LICENSEE EVENT REPORT (LER)

Facility Name (1)	Docket Number (2)	Page (3)
QUAD-CITIES NUCLEAR POWER STATION, UNIT ONE	0 5 0 0 0 2 5 4	1 of 0 5

Title (4) MISSED TECHNICAL SPECIFICATIONS REQUIRED SURVEILLANCE DUE TO SCHEDULING LAPSE

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)
										QUAD CITIES UNIT TWO	0 5 0 0 0 2 6 5
0 3	2 5	8 8	8 8	---	0 0 6	0 0	0 4	1 2	8 8		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)	___ 50.73(a)(2)(iv)	___ 73.71(b)		
POWER LEVEL (10)	0 8 7	___ 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)	X 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
Tim Hanley, Technical Staff Engineer Extension 2171	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

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)

On March 25, 1988, Units One and Two were both in the RUN mode at 87 and 84 percent power respectively. At 1600 hours it was determined that the Instrument Maintenance (IM) Department's Weekly Power Operation Functional Test had exceeded both criteria of the Technical Specifications required interval, weekly plus 25 percent and 3 consecutive surveillances within 3.25 percent of the surveillance interval. The functional testing was satisfactorily completed on both units within 35 minutes of discovery.

The cause for this event is management deficiency because there was not adequate guidance or other means in place to ensure these required surveillances were performed when key IM personnel were absent.

A task force is being established to review the existing Station surveillance program to verify adequate controls are in place. Corrective actions will be implemented as deemed appropriate.

This report is provided to comply with the requirements of 10CFR50.73(a)(2)(i)(B).

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PLANT AND SYSTEM IDENTIFICATION:

General Electric - Boiling Water Reactor - 2511 MWt rated core thermal power. Energy Industry Identification System (EIIS) codes are identified in the text as [XX].

EVENT IDENTIFICATION: Tardy Technical Specification required surveillance due to management deficiency

A. CONDITIONS PRIOR TO EVENT:

Unit: One | Event Date: March 25, 1988 | Event Time: 1600
Reactor Mode: 4 | Mode Name: RUN | Power Level: 87%

This report was initiated by Deviation Report D-4-1-88-025

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 March 25, 1988, Unit One and Two were both operating in the RUN mode at 87 and 84 percent rated thermal power respectively. At 1600 hours, the Shift Engineer was notified by the Instrument Maintenance (IM) Department that the Weekly Power Operation Functional Test period had been exceeded on both units. This surveillance test is required by Technical Specifications (Tech Specs) Table 4.1-1, to be performed weekly plus 25 percent (7 days + 1.75 days) and 3 consecutive surveillances must be within 3.25 percent of the surveillance interval. This surveillance was last performed 11 days earlier on March 14, 1988. The two previous surveillances were performed on March 7 and February 29, 1988. A Deviation Report was initiated and the surveillance performed immediately. Results were satisfactory for both units.

Exceeding the surveillance interval plus the allowable 25 percent extension results in the scram instrumentation being declared inoperable and applying the appropriate Limiting Condition of Operation (LCO) action statement. Tech Spec Table 3.1-3, Reactor Protection System (Scram) Instrumentation Requirements Run Mode, states the actions to be taken with less than the minimum number of operable or tripped instrument channels for both trip systems. With less than the required number of operable Average Power Range Monitors (APRMs) [MON] complete insertion of all operable control rods [AA,JC] within four hours or reduce power level to the Intermediate Range Monitors (IRMs) [MON] range and place the mode switch [HS] in Startup/Hot Standby position within eight hours.

With less than the required number of operable main steam line radiation monitors [IL,MON], all operable control rods shall be inserted within four hours or turbine [TA,TRB] load shall be reduced and the main steam isolation valves [SB,ISV] shall be closed within eight hours. Tech Spec Table 3.2-1, Instrumentation That Initiates Primary Containment Isolation Functions also requires an orderly load reduction such that the unit is in Hot Standby within eight hours if there is less than the minimum required number of operable main steam line radiation monitors.

Application of the time limitations of the action statements from the point of time that it is recognized that an LCO is not met is supported by the November 22, 1985 letter from H.L. Thompson, Director Division of Licensing, NRR to the NRC Regional Administrators. As stated in the letter, the interpretation precludes having to initiate an immediate shutdown upon discovering a surveillance has been missed. This interpretation is also supported by April 24, 1986 letter from M.S. Turbak to R. L. Bax.

The missed surveillances were begun immediately upon discovery of the error and completed within 35 minutes of discovery. A shutdown of the units was not immediately initiated since sufficient time was still available to meet the time limits of the action statements, if needed. Upon review of the 10CFR50.72 and 73 reporting requirements, it was determined that the event was reportable as a Licensing Event Report (LER) under 10CFR50.73(a)(2)(i). Since corresponding reporting requirements are not listed in 10CFR50.72, and initiation of a reactor shutdown was not begun, the Emergency Notification System (ENS) was not required.

C. APPARENT CAUSE OF EVENT:

This report is provided per the requirements of 10CFR50.73(a)(2)(i)(B), which requires a report for any operation or condition prohibited by the plant's Technical Specifications.

