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November 20, 2006

SVP-06-106

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, Revision 1, "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, Revision 1, "Unexpected Start of the Division II Emergency Diesel Generator Due to Failure to Open Test Switch," for Quad Cities Nuclear Power Station, Unit 1.

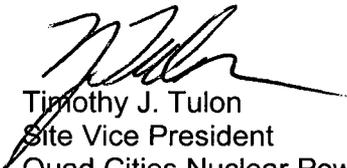
This report is submitted in accordance with the requirements of the Code of Federal Regulations, Title 10, Part 50.73(a)(2)(iv)(A), which requires the reporting of any event or condition that resulted in manual or automatic actuation of listed systems, including the Emergency Diesel Generator.

This revision provides additional details concerning the causes and corrective actions for the event.

No new commitments are made in this submittal. The additional corrective actions are described for completeness.

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

IE22

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

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO.	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
05	14	2006	2006	- 003 -	01	11	20	2006	N/A	N/A
									N/A	N/A

9. OPERATING MODE 5	11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR§: (Check all that apply)									
10. POWER LEVEL 000%	<input type="checkbox"/> 20.2201(b)	<input type="checkbox"/> 20.2203(a)(3)(i)	<input type="checkbox"/> 50.73(a)(2)(i)(C)	<input type="checkbox"/> 50.73(a)(2)(vii)						
	<input type="checkbox"/> 20.2201(d)	<input type="checkbox"/> 20.2203(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)						
	<input type="checkbox"/> 20.2203(a)(1)	<input type="checkbox"/> 20.2203(a)(4)	<input type="checkbox"/> 50.73(a)(2)(ii)(B)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)						
	<input type="checkbox"/> 20.2203(a)(2)(i)	<input type="checkbox"/> 50.36(c)(1)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)(A)						
	<input type="checkbox"/> 20.2203(a)(2)(ii)	<input type="checkbox"/> 50.36(c)(1)(ii)(A)	<input checked="" type="checkbox"/> 50.73(a)(2)(iv)(A)	<input type="checkbox"/> 50.73(a)(2)(x)						
	<input type="checkbox"/> 20.2203(a)(2)(iii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(v)(A)	<input type="checkbox"/> 73.71(a)(4)						
	<input type="checkbox"/> 20.2203(a)(2)(iv)	<input type="checkbox"/> 50.46(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(v)(B)	<input type="checkbox"/> 73.71(a)(5)						
	<input type="checkbox"/> 20.2203(a)(2)(v)	<input type="checkbox"/> 50.73(a)(2)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(v)(C)	<input type="checkbox"/> OTHER						
	<input type="checkbox"/> 20.2203(a)(2)(vi)	<input type="checkbox"/> 50.73(a)(2)(i)(B)	<input type="checkbox"/> 50.73(a)(2)(v)(D)		Specify in Abstract below or in NRC Form 366A					

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	MANU-FACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX

14. SUPPLEMENTAL REPORT EXPECTED

YES (If yes, complete 15. EXPECTED SUBMISSION DATE)

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 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 actions include establishment of formal guidance for use of the Procedure in Progress (PIP) book, training concerning Technical Human Performance, a revision to the shift Turnover Checklist to require review of the PIP book, and clarified expectations concerning use of non-carded Clearance Order steps.

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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 root 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. Operator performance could have been improved through both rigorous application of technical human performance behaviors and enhanced process barriers. Numerous data points (shift logs, procedure in progress book, verbal turnover, Clearance Order (CO) checklist) were available to insure the crew understood plant status during turnover. Imprecise verbal information, inadequate review of the logs, and inadequate review of the procedures in progress, led to a situation where the EDG was inadvertently auto started.

A contributing cause of this event was the inappropriate use of the CO special instruction for the U1 EDG control switch for configuration control. The Unit Supervisor stated that the EDG control switch was put in the "AUTO" position per

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the turnover and the CO special instruction. The clearance and tagging procedure does not allow configuration control through special instructions.

Additional contributing causes of the event include the lack of an established policy/process for using or reviewing the Procedures-in-Progress (PIP) book, and inconsistent usage of Equipment Status Tags for heightening awareness of procedures in progress.

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 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 has been developed and implemented that governs use of the PIP book. In addition, the administrative procedure for the PIP book includes guidance concerning the use of Equipment Status Tags.

Technical Human Performance requirements and use of a questioning attitude have been reinforced through operations crew training.

The Shift Turnover Checklist has been revised to require documented review of the PIP book as part of the shift turnover process.

An Operations Standing Order has been issued clarifying expectations concerning the use of non-carded CO steps and special instructions/notes in COs, pending completion of a permanent procedure revision.

F. PREVIOUS OCCURRENCES

One similar non-reportable previous event at Quad Cities Station was identified.

On October 7, 2004, the 1A Residual Heat Removal Service Water (RHRSW) system was started following maintenance without a discharge flow path established. All of the heat exchanger isolation valves had been tagged closed but were not opened during the final clear. The pump was subsequently re-started two more times within a 10-minute span before it was determined that a discharge flow path had not been established.

The root cause of the event was that during the preparation of the Final Clear for an associated CO, the preparer and the reviewer both made inappropriate assumptions regarding the use of the CO procedure. In particular there were inappropriate assumptions about CO special instructions and configuration control using non-carded steps. The Final Clear contained a special instruction concerning positioning of the heat exchanger valves. The Unit Supervisor recalled seeing a

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special instruction during authorization but did not remember to take positive action to ensure the special instruction would be performed. The CO was able to be fully completed without performing this instruction. Corrective actions included training on the procedural requirements regarding CO special instructions and the use of non-carded steps for configuration control.

The similarities between the October 7, 2004, event and the May 14, 2006, event relate to the misapplication of a special instruction/note; however, there are several differences between the events. The misapplication in the October 7, 2004, event related to CO development, as the CO Final Clear resulted in the plant being in an unacceptable configuration when completed. The use of non-carded steps for realignment was overlooked and only the special instruction/note was used for configuration control. In the May 14, 2006, event, there is no inherent deficiency in the note; the plant was in an acceptable configuration when the CO was completed. The misapplication was by the crew personnel invoking the special instruction to perform an action outside of procedure. The training performed for the October 7, 2004, event was not effective in preventing the May 14, 2006 event.

G. COMPONENT FAILURE DATA

There were no equipment failures associated with this event.