

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)

LaSalle County Station Unit 2

DOCKET NUMBER (2)

0 5 0 0 0 3 7 4

PAGE IS

1 OF 03

TITLE (4)

Inadvertant RHR Shutdown Cooling Isolation

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 (5)		
03	31	85	85	012	00	04	18	85		0 5 0 0 0		
OPERATING MODE (9)			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5. (Check one or more of the following) (11)									
4												
POWER LEVEL (10)			0 0 0									
			20.402(a) 20.406(e) X 80.73(a)(2)(iv) 73.71(b)									
			20.406(a)(1)(i) 80.38(a)(1) 80.73(a)(2)(v) 73.71(c)									
			20.406(a)(1)(ii) 80.38(a)(2) 80.73(a)(2)(vi) OTHER (Specify in Abstract below and in Text, NRC Form 366A)									
			20.406(a)(1)(iii) 80.73(a)(2)(i) 80.73(a)(2)(vii)(A)									
			20.406(a)(1)(iv) 80.73(a)(2)(ii) 80.73(a)(2)(vii)(B)									
			20.406(a)(1)(v) 80.73(a)(2)(iii) 80.73(a)(2)(x)									

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
Kenneth J. Kalmon, extension 325	AREA CODE 815 357-6761

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC
A	JM	PD	IS	I204	N				

SUPPLEMENTAL REPORT EXPECTED (14)

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

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

At 1103 hours on March 31, 1985, with LaSalle Unit 2 in Cold Shutdown, a Residual Heat Removal (RHR, BO) Shutdown Cooling isolation occurred during the performance of LIS-RH-10, "LPCS/RHR Injection Line Integrity Monitor Calibration and Functional Test".

An Instrument Maintenance Technician intending to isolate instrument 2E12-N029B per LIS-RH-10 incorrectly traced the instrument piping and isolated a supply line to instrument 2E31-N012B. 2E31-N012B senses differential pressure (DP) caused by flow through the RHR Shutdown Cooling suction piping. It is designed to actuate on high flow (high DP). When the supply line to 2E31-N012B was isolated it saw a high DP and actuated. A Primary Containment Isolation System Group 6, Division 2, isolation occurred resulting in the loss of RHR Shutdown Cooling.

The Instrument Maintenance Technician promptly notified the Unit Operator of the valving error and as a result RHR Shutdown Cooling was returned to operation in approximately four minutes.

The Instrument Maintenance Department will be trained on this occurrence. The need to eliminate personnel error and attention to detail will be stressed.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO 3150-0104
EXPIRES 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
LaSalle County Station Unit 2	05000374	85	012	00	02	OF	03

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

I. EVENT DESCRIPTION

At 1103 hours on March 31, 1985, with LaSalle Unit 2 in Cold Shutdown, a Residual Heat Removal (RHR, BO) Shutdown Cooling isolation occurred during the performance of surveillance procedure, LIS-RH-10, "LPCS/RHR Injection Line Integrity Monitor Calibration and Functional Test".

A Group 6, Division 2, Primary Containment Isolation (PCIS, JM) occurred on an apparent RHR suction high flow signal. The RHR Suction Inboard Isolation Valve, 2E12-F009, automatically closed. All other Group 6, Division 2, isolation valves had been previously closed. The operating RHR pump, 2E12-C002A, tripped as required on the closure of valve 2E12-F009.

The Instrument Maintenance Technician performing surveillance LIS-RH-10 promptly notified the Unit Nuclear Station Operator (NSO) of an instrument valving error. This was identified as the cause of the isolation; RHR Shutdown Cooling piping integrity was verified, and the RHR loop was returned to operation at 1107 hours on March 31, 1985.

II. CAUSE

The 2E12-F009 isolation occurred due to the valving out of instrument 2E31-N012B. Under LIS-RH-10 instrument 2E12-N029B was to be valved out but the Instrument Maintenance Technician performing the surveillance incorrectly traced the piping from instrument 2E12-N029B and without looking at the tag on the instrument isolation valve, mistakenly isolated a line to instrument 2E31-N012B.

2E31-N012B is a Barton 288A Differential Pressure Indicating Switch (DPIS) and is physically located next to 2E12-N029B, another Barton 288A DPIS. 2E31-N012B senses differential pressure caused by flow through the RHR Shutdown Cooling suction piping. When the low pressure sensing line to 2E31-N012B was mistakenly isolated, a lower than actual pressure was sensed at the low side of 2E31-N012B. With the high pressure side unchanged, a high differential pressure (high flow) condition was simulated and 2E31-N012B actuated.

The Instrument Maintenance Technician's incorrect tracing of the piping from instrument 2E12-N029B and failure to read the valve tag before moving the valve caused the March 31, 1985 occurrence.

III. PROBABLE CONSEQUENCES OF THE OCCURRENCE

The probable consequences of this occurrence were minimal because the Instrument Maintenance Technician acted promptly and notified the Unit NSO immediately after recognizing the valving error. As a result, the RHR Shutdown Cooling loop was returned to service within four minutes of the isolation of valve 2E12-F009. Review of RHR heat exchanger inlet temperatures before and after the isolation indicate no significant change in reactor coolant temperature.

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

TEXT (If more space is required, use additional NRC Form 365A's) (17)

IV. CORRECTIVE ACTION

The isolation on valve 2E12-F009 was reset and the RHR Shutdown Cooling loop was returned to operation at 1107 hours on March 31, 1985.

An investigation followed this occurrence and a meeting was set up between the Instrument Maintenance Technician involved, the Foreman in charge of the work, and the Assistant Superintendent of Maintenance. The events of this occurrence were discussed and the need for attention to detail was stressed.

The Instrument Maintenance Department will be trained on this occurrence with a focus on positive identification of instruments to be valved out. The completion of this training is being tracked by AIR 01-85-67055.

V. PREVIOUS OCCURRENCES

No similar occurrences of valving out the wrong instruments have been recorded in the past three years. On April 9, 1983, a HPCS injection and reactor scram resulted while a reactor vessel level instrument was being valved into service. LER's 374/84-25 and 373/85-29 documented scrams due to improper instrument valving.

VI. NAME AND PHONE NUMBER OF PREPARER

Kenneth J. Kalmon, 815/357-6761, extension 325.



Commonwealth Edison
LaSalle County Nuclear Station
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Telephone 815/357-6761

April 18, 1985

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

Dear Sir:

Reportable Occurrence Report #85-012-00, Docket #050-374 is being submitted to your office in accordance with 10CFR 50.73.

for *R.D. Bishop*
G. J. Diederich
Superintendent
LaSalle County Station

GJD/MLD/kg

Enclosure

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

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11