



Commonwealth Edison
Quad Cities Nuclear Power Station
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RLB-92-029

January 28, 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) 92-003, 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

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LICENSEE EVENT REPORT (LER)

Form Rev 2.0

Facility Name (1) Quad Cities Unit Two
 Title (4)
 Docket Number (2) 0 | 5 | 0 | 0 | 0 | 2 | 6 | 5
 Page (3) 1 | of | 0 | 4

Rx Bldg Vent Isolation and S> Start Due to Pulled Fuse During Out of Service

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 1	0 6	9 2	9 2	0 0 3	0 0	0 1	2 8	9 2		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9) 1

POWER LEVEL (10) 0 | 0 | 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)

20.402(b)	20.405(c)	X	50.73(a)(2)(iv)	73.71(b)
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)	Cover (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 Rachel A. Luebke Ext. 2119

TELEPHONE NUMBER AREA CODE 3 | 0 | 9 | 6 | 4 | 4 | 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

SUPPLEMENTAL REPORT EXPECTED (14)

Yes (If yes, complete EXPECTED SUBMISSION DATE) X | NO

Expected Submission Date (15) Month | Day | Year

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

ABSTRACT:

On January 6, 1992 at 1154 hours, Unit Two was in the Shutdown mode for a refueling outage. The Operating Department was taking the Unit 2 Torus to Oxygen Analyzer Solenoid [SOL] (2-8801-D) Out of Service (OOS). During OOS #3938 fuse [FU] F-6 was pulled from the 902-40 panel [PL]. This fuse pull caused the 595-133 relay [RLY] to deenergize which gave an autostart signal to Standby Gas Treatment (S>) [VI], isolated the Reactor Building Vents [VA], and a partial Group II isolation was received.

At 1221 hours the S> train was secured and the Reactor Building Vents were reset and restarted. At 1314 hours, OOS #3938 was successfully completed without pulling the fuse. On January 6, 1992, Memo 92-1 was issued to operating personnel which put a stop to all fuse pulls in the 901(2)-40 and 901(2)-41 panels until an operator aide addressing inadvertent actuations is made up.

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

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

Form Rev 2.0

FACILITY NAME (1)	DOCKET NUMBER (2)	LCR NUMBER (6)				Page (3)	
		Year	Sequential Number	Revision Number			
Quad Cities Unit Two	0 5 0 0 0 2 6 5	9 2	- 0 0 3	- 0 0	0 3	OF 0 4	

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

D. SAFETY ANALYSIS OF EVENT:

The safety consequences of this event were minimal. The Rx Bldg Vents and SBGT functioned as designed. All valves affected by the event failed in the safe direction. Unit 2 was in a refueling outage during the time of the event. The Reactor Building maintained its negative differential pressure with SBGT.

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

E. CORRECTIVE ACTIONS:

The immediate corrective action was to replace fuse F-6 in the 902-40 panel. The SBGT train was locked off and the Rx Bldg Vents were reset and turned back on at 1221 hours on January 6, 1992. At 1314 hours, OOS #3938 was successfully completed without pulling the fuse. Individuals involved in this event were counseled.

On January 6, 1992, Memo 92-1 was issued from the Assistant Superintendent of Operations which addressed several immediate actions to be taken for this event. First, it was stressed to all individuals who prepare electrical OOS's that all actions that will occur as a result of the OOS be thoroughly researched. It was also emphasized that the individuals who prepare and verify the OOS's are accountable for ensuring they are correct and complete. Second, all fuses in the 901(2)-40 and 901(2)-41 panels were researched and an operator aid was developed to list all actuations that will occur when the fuses are removed. This temporary operator aid will be replaced by a permanent engraved placard which will reference a procedure listing the consequences of pulling a fuse in the 901(2)-40 and 901(2)-41 panels. Third, until the operator aid is produced and installed, no further fuse removals in the 901(2)-40 and 901(2)-41 panels will be allowed unless a procedure is written to control the activity (WTS #265 200 92 00301). Replacement of blown fuses is an exception of this requirement.

F. PREVIOUS EVENTS:

Deviation Report 4-2-88-038 describes the exact same event as this one except they were taking the 2-1601-56 valve Out of Service. The cause of the event was personnel error and the corrective actions were to counsel the personnel involved in the event.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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		Year	Sequential Number	Revision Number			
Quad Cities Unit Two	0 5 0 0 0 2 6 5	9 2	- 0 0 3	- 0 0	0 4	OF	0 4

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The following is a list of previous events that deal with personnel errors experienced during Out of Services.

- D4-1-91-002 Partial Group II actuation from fuse removal for OOS work. Fuse F-7 pulled from 901-40 and 901-41 panel.
- D4-2-88-038 Fuse pull during Out of Service caused an isolation of the Rx Bldg Vents; Fuse F-6 pulled from the 902-40 panel.

G. COMPONENT FAILURE DATA:

There is no component failure data because this is a personnel error event.