LICENSEE EVENT REPORT

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

Line	Field	Value
0 1	LICENSEE CODE (2)	I L L S C 1
	LICENSE NUMBER (3)	0 0 - 0 0 0 0 0 - 0 0
	LICENSE TYPE (4)	4 1 0 0 0
	CAT (5)	1
CON'T 0 1	REPORT SOURCE (6)	L
	DOCKET NUMBER (7)	0 5 0 0 0 3 7 3
	EVENT DATE (8)	1 2 2 4 8 2
	REPORT DATE (9)	0 1 2 0 8 3

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 On December 24, 1982 when cycling containment Vacuum Breaker 1PC001B to verify
0 3 operability in accordance with Tech. Spec. 3/4.6.4.1 the Division 2 position
0 4 indicator would not indicate closed. The vacuum breaker was verified closed and
0 5 redundant indication off of Division 1 indicated closed. The operation of the plant
0 6 was not affected and the health and safety of the public was maintained.

Line 0 9		
SYSTEM CODE (11)	S D	
CAUSE CODE (12)	E	
CAUSE SUBCODE (13)	X	
COMPONENT CODE (14)	X X X X X X	
COMP. SUBCODE (15)	X	
VALVE SUBCODE (16)	Z	

LER/RO REPORT NUMBER (17)	
EVENT YEAR	8 2
SEQUENTIAL REPORT NO.	1 7 5
OCCURRENCE CODE	0 3
REPORT TYPE	L
REVISION NO.	0

ACTION TAKEN (18)	FUTURE ACTION (19)	EFFECT ON PLANT (20)	SHUTDOWN METHOD (21)	HOURS (22)	ATTACHMENT SUBMITTED (23)	NPRD-4 FORM SUB. (24)	PRIME COMP. SUPPLIER (25)	COMPONENT MANUFACTURER (26)
X	Z	Z	Z	0 0 0 0	Y	N	A	V 0 5 2

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of the indicator malfunction (Div. 2) for vacuum breaker 1B001B could not be
1 1 determined. The Division 2 position indicator did indicate closed after several
1 2 cycles. A Work Request (L21274) was written and an inspection was performed. The
1 3 vacuum breaker was cycled repeatedly and functioned properly everytime. No further
1 4 action was required.

Line	Field	Value
1 5	FACILITY STATUS (28)	B
	% POWER (29)	0 4 3
	OTHER STATUS (30)	NA
	METHOD OF DISCOVERY (31)	C
	DISCOVERY DESCRIPTION (32)	SRV TEST
1 6	ACTIVITY RELEASED (33)	Z
	CONTENT OF RELEASE (34)	Z
	AMOUNT OF ACTIVITY (35)	NA
	LOCATION OF RELEASE (36)	NA
1 7	PERSONNEL EXPOSURES NUMBER (37)	0 0 0
	TYPE (38)	0
	DESCRIPTION (39)	NA
1 8	PERSONNEL INJURIES NUMBER (40)	0 0 0
	DESCRIPTION (41)	NA
1 9	LOSS OF OR DAMAGE TO FACILITY TYPE (42)	Z
	DESCRIPTION (43)	NA
2 0	PUBLICITY ISSUED (44)	N
	DESCRIPTION (45)	NA

NRC USE ONLY

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PDR ADOCK 05000373
S PDR

NAME OF PREPARER V. Masterson PHONE: 357-6761

GPO 917-928

I. LER NUMBER: 82-175/03L-0

II. LASALLE COUNTY STATION: Unit 1

III. DOCKET NUMBER: 050-373

IV. EVENT DESCRIPTION:

On December 24, 1982 when cycling primary containment vaccum breaker 1PC001B to verify operability following safety relief valve discharge to the suppression pool in accordance with Technical Specification surveillance 4.6.4.1, one of two separate position indicators for vacuum breaker 1PC001B would not indicate fully closed. The vacuum breaker was cycled several times shortly afterwards with still no improvement.

Upon a later attempt the vacuum breaker indication functioned properly and closed indication was received on both divisions.

V. PROBABLE CONSEQUENCES OF THE OCCURRENCE:

At the time of the occurrence Reactor Power was at 45% with the Reactor Mode Switch in run. Safety relief valve testing had been performed earlier that day and drywell vacuum breaker 1PC001B was being verified operable in accordance with the requirements of technical specification surveillance 4.6.4.1.

Upon cycling of the drywell vacuum breaker dual indication was received on the Division 2 position indicator, the position indicator for Division 1 indicated closed. Both Division 1 and Division 2 position indicators are redundant indicators for increased reliability. During the entire period of the occurrence the position indicator off the Division 1 Bus indicated closed. The vacuum breaker 1PC001B was visually verified to be closed in accordance with the action statement of technical specification 3.6.4. This requires the vacuum breaker to be visually verified closed once every 24 hours. The vacuum breaker 1PC001B was cycled several times with no improvement. Upon a later attempt at cycling the vacuum breaker closed indication was received on both Division 1 and 2 position indicators.

Because of the fact that redundant indication was available and that the vacuum breaker was visually verified to be closed the operation of the plant was not affected. The health and safety of the general public was maintained at all times.

VI. CAUSE:

The Division 1 position indicator for vacuum breaker 1PC001B indicated closed and functioned properly even though the position indicator for division 2 indicated intermediate. The vacuum breaker was cycled several times with no improvement. A later attempt was made to cycle vacuum breaker 1PC001B and this time the Division 2 position indicator functioned properly.

Upon further cycling the problem that had existed earlier could not be duplicated and both Division 1 and Division 2 indicators functioned properly. No apparent cause could be determined as to why the Division 2 indicator had malfunctioned earlier. A possible cause may have been oxidation build-up on the contacts of the limit switch assembly that went away after subsequent cycling. This cannot be determined however due to the fact that the limit switch assemblies themselves are sealed units environment free with maintenance consisting of replacing the entire assembly.

VII. CORRECTIVE ACTION:

Work Request (L21274) was written to inspect the position indicator and adjust if required. At the next outage the inspection of the position indicator was performed. The position indicator was cycled repeatedly. No malfunctioning could be detected and no cause for the earlier occurrence could be determined. The position indicator did not require adjustment and proper operation was verified. The limit switch and vacuum breaker assembly are made by G.P.E. Controls a division of Vapor corporation. No further action was required.

Prepared by: Vincent Masterson