

LICENSEE EVENT REPORT

CONTROL BLOCK:

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(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

0 1 | 1 | L | Q | A | D | 2 | 2 | 0 | 0 | 0 | - | 0 | 0 | 0 | - | 0 | 0 | 0 | 3 | 4 | 1 | 1 | 1 | 1 | 1 | 4 | 5

LICENSEE CODE LICENSE NUMBER LICENSE TYPE CAT 58

CON'T

REPORT SOURCE: L 6 0 5 0 0 0 2 6 5 7 0 5 1 8 8 1 8 0 6 1 0 8 1 9

60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

At 0010 on May 18, 1981, while performing surveillance test QOS 1000-3, per Technical Specification 4.9.E., valve M0-2-1001-7B was closed but was unable to be re-opened. The probable consequences of this occurrence are minimal. The other three RHR pumps were fully operable therefore, the LPCI mode of RHR remained unaffected by this occurrence.

SYSTEM CODE C F 11		CAUSE CODE E 12		CAUSE SUBCODE A 13		COMPONENT CODE R E L A Y X 14		COMP. SUBCODE F 15		VALVE SUBCODE Z 16	
EVENT YEAR 8 1 21 22		SHUTDOWN METHOD Z 21		SEQUENTIAL REPORT NO. 0 1 2 24 26		HOURS 0 0 0 0 22 37 40		REPORT TYPE L 30		REVISION NO. 0 32	
ACTION TAKEN A 18		EFFECT ON PLANT Z 20		ATTACHMENT SUBMITTED Y 23		PRIME COMP. SUPPLIER A 25		NPRD-4 FORM SUB. Y 24		COMPONENT MANUFACTURER G 0 8 0 44 47	
FUTURE ACTION Z 19		ACTION TAKEN A 18		ATTACHMENT SUBMITTED Y 23		PRIME COMP. SUPPLIER A 25		NPRD-4 FORM SUB. Y 24		COMPONENT MANUFACTURER G 0 8 0 44 47	

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 2 The auxiliary contacts in the circuit breaker failed to disengage. Therefore, the

1 1 opening coil could not energize disabling the valve. The corrective action was to

1 2 immediately manually open the valve. The auxiliary contacts were then replaced

1 3 and the valve demonstrated operable at 1505 on May 18, 1981.

1 4

FACILITY STATUS		% POWER		OTHER STATUS		METHOD OF DISCOVERY		DISCOVERY DESCRIPTION	
1	E	0	9	NA	B	Routine Surveillance			
ACTIVITY CONTENT RELEASED OF RELEASE		AMOUNT OF ACTIVITY		LOCATION OF RELEASE					
1	Z	Z	NA	NA					
PERSONNEL EXPOSURES NUMBER		TYPE		DESCRIPTION					
0	0	Z	NA						
PERSONNEL INJURIES NUMBER		DESCRIPTION							
0	0		NA						
LOSS OF OR DAMAGE TO FACILITY TYPE		DESCRIPTION							
Z			NA						
PUBLICITY ISSUED		DESCRIPTION		NRC USE ONLY					
N		NA	S	8107160395 810610 PDR ADOCK 05000265 PDR					

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I. LER NUMBER: LER/RO 81-12/03L-0

II. LICENSEE NAME: Commonwealth Edison Company
Quad-Cities Nuclear Power Station

III. FACILITY NAME: Unit Two

IV. DOCKET NUMBER: 050-265

V. EVENT DESCRIPTION:

At 0010 on May 18, 1981, while performing surveillance testing, QOS 1000-3, for a Unit Two Diesel Generator outage, valve M0-2-1001-7B was closed but would not re-open from the Control Room. After repeated attempts were made to open the valve from the Control Room without success, the valve was manually opened.

VI. PROBABLE CONSEQUENCES OF THE OCCURRENCE:

The safety aspects of this event are minimal. The failure of the M0-2-1001-7B valve to open prohibited the "B" RHRS pump to take its normal suction from the pressure suppression pool, thereby rendering the pump inoperable for use in the LPCI mode of RHRS. However, the other three RHRS pumps were fully operable, hence the LPCI and containment cooling modes of the RHRS were still capable of performing their designed functions.

VII. CAUSE:

The cause of the deviation was equipment failure. The auxiliary contacts in the circuit breaker failed to disengage. With the auxiliary contacts engaged, the opening coil was unable to energize, therefore disabling the valve.

VIII. CORRECTIVE ACTION:

The valve was immediately manually opened. Work Request Q12549 was initiated to investigate and correct the cause of the deviation. The auxiliary contacts in the circuit breaker were replaced like for like under this Work Request. M0-2-1001-7B was tested satisfactorily at 3:05 p.m. on May 18, 1981. No further corrective action was necessary. On September 5, 1979, the M0-2-1001-7C valve failed to close during testing due to faulty auxiliary contacts.