Exelon Generation Company, LLC Quad Cities Nuclear Power Station 22710 206<sup>th</sup> Avenue North Cordova, IL 61242-9740 www.exeloncorp.com



July 13, 2006

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SVP-06-060

U. S. Nuclear Regulatory Commission ATTN: Document Control Desk Washington, D.C. 20555

> Quad Cities Nuclear Power Station, Unit 1 Renewed Facility Operating License No. DPR-29 NRC Docket No. 50-254

Subject: Licensee Event Report 254/06-003, "Unexpected Start of the Division II Emergency Diesel Generator Due to Failure to Open Test Switch"

Enclosed is Licensee Event Report (LER) 254/06-003, "Unexpected Start of the Division II Emergency Diesel Generator Due to Failure to Open Test Switch," for Quad Cities Nuclear Power Station, Unit 1.

This report is submitted in accordance with the requirements of the Code of Federal Regulations, Title 10, Part 50.73(a)(2)(iv)(A), which requires the reporting of any event or condition that resulted in manual or automatic actuation of listed systems, including the Emergency Diesel Generator.

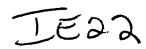
There is one commitment in the enclosed LER. An administrative procedure will be developed and implemented that governs use of the Procedure in Progress book.

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

Respectfully,

Tirrothy 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



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The cause of this event was that the crews did not take prudent measures to ensure all activities in progress were integrated into their awareness of plant status. The crews did not review the entire Procedure in Progress book.														
The safety significance of this event was minimal. This event occurred while the unit was shut down for a refueling outage. The crew immediately recognized that the														
	automatic start was inappropriate and shut down the EDG. The division I EDG was operable throughout the event.													
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U.S. NUCLEAR REGULATORY COMMISSION

# LICENSEE EVENT REPORT (LER)

TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
Quad Cities Nuclear Power Station Unit 1	05000254	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
		2006	003	00	2 of 3

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

## PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor, 2957 Megawatts Thermal Rated Core Power

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

#### EVENT IDENTIFICATION

Unexpected start of the Division II Emergency Diesel Generator due to failure to open test switch.

#### A. CONDITION PRIOR TO EVENT

Unit: 1	Event Date: May 14, 2006	Event Time: 0957 hours
Reactor Mode: 5	Mode Name: Refueling	Power Level: 000%

#### B. DESCRIPTION OF EVENT

On May 14, 2006, at 0957 hours, an unexpected start of the Unit 1 Division II Emergency Diesel Generator (EDG) [EK] occurred at Quad Cities Nuclear Power Station when the EDG control switch was put in the "AUTO" position. At the time of the event, Unit 1 was in an abnormal electrical lineup such that the Division II emergency 4KV bus was de-energized to allow testing of the Reserve Auxiliary Transformer (RAT). There are three test switches that are required to be open to allow the EDG to be in AUTO with the emergency bus de-energized without causing an automatic start of the EDG. The Operations crew believed that the previous crew had opened these switches. The previous crew had opened two of the switches, but had not realized that the third switch was required to be opened.

#### C. CAUSE OF EVENT

The cause of this event was that the crews did not take prudent measures to ensure all activities in progress were integrated into their awareness of plant status. The previous crew had not reviewed the entire Procedure in Progress book prior to taking the shift, and did not recognize that an additional procedure was in progress, requiring an additional test switch to be open if the EDG control switch was put in AUTO. Also, the Operations crew on shift at the time of the event did not check the Procedure in Progress book prior to placing the EDG control switch in AUTO.

#### D. SAFETY ANALYSIS

The safety significance of this event was minimal. This event occurred while the unit was shut down for a refueling outage. The crew immediately recognized that

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## U.S. NUCLEAR REGULATORY COMMISSION

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

the automatic start was inappropriate and shut down the EDG. The Division I EDG was operable throughout the event.

## E. CORRECTIVE ACTIONS

An administrative procedure will be developed and implemented that governs use of the Procedure in Progress book.

## F. PREVIOUS OCCURRENCES

No previous events were identified that involved failure to review the Procedure in Progress book.

### G. COMPONENT FAILURE DATA

There were no equipment failures associated with this event.