NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO 3150-0104
EXPIRES 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
LaSalle County Station Unit 1	0 5 0 0 0 3 7 3	1 OF 0 4

TITLE (4)
Standby Gas Treatment Door Leakage Event

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
									NA	0 5 0 0 0 3 7 4
1 0	3 0	8 4	8 4	— 0 7 2	— 0 0	1 1	2 9	8 4	NA	0 5 0 0 0

OPERATING MODE (9)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
4	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10)	20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
0 0 0	20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
	20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
	20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
	20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
Charles K. Sprunger, extension 779	AREA CODE 8 1 5 — 3 5 7 - 6 7 6 1

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	
E	B H	F L T	C 7 8 0	N							

SUPPLEMENTAL REPORT EXPECTED (14)

		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

NRC Resident Inspector was touring the Unit 1 Reactor Building on 10/30/84 and noticed air leaking out of the doors on the Unit 1 Standby Gas Treatment Train (SBGT). The outlet airflow from the train was found to be 3350 SCFM instead of 4000 SCFM ±10%. An investigation into the problem revealed that three of the seven doors to the SBGT train were improperly closed. The doors were properly closed and the required outlet airflow of 4000 SCFM was obtained.

IE22
1/1

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
LaSalle County Station Unit 1	0 5 0 0 0 3 7 3	8 4	— 0 1 7 2	— 0 0	0 2 OF 0 4

TEXT (If more space is required, use additional NRC Form 366A's) (17)

I. EVENT DESCRIPTION

On 10/30/84 a NRC Resident Inspector was touring the Unit 1 Reactor Building (NG) during the performance of LES-PC-02, LaSalle Electrical Surveillance Group 2 and 4 Isolation Actuation Logic System (JM) Functional Test, and noticed air leaking out of the doors on the Unit 1 Standby Gas Treatment Train (BH, SBGT) which was operating per this surveillance. He then entered the Control Room and observed Unit 1 SBGT flow to be indicating 3350 SCFM instead of 4000 ±10% SCFM required by Technical Specification 3.6.5.3. At approximately 1430 hours he informed the off-going Shift Control Room Engineer (SCRE) of the low flow condition. The off-going SCRE then informed the on-coming afternoon SCRE that the Resident Inspector had questioned why the flow was not in the greenband on the recorder. He also informed the afternoon Shift Center Desk Operator (NSO), of the same.

After consulting LOS-VG-M1 which reflects the normal train line up, the Center Desk NSO closed dampers 1VQ041 and 2VQ041 (SBGT system's tie into the Reactor Building Ventilation System, VA, return air riser) and rechecked the system flow. Since this did not correct the low flow condition he requested the Unit 2 Shift Foreman to adjust the flow contoller.

At 1503 hours the Unit 2 Shift Foreman and two Equipment Attendants adjusted the Unit 1 SBGT flow controller to 3950 SCFM outlet flow.

After further discussions the SCRE and the NSO concluded the low airflow problem to be the result of a malfunctioning flow controller and a work request was written to have it repaired.

At approximately 1505 hours the Shift Engineer and the NRC Resident Inspector returned to the Control Room following a discussion in the Shift Engineer's Office. The SBGT system outlet flow was observed to be normal. Following some discussion as to the corrective action the Shift Engineer continued his Control Room review.

The NRC Inspector then informed the Operating Assistant Superintendent who requested Unit 1 Operating Engineer to look into the problems with Unit 1 SBGT system. The Unit 1 Operating Engineer and a cognizant SBGT system Technical Staff Engineer proceeded to the Control Room for a brief inspection of the system airflow. The Technical Staff Engineer then left the Control Room and went to inspect the train located in the Reactor Building.

At approximately 1645 hours the Technical Staff Engineer discovered three of the seven doors on the train were improperly closed (latches dogged incorrectly). These doors were then properly closed and the Unit 1 SBGT outlet flow readjusted to 4000 SCFM. Then the Technical Staff Engineer called the Center Desk NSO and was informed the inlet flow indicator and outlet flow recorder for the system were both reading approximately 4000 SCFM. A review of the previous SBGTs monthly surveillance was made to determine if the SBGT system had been worked on or if the low flow condition existed prior to 10/30/84. All of the surveillances reviewed indicated that the SBGTs was always operable.

II. CAUSE

At the time of the occurrence, when the NRC Resident Inspector found low outlet flow from Unit 1 SBGT, Unit 1 was at 0% power in cold shutdown and Unit 2 was at approximately 79% power in Mode 1. Both SBGT trains are common to both Unit 1 and Unit 2 neither was being used to maintain Reactor Building differential pressure at the time.

