

LICENSEE EVENT REPORT

CONTROL BLOCK:

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CONTROL BLOCK: 1 2 3 4 5 6 ① (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

② ③ ④ ⑤

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

LICENSEE CODE LICENSE NUMBER LICENSE TYPE JO CAT 58

CON'T

REPORT SOURCE 0 1 7 8 L 6 0 5 0 0 0 2 5 4 7 0 4 1 2 8 3 8 0 5 0 3 8 3 9 60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | On April 12, 1983, while performing routine Control Room panel checks, the Station
0 3 | Control Room Engineer observed that the 1A loop Core Spray discharge piping pressure
0 4 | was indicating 105 psig. This pressure was outside of the pressure limit specified
0 5 | in Technical Specification 3.5.G.2. No Control Room alarm was present to indicate
0 6 | the high pressure condition. The "Auto-Blowdown Interlock Core Spray/RHR" alarm
0 7 | was not received in the Control Room. Thus, the Automatic Depressurization System
0 8 | did not receive the blowdown permissive signal from the Core Spray System. All ECCS
0 8 | Systems would have performed as designed; and safe operation of the Reactor was
7 8 9 unaffected.

unaffected

SYSTEM CODE		CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE						COMP SUBCODE	VALVE SUBCODE	
0	9	S	F	A	A	Z	Z	Z	Z	Z	Z	Z
7	8	9	10	11	12	13	14	15	16	17	18	19

LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.	OCCURRENCE CODE	REPORT TYPE	REVISION NO.
17	8	3	019	03	L	0
20	21	22	23	24	25	26

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS	ATTACHMENT SUBMITTED	NPRO-4 FORM SUB.	PRIME COMP SUPPLIER	COMPONENT MANUFACTURER
H	F	Z	Z	0000	Y	N	Z	Z Z Z Z
33	34	35	36	37	40	41	43	44

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 After having operated the 1A Core Spray pump earlier that same day, the Operator

1 1 apparently failed to properly bleed down the Core Spray discharge piping. A con-

1 2 tributing cause was the failure of the high pressure alarm to annunciate due to the

1 3 location of the pressure switch and the piping configuration. The pressure was

1 4 immediately bled down to within acceptable limits. A modification has been

initiated to provide additional high pressure switches and alarms in order to

immediately alert the Operator of a high pressure condition.

FACILITY STATUS		% POWER		OTHER STATUS		METHOD OF DISCOVERY		DISCOVERY DESCRIPTION	
1	5	E	28	0	9	9	29	NA	44
7	8	9	10	11	12	13	14	15	16
ACTIVITY CONTENT		RELEASED OF RELEASE		AMOUNT OF ACTIVITY		LOCATION OF RELEASE			
1	6	Z	33	Z	34	NA	44	45	80
7	8	9	10	11	12	13	14	15	16
PERSONNEL EXPOSURES		NUMBER		TYPE		DESCRIPTION			
1	7	0	0	0	37	Z	38	NA	44
7	8	9	10	11	12	13	14	15	16
PERSONNEL INJURIES		NUMBER		DESCRIPTION					
1	8	0	0	0	40			NA	44
7	8	9	10	11	12	13	14	15	16
LOSS OF OR DAMAGE TO FACILITY		TYPE		DESCRIPTION					
1	9	Z	42			NA	44	45	80
7	8	9	10	11	12	13	14	15	16
PUBLICITY		ISSUED		DESCRIPTION					
2	0	N	44			NA	44	45	80
7	8	9	10	11	12	13	14	15	16

NAME OF PREPARER C Hebel

PHONE 309-654-2241, ext 193

- I. LER NUMBER: 83-19/03L-0
- II. LICENSEE NAME: Commonwealth Edison Company
Quad-Cities Nuclear Power Station
- III. FACILITY NAME: Unit One
- IV. DOCKET NUMBER: 050-254
- V. EVENT DESCRIPTION:

On April 12, 1983, with Unit One operating at full power, the Station Control Room Engineer was performing the routine panel checks during the shift change. He observed the "A" loop Core Spray discharge piping pressure to be 105 psig. This is outside the specified pressure range of greater than 40 psig and less than 90 psig as specified by Technical Specification 3.5.G.2. No alarm was present to indicate the pressure was out of the required range. Actions were immediately initiated to return the discharge header pressure to acceptable limits.

VI. PROBABLE CONSEQUENCES OF THE OCCURRENCE:

The discharge piping pressure of the Core Spray System is required to be less than 90 psig; such that, the Automatic Depressurization System (ADS) will not receive a false signal that a Core Spray pump is operating. Since Core Spray is a low pressure system, pump operation as signaled by the discharge pressure is required for ADS actuation. However, in this instance, ADS did not receive the low pressure pump running permissive signal since the "Auto-Blowdown Interlock Core Spray/RHR" alarm did not annunciate. The pressure switches that provide the Auto-Blowdown Interlock are located upstream of the 1A Core Spray pump discharge stop check valve. As a result, the pressure switch was not subjected to the high pressure condition. Therefore, the engineered safety systems would have operated as designed. At no time did this occurrence affect the safety of the plant, nor the health and safety of the public.

VII. CAUSE:

The "A" Core Spray pump had been operated at 1330 hours earlier the same day. The Operator apparently failed to properly bleed down the "A" Core Spray discharge piping after running the pump. At the completion of a surveillance, the Operator attempts to coordinate pump discharge valve closure and pump shutdown in order to maintain the proper pressure in the discharge piping. In this case, the Operator apparently shutdown the Core Spray pump too late, and the high pressure was contained in the discharge piping.

VIII. CORRECTIVE ACTION:

The immediate corrective action was to bleed the pressure down to less than 90 psig. The preventative action taken was to re-emphasize to the Operator the need to observe that proper pressure is maintained in all ECCS discharge piping.

Modifications M-4-1(2)-83-16 have been initiated to install a high pressure alarm on the Core Spray piping which would warn the Operator that the discharge piping pressure is approaching 90 psig.