NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

Line	Field	Value
01	Licensee Code (2)	I L Q A D 1
01	License Number (3)	0 0 0 - 0 0 0 - 0 0 0
01	License Type (4)	4 1 1 1 1
01	CAT (5)	
01 CON'T	Report Source (6)	L
01	Docket Number (7)	0 5 0 0 0 2 5 4
01	Event Date (8)	0 2 0 6 8 0
01	Report Date (9)	0 3 0 6 8 0

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 While performing the LPCI Motor Operated Valve Operability Test, procedure QOS 1000-3,
03 the RHR to suppression chamber dump valve, MO 1-1001-36A, circuit breaker tripped
04 out. The test was performed to comply with Technical Specification 4.5.A.1.d. The
05 valve failed in the closed position, which is the normal operating position. The
06 upstream isolation valve, MO-1-1001-34A, was fully operable to provide isolation of the
07 primary containment had it been necessary.
08

09	System Code (11)	Cause Code (12)	Cause Subcode (13)	Component Code (14)	Comp. Subcode (15)	Valve Subcode (16)
	S F	E	A	T R A N S F	Z	Z

(17) LER/RO Report Number	Event Year		Sequential Report No.		Occurrence Code	Report Type		Revision No.
	8 0	—	0 0 3	/	0 3	L	—	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)
A	Z	Z	Z	0 0 0 0	Y	Y	A	G 0 8 0

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The 480/120 V control power transformer in the valve circuit breaker cabinet was
11 found burned out. No apparent cause for the failed transformer could be found. The
12 transformer was replaced and the valve was operated three times satisfactorily.
13
14

Line	Facility Status (28)	% Power (29)	Other Status (30)	Method of Discovery (31)	Discovery Description (32)
15	E	0 9 8	NA	B	Routine Test

Line	Activity Released (33)	Content of Release (34)	Amount of Activity (35)	Location of Release (36)
16	Z	Z	NA	NA

PERSONNEL EXPOSURES

Line	Number (37)	Type (38)	Description (39)
17	0 0 0	Z	NA

PERSONNEL INJURIES

Line	Number (40)	Description (41)
18	0 0 0	NA

LOSS OF OR DAMAGE TO FACILITY (43)

Line	Type (42)	Description
19	Z	NA

PUBLICITY

Line	Issued (44)	Description (45)	NRC Use Only
20	N	NA	

NAME OF PREPARER D. Clark 8003200410 PHONE: 309-654-2241 ext. 170

GPO 917-224

I. LER NUMBER: LER/RO 80-03/03L-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 February 6, 1980, while performing the LPCI Motor Operated Valve Operability Test, procedure QOS 1000-3, the RHR to suppression chamber dump valve, MO-1-1001-36A, circuit breaker tripped out. The test was performed to comply with the surveillance requirements spceified in Technical Specification 4.5.A.1.d. The valve was in the normally closed position, and would have been used only for testing the RHR loop and for containment cooling. A work request was written to inspect the valve operator and circuit breaker.

There have been no previous occurrences with problems similar to this failure.

VI. PROBABLE CONSEQUENCES OF THE OCCURRENCE:

The probable consequences of this occurrence were minimal. The valve failed in the closed position, which is the normal operating position. The valve is used for testing the "A" RHR loop and for suppression chamber cooling. The valve could have been manually operated if the valve was needed. The upstream isolation valve, MO 1-1001-34A, was fully operable to provide isolation of the primary containment had it been necessary. The "B" Containment Cooling loop was also available for use, if needed. Safe operation of the reactor was not affected as a result of this occurrence.

VII. CAUSE:

The cause of this occurrence is attributed to equipment failure. The 480/120 V control power transformer in the valve circuit breaker cabinet was found burned out. The control power transformer is fed from the incoming 480 volt line, and supplies 120 volt power through the control switches to operate the motor contactors. No apparent cause for the failed transformer could be found.

The transformer was a General Electric 480/120 volt dry-type transformer, type #9T56Y1805, KVA-.150.

VIII. CORRECTIVE ACTION:

The immediate corrective action was to verify that the valve was in the closed position. The electrical maintenance department replaced the transformer and the valve was operated three times satisfactorily. Since this is the first time the control power transformer has failed, no further corrective action was deemed necessary.