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MISAK,A.L. Commonwealth Edison Co.
BAX,R.L. Commonwealth Edison Co.
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 93-019-00:on 930903,RHR Pump 1A inadvertently started due to personnel error.Pump immediately secured & individual involved counselled on importance of self-check.W/931001 ltr.

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RLB-93-133

October 1, 1993

U.S. Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

Reference: Quad Cities Nuclear Power Station
Docket Number 50-254, DPR-29, Unit One

Enclosed is Licensee Event Report (LER) 93-019, 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)(iv). The licensee shall report any event or condition that resulted in manual or automatic actuation of any Engineered Safety Feature.

Respectfully,

COMMONWEALTH EDISON COMPANY
QUAD CITIES NUCLEAR POWER STATION

R. L. Bax
Station Manager

RLB/TB/plm

Enclosure

cc: J. Schrage
T. Taylor
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LICENSEE EVENT REPORT (LER) Form Rev. 2.0

Facility Name (1)	Docket Number (2)	Page (3)
Quad Cities Unit One	0 5 0 0 0 2 5 4	1 of 0 3

Title (4)

Inadvertent Start of 1A RHR Pump

Event Date (5)			LER Number (6)			Report Date (7)			Other Facilities Involved (8)	
Month	Day	Year	Year	Sequential Number	Revision Number	Month	Day	Year	Facility Names	Docket Number(s)
0 9	0 3	9 3	9 3	– 0 1 9	– 0 0	1 0	0 1	9 3		0 5 0 0 0
										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)				
4		20.402(b)	20.405(c)	X 50.73(a)(2)(iv)	73.71(b)	
POWER LEVEL (10)	1 0 0	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)	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
Alex L. Misak, Ext. 3100	AREA CODE 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 NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS
A									

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

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

ABSTRACT:

At 0059 hours on September 3, 1993, performance of QCOP 1000-27, "Flushing A RHR Heat Exchanger using Two RHR Service Water Pumps." was in progress. At the point in the procedure requiring the start of the A Residual Heat Removal (RHR) Service Water pump, the 1A RHR pump was inadvertently started. The pump was immediately secured.

The cause of this event is personnel error. The Unit One Nuclear Station Operator (NSO) failed to ensure that the correct switch was located prior to actuation, and as a result, the 1A RHR pump was started instead of the intended 1A RHR Service Water pump.

The NSO was immediately counselled by the Shift Engineer on the importance of self-check. Additional disciplinary action was also administered.

PLANT AND SYSTEM IDENTIFICATION:

General Electric - Boiling Water Reactor - 2511 MWt rated core thermal power.

EVENT IDENTIFICATION: Inadvertent start of 1A RHR Pump.

A. CONDITIONS PRIOR TO EVENT:

Unit: One Event Date: September 3,1993 Event Time: 0059
Reactor Mode: 4 Mode Name: Run Power Level: 100

This report was initiated by Licensee Report 254\93-019.

RUN (4) - In this position the reactor system pressure is at or above 825 psig, and the reactor protection system is energized, with APRM protection and RBM interlocks in service (excluding the 15% high flux scram).

B. DESCRIPTION OF EVENT:

At 0059 hours on September 3, 1993, performance of QCOP 1000-27, "Flushing A RHR Heat Exchanger using Two RHR Service Water Pumps." was in progress. At the point in the procedure requiring the start of the A Residual Heat Removal (RHR) Service Water pump, the 1A RHR pump was inadvertently started. The pump was immediately secured.

At 0423 hours, an Emergency Notification System notification was made to notify the NRC of the unplanned ESF actuation in accordance with 10 CFR 50.72(b)(2)(ii).

C. APPARENT CAUSE OF EVENT:

The cause of this event is personnel error. The Unit One Nuclear Station Operator (NSO) failed to ensure that the correct switch was located prior to actuation, and as a result, the 1A RHR pump was started instead of the intended 1A RHR Service Water pump.

D. SAFETY ANALYSIS OF EVENT:

The safety consequences of this event were minimal. This event had no affect on the ability of the RHR pump to perform its intended function had it been called on during an accident condition.

E. CORRECTIVE ACTIONS:

The NSO was immediately counselled by the Shift Engineer on the importance of self-check. Additional disciplinary action was also administered.

F. PREVIOUS EVENTS:

During the past three years, two previous events have occurred which resulted in inadvertent ESF actuation due to operation of incorrect control panel switches in the control room. These events are documented in the following LERS:

254-91-004 Inadvertent Actuation of 1C and 1D RHR Pump

254-93-006 Inadvertent Start of the U-1 Diesel Generator.

G. COMPONENT FAILURE DATA:

There were no component failures associated with this event.