The root cause of this event was management deficiency in that there was not adequate guidance or other positive means in place to assure that required surveillances are carried out in the absence of the Instrument Maintenance Scheduler and/or other key individuals. Contributing factors were the scheduling of training, sickness and alternation of personnel, as detailed below, which all occurred simultaneously.

Weekly Surveillance Testing is routinely performed by the Instrument Maintenance (IM) Department on Monday of each week except in the case of such things as a holiday or system status which would preclude these tests. In these cases, testing is performed as soon as possible to meet the allowable Specification surveillance interval. The requirement to perform this weekly surveillance test is normally identified on a weekly schedule which is developed by the scheduler and distributed to the IM foremen on Friday or Monday of each week. This surveillance is normally performed by the day shift as a portion of their routine activities and is not performed on the afternoon shift unless special circumstances arise as explained above. The normal Instrument Department management staffing on days is as follows: the Master Instrument Mechanic, one Scheduler, one Analyst, two day Foremen, one extra day Foreman, one Engineering Assistant (EA), and one Department Training Coordinator. The afternoon shift includes one Foreman. During the week beginning on March 21, 1988, the following staffing situations occurred: the Master Instrument Mechanic was on site all week; the Scheduler was off sick all week; the Analyst was in Training the entire week; one of the regular day Foremen was sick Monday and upon return Tuesday, filled in for the Analyst; the other

regular day Foreman was in Training for the week. The extra day Foreman was moved to the afternoon shift for the week. The department EA remained on the day shift all week. The Training Coordinator was on vacation the first part of the week and returned to attend training the remainder of the week. Finally, the regular afternoon Foreman was moved to dayshift for the week. The result of these scheduling changes was one Foreman on days, who was unfamiliar with the routine of completing weekly surveillances on Mondays and lacked adequate guidance to assure all surveillance requirements were met by his crew. The previous Friday, March 18, 1988, the Scheduler had established a schedule which included the required weekly Surveillance tests. This schedule was not handed out on Friday, and because of the Scheduler's absence, was also not distributed Monday.

On Friday, March 18, 1988, the afternoon Foreman, anticipating his move to the day shift Monday had developed a work schedule for what he thought was to be one half the day shift crew. Upon reporting to work Monday morning, March 21, 1988, the Foreman realized he was in charge of the entire crew, due to training and sickness of the regularly scheduled staff. He made adjustments as he deemed necessary but failed to recognize the need to perform the Weekly Required Surveillances. The requirement to perform these surveillances went unrecognized until Friday afternoon, March 25, 1988, at which time the afternoon Foreman discovered the error.

During this review, it was also recognized that the potential for this type of event exists in other areas in addition to the Instrument Maintenance Department.

D. SAFETY ANALYSIS OF EVENT:

The safety significance of this event is minimal. The purpose of this test is only to verify that the APRM high flux, inoperative, and downscale scrams, the APRM high flux rod block, and the Main Steam Line Radiation Monitor scram and isolation capabilities are functional. This test does not include any calibration or verification of trip setpoints.

For the APRM system to fail to actuate a system trip, all three APRMs in a trip system would have to be failed at the same time. Based on the past performance of these instruments, the probability of this occurring in the time span of 11 days is extremely low.

For the Main Steam Line Radiation Monitor system to fail to actuate a system trip, both radiation monitors in a trip system would have to be failed at the same time. Again, based on past performance of these instruments, the probability of this occurring in the time span of 11 days is extremely low.

Additionally, all instruments were found to function satisfactorily when the functional test was performed.

E. CORRECTIVE ACTIONS:

Immediate corrective action was taken by performing the required surveillance (QIS 60-1) with acceptable results for both Unit One and Unit Two.

The following corrective action has been undertaken to prevent recurrence:

The Station Manager has assigned a Technical Staff Engineer to head a task force to review the existing Surveillance program and verify adequate controls are in place to assure that scheduled surveillances are performed as required. The results of this review and actions implemented will correct the root cause of this event. The program will address this concern stationwide and will be implemented per the recommendations of the task force. Progress will be tracked with Nuclear Tracking System (NTS) number 2545418800301.

F. PREVIOUS EVENTS:

The time interval for this surveillance (QIS 60-1) was exceeded once before on June 1, 1984 and was reported in LER 265/84-006.

G. COMPONENT FAILURE:

There was no component failure involved in this event.

Commonwealth Edison
Quad Cities Nuclear Power Station
22710 206 Avenue North
Cordova, Illinois 61242
Telephone 309/654-2241

RLB-88-128

April 12 1988

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 please find Licensee Event Report (LER) 88-006, 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)(i) (B), which requires the reporting of any operation or condition prohibited by the plant's Technical Specifications.

Respectfully,

COMMONWEALTH EDISON COMPANY
QUAD-CITIES NUCLEAR POWER STATION

R. L. Bax
Station Manager

RLB/MSK/clr

Enclosure

cc: I. Johnson
R. Higgins
INPO Records Center
NRC Region III

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