHR functions. At the time the loose wire was identified, the work order had not yet been completed.

C. CAUSE OF EVENT

A root cause of the detached wire was poor installation of control wiring at some time prior to February 18, 2002. A second root cause was a lack of formal expectations and written guidance to rigorously inspect or otherwise test equipment or components disturbed during work activities.

D. SAFETY ANALYSIS

The safety significance of this event was minimal. The Division I pumps would have started and the Division I valves would have operated properly at all times, and the Division II pumps and valves could have been manually controlled from the control room control panel, in accordance with station procedures and operator training.

E. CORRECTIVE ACTIONS

Immediate Actions:

The detached wire and improperly connected wire were properly connected and the surveillance logic test was performed successfully.

Wiring in the ECCS panels on Unit 1 and Unit 2 were inspected. No discrepancies were identified that would affect operability.

Corrective Actions to be Completed:

A detailed inspection of all fuse block compression fitting control wiring in the Control Room, Auxiliary Electric Room and Emergency Diesel Generator Rooms will be performed.

Expectations will be established and implemented concerning the performance of inspections for electrical components and equipment to ensure they remain intact following work activities.

F. PREVIOUS OCCURRENCES

A search of reportable events did not identify any examples of detached wires during the last five years.

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TEXT CONTINUATION

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		2002	005	00	

(If more space is required, use additional copies of NRC Form 366A)(17)

G. COMPONENT FAILURE DATA

There were no component failures associated with this event.