

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

CON'T

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REPORT SOURCE

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80 81 DOCKET NUMBER 88 89 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | On July 15, 1982, at 0900 hours, while performing LPCI motor operated valve

0 3 | operability surveillance, LPCI inboard injection valve M0-2-1001-29B failed to open.

0 4 | The valve was manually opened and the outboard injection valve, M0-2-1001-28B, was

0 5 | closed; thus making the LPCI mode of PHR operable. All RHR and RHR Service Water

0 6 | pumps were operable and the LPCI "A" injection loop was operable. In addition,

0 7 | both Core Spray loops and the Diesel Generators associated with Unit Two were

0 8 | operable. Thus the consequences were minimal.

0	9	SYSTEM CODE		5	F	11	CAUSE CODE	X	12	CAUSE SUBCODE	Z	13	COMPONENT CODE				V	A	L	V	O	P	14	COMP SUBCODE	A	15	VALVE SUBCODE	Z	16					
7	8	9	10	11			11			12			13								18	19			20									
17	LER/RO REPORT NUMBER	EVENT YEAR		8	2	21	22	23	—	SEQUENTIAL REPORT NO.		0	1	1	24	25	26	27	/	OCCURRENCE CODE		0	1	28	29	REPORT TYPE		T	30	31	—	32	REVISION NO. #	0
ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB		PRIME COMP SUPPLIER		COMPONENT MANUFACTURER																		
A	18	Z	19	Z	20	Z	21	0	0	0	0	Y	23	Y	24	N	25	L	2	0	0	26												
33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55												

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | The cause of this occurrence was a detached electrical lead on a torque switch of the

1 1 | valve motor operator. An inspection of the torque switch showed no apparent reason

1 2 | for the loose connection. The immediate corrective action was to manually open the

1 3 | inboard valve and close the outboard valve making LPCI operable. The torque switch

1 4 | was subsequently replaced as preventative maintenance.

FACILITY STATUS (E) (28) % POWER (0) (9) (8) (29) OTHER STATUS (30) NA
 METHOD OF DISCOVERY (B) (31) Monthly Surveillance
 DISCOVERY DESCRIPTION (32)
 ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY (35) NA
 LOCATION OF RELEASE (36)
 PERSONNEL EXPOSURES NUMBER (0) (0) (0) (37) TYPE (Z) (38) DESCRIPTION (39) NA
 PERSONNEL INJURIES NUMBER (0) (0) (0) (40) DESCRIPTION (41) NA
 LOSS OF OR DAMAGE TO FACILITY TYPE (Z) (42) DESCRIPTION (43) NA
 PUBLICITY ISSUED (N) (44) DESCRIPTION (45)
 B208090255 820728
 PDR ADOCK 05000265
 S PDR
 NRC USE ONLY

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- I. LER NUMBER: LER/RO 82-11/01T-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 July 15, 1982, at 0900 hours, the Operations Department performed the monthly Low Pressure Coolant Injection (LPCI) Motor Operated Valve Operability surveillance, QOS 1000-3. During this surveillance, the LPCI Inboard Injection Stop Valve, M0-2-1001-29B, failed to open upon receiving an open signal from the Control Room. Due to the fact the valve could only be opened manually, the LPCI system was declared inoperable. The inboard valve, which is normally closed, was manually opened and the Outboard Injection Stop Valve, M0-2-1001-28B, was closed, thus making the LPCI "B" loop operable. A Work Request was written to investigate the valve failure and perform the necessary repairs. As required by Technical Specification 3.5.A.5, operability surveillances for an inoperable LPCI loop were immediately initiated since these tests were already in progress as part of the routine monthly testing. The valve was returned to service at 1430 hours the same day and normal valve line-up was established.

VI. PROBABLE CONSEQUENCES OF THE OCCURRENCE:

The LPCI mode of the RHR System is used to restore and maintain Reactor water level after a loss-of-coolant accident. It consists of two 100 percent injection loops and uses the RHR pumps to inject water. At the time of the occurrence, monthly surveillance testing was being performed to verify RHR System operability. All RHR and RHR Service Water pumps were operable, as was the Containment Cooling mode of RHR. The "A" loop of LPCI was operable during the occurrence and "B" loop was quickly made operable by manually opening the inboard valve. The outboard valve was capable of automatically opening upon a LPCI initiation signal. The valve was returned to service in a short period of time, so operability testing of Core Spray and the Diesel Generator was not completed, as LPCI was now operable according to the Technical Specifications. Since at least one valve was closed at all times, Primary Containment isolation was not lost during the occurrence. Due to the redundancy of the RHR System and the short duration of the occurrence, the safety implications of this occurrence were minimal.

VII. CAUSE:

The cause of this occurrence is attributed to a detached electrical lead on the torque switch of the motor operator. The M021001-29B is a 16 inch Crane gate valve using a type SMB Limitorque motor operator, catalog number SPL-783-U. The movement of the operator is controlled

VII. CAUSE: (continued)

through a normally closed limit switch and a normally closed torque switch. In this occurrence, however, an electrical lead was not making sufficient contact from the contact terminal of the torque switch. This condition simulates an open torque switch contact such that when the open signal was received, the valve did not open. An inspection of the torque switch was conducted and no apparent reason for the loose connection could be determined. The valve's operability was last demonstrated on June 14, 1982.

VIII. CORRECTIVE ACTION:

The immediate corrective action was to manually open the 1001-29B valve to render the LPCI "B" loop operable. The Electrical Maintenance Department replaced the torque switch, like-for-like, as a preventative maintenance measure. All connections were checked for tightness and the valve was operated three times satisfactorily.