

LICENSEE EVENT REPORT

"Update Report - Previous Report Date 022483".

CONTROL BLOCK: 1

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 1 1 L L S C 1 2 0 0 0 - 0 0 0 0 0 - 0 0 0 3 4 1 0 0 0 4 5
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LICENSEE CODE LICENSE NUMBER LICENSE TYPE JO CAT 58

CONT

0 1 REPORT SOURCE 1 5 0 5 0 0 0 3 7 3 7 0 2 0 2 8 3 2 0 3 0 7 8 3 9
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
DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES 10

0 2 While performing inspections, steam was observed leaking from MSIV 1B21-F028A. Upon
0 3 further investigation, it was determined that two cracks 180° apart existed in weld where
0 4 1MS20AA-2" drain line was attached to valve body. Unit was in startup, heating up at
0 5 approximately 400°F. Leak not of sufficient size to cause VR fan isolations. No increase
0 6 in ventilation stack radiation levels. Unit shutdown commenced. Safe operation of the
0 7 plant was maintained at all times.

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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
SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP. SUBCODE VALVE SUBCODE
C C 11 B 12 C 13 P I P E X X 14 A 15 Z 16
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
LER/RO REPORT NUMBER EVENT YEAR SEQUENTIAL REPORT NO. OCCURRENCE CODE REPORT TYPE REVISION NO.
8 3 0 0 6 0 1 X 1
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
ACTION TAKEN FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED NPD-4 FORM 508 PRIME COMP. SUPPLIER COMPONENT MANUFACTURER
B 18 B 19 A 20 A 21 0 0 8 3 Y 23 N 24 A 25 Z 9 9 9
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

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27

1 0 Analysis determined most likely cause of failure to be improper weld application. No
1 1 procedural non-compliances, however, pre-heat and welding electrode determined less than
1 2 optimum. Weld repaired per W.R. #22245 using station procedures. New weld ground down to
1 3 eliminate notches between passes and magnetic particle tested. Instrumentation installed,
1 4 hydro completed, and common mode failure analyzed.

1 5 FACILITY STATUS % POWER OTHER STATUS 30 METHOD OF DISCOVERY DISCOVERY DESCRIPTION 32
B 28 0 0 0 29 NA C 31 Inspection
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
ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY 35 LOCATION OF RELEASE 36
Z 33 Z 34 NA
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
PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION 39
0 0 0 37 Z 38 NA
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
PERSONNEL INJURIES NUMBER DESCRIPTION 41
0 0 0 40 NA
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
LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION 43
Z 42 NA
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
PUBLICITY ISSUED DESCRIPTION 45
Y 44 Newspaper
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
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NAME OF PREPARER D. Spencer PHONE (815) 357-6761 Ext. 639

- I. LER NUMBER 83-006/01X-1
- II. LASALLE COUNTY STATION: Unit 1
- III. DOCKET NUMBER: 050-373/374
- IV. EVENT DESCRIPTION:

While performing an inspection of the Outboard Main Steam Isolation Valves, maintenance personnel observed steam leakage from MSIV 1B21-F028A. Upon further investigation, it was determined that two cracks, approximately 180° apart existed in the weld material where 1MS20AA-2" drain line was attached to the valve body.

V. PROBABLE CONSEQUENCES OF THE OCCURRENCE:

At the time of this event, the unit was in the Start Up Mode heating up at approximately 400°F. The leak was not of sufficient size to cause any VR fan isolations due to high radiation. In addition, no increase in Ventilation Stack Radiation levels was observed. When it was determined that the leak could not be adequately isolated to permit repair, a unit shutdown was commenced. Therefore, the health and safety of the public was not affected and safe operation of the plant was maintained at all times.

VI. CAUSE:

Analysis by Sargent & Lundy, Systems Materials Analysis Department, Station Nuclear Engineering Department and LSCS revealed the most likely cause of failure to be improper weld application and installation by construction. Although no specific procedural non-compliances were noted, the application of pre-heat treatment, as well as the welding electrode used, were determined less than optimum. Normal vibration was noted as possible in assisting crack propagation.

VII. CORRECTIVE ACTION:

Work request L22245 was initiated to repair the leak. Using station maintenance procedures, the existing weld was ground out and the connection rewelded. The new weld was ground down to eliminate any notches between passes and magnetic particle examined to ensure no existing cracks remained. Instrumentation was installed on the line to verify that no abnormal vibration amplitude or frequencies exist during normal modes of operation. An 1150 pound hydrostatic test was performed to verify the repair was satisfactory. As a long term corrective action, all main steam line drain to MSIV connections were rewelded and an investigation performed to ensure no other similar installations exist.

Prepared by: Dale Spencer