The cause of the low outlet flow from the Unit 1 SBGT system was the result of three of the seven doors on the train being improperly closed. This allowed air to escape past the seal area of the doors. The airflow through the system is controlled by a flow sensing element and a control damper located at the inlet to the SBGT train. The control damper is designed to regulate the airflow into the train at 4000 SCFM. With air leaking by three of the seven doors all located downstream of the sensing element, the control damper allowed 4000 SCFM to enter the train but only 3350 SCFM to exit the train.

The failure to recognize the low flow condition occurred because the Unit 1 SBGT train was operating in an abnormal line up. Dampers 1VQ041 and 2VQ041 were open and the Center Desk NSO, while taking routine data at approximately 1345 hours, determined this to be the reason for the low outlet flow. He also knew the monthly SBGT operability surveillance LOS-VG-M1 was to be performed when LES-PC-02 was complete and if there was a problem it would be verified then. Also when LES-PC-02 auto-started Unit 1 SBGT system at approximately 1050 hours it was not required by the surveillance to verify proper outlet flow from the train. This surveillance verifies auto-start logic and not SBGT system performance which is verified by other procedures.

III. PROBABLE CONSEQUENCES OF THE OCCURRENCE

The time at which the doors to the Unit 1 SBGT train were improperly closed is not known. The subsequent investigation held by the station indicated the last known date of the doors being opened was 10/16/84, to install seven non-safety related Static Pressure Probes per Work Request L39971. The probes were added to increase the accuracy of differential pressures measured by several non-safety related pressure switches and indicators (1PDI-VG021, 1PDS-VG021, 1PDI-VG022, 1PDS-VG022, 1PDI-VG016, 1PDS-VG016, 1PDI-VG025, and 1PDS-VG025) across the various filters in the train. The doors were closed by the individuals performing the work upon completion of a Q.C. inspection. The Q.C. inspector confirmed the train doors were properly secured. However Unit 1 SBGT system integerity could not be verified after 10/17/84 and Limiting Condition for Operation 3.6.5.3 of the Technical Specifications may have been violated.

The surveillance LES-PC-02 initially auto-started both SBGT trains at 1050 hours. Between 1053 hours and 1400 hours Unit 2 SBGT Control Switch was taken to Pull-to-Lock (PTL) and returned to normal three times. Each time it was taken to PTL after auto-initiation per the Logic Surveillance to prevent both SBGT trains from running per Operating Procedures. This is to allow isokinetic flow to be maintained for the low range of the SBGT Wide Range Monitor (IL), and will ensure that one train remains operable.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
LaSalle County Station Unit 1	0 5 0 0 0 3 7 3	8 4	— 0 7 2	— 0 0	0 4 OF 0 4

TEXT (If more space is required, use additional NRC Form 366A's) (17)

III. PROBABLE CONSEQUENCES OF THE OCCURRENCE (continued from Page 3)

Following investigation it was determined the low flow condition on Unit 1 SBGT and the PTL condition on Unit 2 rendered both trains technically inoperable. Technical Specification 3.03 was entered and NRC notification was made on 11/2/84. Both SBGT trains were not inoperable for more than six hours.

IV. CORRECTIVE ACTIONS

After the doors to the Unit 1 SBGT system were properly closed and the flow controller readjusted to 4000 SCFM the Technical Staff Engineer inspected the Unit 2 SBGT system. All the doors were found to be correctly latched.

Subsequent to the event operability of both SBGT systems was demonstrated by performing LaSalle Operating Surveillance LOS-VG-M1. Unit 1 was completed on 10/31/84 and Unit 2 on 11/1/84.

Various groups at the station were informed of the specifics of the event in an effort to eliminate any other occurrences. Interviews with a large percentage of Station employees in all departments was conducted to determine when the Unit 1 SBGT system doors may have been opened.

The doors to both SBGT systems have been lock wired to prevent unauthorized entry. Arrows have been painted to indicate the proper position of each dog. Signs have been posted on the doors indicating Shift Engineer's permission is required before opening.

V. PREVIOUS EVENTS

None.

VI. NAME AND TELEPHONE NUMBER OF PREPARER

Charles K. Sprunger, 815/357-6761, extension 779.

Commonwealth Edison
LaSalle County Nuclear Station
Rural Route #1, Box 220
Marseilles, Illinois 61341
Telephone 815/357-6761

November 26, 1984

U.S. Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

Dear Sir:

Reportable Occurrence Report #84-072-00, Docket #050-373 is being submitted to your office in accordance with 10 CFR 50.73.

G. J. Diederich
Superintendent
LaSalle County Station

GJD/MLD/lrw

Enclosure

xc: NRC, Regional Director
INPO-Records Center
File/NRC

IE22
1/1