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Quad Cities Nuclear Power Station
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July 13, 2006

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,



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

JE22

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

Estimated burden per response to comply with this mandatory 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 and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects@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 an 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.

1. FACILITY NAME: Quad Cities Nuclear Power Station, Unit 1
2. DOCKET NUMBER: 05000254
3. PAGE: 1 of 3

4. TITLE: Unexpected Start of the Division II Emergency Diesel Generator Due to Failure to Open Test Switch

Table with 4 main columns: 5. EVENT DATE, 6. LER NUMBER, 7. REPORT DATE, 8. OTHER FACILITIES INVOLVED. Includes sub-columns for month, day, year, sequential number, rev no., and facility name/docket number.

9. OPERATING MODE: 5
10. POWER LEVEL: 000%
11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR§: (Check all that apply)
List of regulatory codes with checkboxes.

12. LICENSEE CONTACT FOR THIS LER
NAME: Wally Beck, Regulatory Assurance Manager
TELEPHONE NUMBER: (309) 227-2800

13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT
Table with columns: CAUSE, SYSTEM, COMPONENT, MANUFACTURER, REPORTABLE TO EPIX.

14. SUPPLEMENTAL REPORT EXPECTED: [] YES, [X] NO
15. EXPECTED SUBMISSION DATE: MONTH, DAY, YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)
On May 14, 2006, at 0957 hours, an unexpected start of the Unit 1 Division II Emergency Diesel Generator (EDG) occurred 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. The Operations crew believed that the previous crew had opened the three required test switches. The previous crew had opened two of the switches, but had not realized that the third switch was required to be opened.
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.
Corrective action is to establish formal guidance for use of the Procedure in Progress book.

NRC FORM 366A (7-2001)		U.S. NUCLEAR REGULATORY COMMISSION			
LICENSEE EVENT REPORT (LER) TEXT CONTINUATION					
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(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

LICENSEE EVENT REPORT (LER)

TEXT CONTINUATION

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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.