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Quad Cities Nuclear Power Station
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RLB-92-018

January 14, 1992

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

Reference: Quad Cities Nuclear Power Station
Docket Number 50-265, DPR-30, Unit Two

Enclosed is Licensee Event Report (LER) 91-015, 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
INPO Records Center
NRC Region III

STMGR 257

IE22

LICENSEE EVENT REPORT (LER)

Form Rev 2.0

Facility Name (1)	Docket Number (2)	Page (3)
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Title (4)

U2 Rx Bldg Vent Isolation During Return to Service Verification

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 5 0 0 0
1 2	2 4	9 1	9 1	0 1 5	0 0	0 1	1 8	9 2		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(h)	20.405(c)	X	50.73(a)(2)(iv)		73.71(b)
POWER LEVEL (10)	0 6 5	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
	AREA CODE
Rachel A. Luebbe Ext. 2119	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	MANUFAC-TURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS	

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:

On December 24, 1991 at 0445 hours Unit Two was in the Run mode at 65% of rated core thermal power. While performing a Return to Service verification on Out of Service 3639, the Unit 2 Equipment Operator (EO) inadvertently removed fuse F-3 and a white plastic fuse holder obstructing view of the fuse, from the 2252-24X panel, Unit Two (U2) Reactor (Rx) Building (Bldg) Vent Control Panel. The fuse removal caused the U2 Rx Bldg Vent Isolation Dampers to fail close and tripped the supply and exhaust fans.

The immediate corrective actions was to notify the Control Room of the event and reinstall the fuse. The Return to Service was completed and the U2 Rx Bldg Vents turned back on. Further corrective actions will be to remove the white plastic fuse holders completely.

The apparent cause of the event was a design deficiency from a human factors standpoint.

This event is being reported in accordance with 10CFR50.73(a)(2)(iv).

PLANT AND SYSTEM IDENTIFICATION:

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

EVENT IDENTIFICATION: U[illegible] Reactor Vent Isolation during return to service verification.

A. CONDITIONS PRIOR TO EVENT

Unit: Two Event Date: December 24, 1991 Event Time: 0445
Reactor Mode: 4 Mode Name: RUN Power Level: 65%

This report was initiated by Deviation Report D-4-2-91-086.

RUN Mode (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:

On December 24, 1991 at 0445 hours Unit Two was in the Run mode at 65% of rated core thermal power. While performing a return to service verification on Out of Service (OOS) 3639, the Unit Two Equipment Operator (EO) attempted to move a white plastic cover out of the way in the 2252-24X panel, Unit Two Reactor Building Vent Control Panel, to verify fuse fuse F-3 was installed properly. The white plastic fuse holder cannot be removed without the fuse being removed with it. Fuse [FU] F-3 inadvertently came out while the EO was trying to look around the fuse holder to verify the fuse installation. The fuse removal caused the Unit 2 Reactor Building (Rx Bldg) Vent Isolation Damper [DMP] Solenoids [SOL] to deenergize. The dampers failed closed and the supply and exhaust fans tripped as required. The EO immediately notified the Control Room and reinstalled the fuse.

Return to Service 3639 on the Unit 2 Rx Bldg Vent Isolation Damper was successfully completed at 0504 hours. The Unit 2 Rx Bldg Fans [VA] were turned back on at 0510 hours.

The Emergency Notification System phone call was made on December 24, 1991 at 0820 hours in accordance with 10CFR50.72.(b)(2)(ii).

C. APPARENT CAUSE OF EVENT:

The apparent cause of the event was a design deficiency from a human factors standpoint. The Unit 2 EO inadvertently removed fuse F-3 from the 2252-24X panel during the return to service of OOS 3639. The Unit 2 EO was having difficulty verifying proper installation of fuse F-3 with a white plastic fuse holder in the way. When he attempted to look around the fuse holder to verify the fuse installation, the fuse and fuse holder inadvertently came out. It is not possible to remove the fuse holder without removing the fuse.

D. SAFETY ANALYSIS OF EVENT:

The safety consequences of the event were minimal. All expected actions occurred upon the removal of fuse F-3. The Unit Two Reactor Building Vent Isolation Dampers failed closed and the supply and exhaust fans tripped. The Unit One Reactor Building Ventilation System was operable and keeping the Reactor Building at a negative differential pressure to ensure no out leakage of contaminants.

This event is being reported in accordance with 10CFR50.73.(a)(2)(iv). The licensee shall report any event or condition that resulted in manual or automatic actuation of any Engineered Safety Feature (ESF).

E. CORRECTIVE ACTIONS:

The immediate corrective action was to notify the Control Room of the event and reinstall fuse F-3 in the 2252-24X panel. The return to service on OOS 3639 on the Unit Two Rx Bldg Vent Isolation Dampers was successfully completed at 0504 hours. The Unit Two Rx Bldg Vents were turned back on at 0510 hours.

An evaluation will be conducted to determine if the white plastic fuse holders can be removed so the fuses can be clearly seen. These fuse holders will then be removed if it is determined that the fuse holders are not necessary (NTS #265 200 91 08601).

In addition, an investigation will be conducted to identify any other fuses that have similar plastic fuse holders. These fuse holders will also be removed after it is determined that these fuse holders are not necessary (NTS # 265 200 91 08602).

F. PREVIOUS EVENTS:

This is an isolated event in that a human factors design deficiency caused an ESF actuation. There have been no previous events of this type.

G. COMPONENT FAILURE DATA:

No component failure data is needed.