

CONTROL BLOCK: [] [] [] [] [] [] (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CONTROL BLOCK: 1 2 3 4 5 6 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 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION

0 1 2 3 4 5 6 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 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

CON'T

REPORT SOURCE: L 6 0 5 0 0 0 2 6 5 0 0 8 2 3 8 1 8 0 9 1 6 8 1 9

DOCKET NUMBER: 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

EVENT DATE: 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

REPORT DATE: 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 On August 23, 1981, while performing monthly surveillance test QNS 1600-1,

0 3 Suppression Chamber to Drywell vacuum breaker exercise, valve 2-1601-320 failed to

0 4 indicate fully closed. After several attempts to close the valve failed, the

0 5 Drywell to Suppression Chamber differential pressure decay rate test was performed

0 6 per Technical Specification 3.7.A.4.d. The test proved the valve to be fully

0 7 closed; therefore, the probable consequences of this occurrence were minimal.

0 8

0 9

SYSTEM CODE: S A 11

CAUSE CODE: E 12

CAUSE SUBCODE: E 13

COMPONENT CODE: I N S T R U 14

COMP SUBCODE: S 15

VALVE SUBCODE: Z 16

EVENT YEAR: 8 1

SEQUENTIAL REPORT NO.: 0 1 5

OCCURRENCE CODE: 0 3

REPORT TYPE: L

REVISION NO.: 0

LER/RO REPORT NUMBER: 17

ACTION TAKEN: X 18

FUTURE ACTION: E 19

EFFECT ON PLANT: Z 20

SHUTDOWN METHOD: Z 21

HOURS: 0 0 0 0

ATTACHMENT SUBMITTED: Y 23

NPRD-4 FORM SUB.: Y 24

PRIME COMP. SUPPLIER: A 25

COMPONENT MANUFACTURER: M 3 0 2 26

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of this occurrence was a misalignment of the position indication limit

1 1 switches. These switches are manufactured by Micro Switch, Model Number BAFI-2RM-

1 2 2H. The limit switches will be adjusted during the current refueling outage.

1 3

1 4

FACILITY STATUS: E 28

% POWER: 0 29

OTHER STATUS: NA 30

METHOD OF DISCOVERY: B 31

DISCOVERY DESCRIPTION: Surveillance Testing 32

ACTIVITY RELEASED: Z 33

CONTENT OF RELEASE: Z 34

AMOUNT OF ACTIVITY: NA 35

LOCATION OF RELEASE: NA 36

PERSONNEL EXPOSURES: 0 0 0 37

TYPE: Z 38

DESCRIPTION: NA 39

PERSONNEL INJURIES: 0 0 0 40

DESCRIPTION: NA 41

LOSS OF OR DAMAGE TO FACILITY: Z 42

DESCRIPTION: NA 43

PUBLICITY: N 44

DESCRIPTION: NA 45

ISSUED: N 46

DESCRIPTION: NA 47

8109290412 810916
PDR ADDOCK 05000265
S PDR

NRC USE ONLY

Anthony Fuhs

309-654-2241, ext 216

- I. LER NUMBER: LER/RO 81-15/03L-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:

On August 23, 1981, at 12:30 a.m., while performing the Suppression Chamber to Drywell vacuum breaker monthly exercise, procedure QOS 1600-1, valve 2-1601-32C failed to indicate fully closed. The valve was operated six times, attempting to clear the valve open alarm, after which the Drywell to Suppression Chamber differential pressure was re-established. At 6 a.m., the Drywell to Suppression Chamber decay rate test, QOS 1600-27, was performed and passed in accordance with Technical Specification 3.7.A.4.d. The valve was exercised intermittently the rest of the day. The full closed indication was received and the annunciator alarm cleared during testing performed on the 3 p.m. to 11 p.m. shift.

VI. PROBABLE CONSEQUENCES OF THE OCCURRENCE:

The consequences of this occurrence are minimal. The differential pressure decay rate test required by Technical Specification 3.7.A.4.d verified that the valve was in its fully closed position; therefore, safe operation was not compromised by this occurrence. This valve has not experienced position indication failures in the past. Several recent failures of position indication on similar valves are currently under review for possible adverse trends.

VII. CAUSE:

This event was caused by the position indicating switches shifting out of position. The switches are manufactured by Micro Switch, Model Number BAFI-2RN-2H.

VIII. CORRECTIVE ACTION:

The immediate corrective action taken was to perform the Suppression Chamber to Drywell separation test and to exercise the valve. The proper operation and positioning of the limit switches will be verified during the current refueling outage.