NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

8005130634

S

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 4 1 0 8 0
01	Report Date (9)	0 4 3 0 8 0

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 While performing the LPCI Motor Operated Valve Operability Test, procedure QOS 1000-3,
03 the thermal overload relay for the B-loop suppression chamber cooling valve, MO-1-
04 1001-36B, tripped while attempting to open the valve. The test was performed to
05 comply with Technical Specification 4.5.A.1.d. The valve failed in the closed
06 position, which is the normal operating position. The A suppression chamber cooling
07 valve MO-1-1001-36A was available.
08

Line	Field	Value
09	System Code (11)	S F
09	Cause Code (12)	E
09	Cause Subcode (13)	A
09	Component Code (14)	V A L V O P
09	Comp. Subcode (15)	A
09	Valve Subcode (16)	Z
(17) LER/RO Report Number	Event Year	8 0
	Sequential Report No.	0 0 9
	Occurrence Code	0 3
	Report Type	L
	Revision No.	0
	Action Taken (18)	E
	Future Action (19)	Z
	Effect on Plant (20)	Z
	Shutdown Method (21)	Z
	Hours (22)	0 0 0 0
	Attachment Submitted (23)	Y
	NPRD-4 Form Sub. (24)	N
	Prime Comp. Supplier (25)	N
	Component Manufacturer (26)	L 2 0 0

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The probable cause of the thermal relay trip is attributed to high motor starting
11 currents caused by a torque switch setting which was too high. The torque switch
12 was adjusted and the valve was successfully operated three times.
13
14

Line	Field	Value
15	Facility Status (28)	E
15	% Power (29)	0 9 4
15	Other Status (30)	NA
15	Method of Discovery (31)	B
15	Discovery Description (32)	Routine Test
16	Activity Released (33)	Z
16	Content of Release (34)	Z
16	Amount of Activity (35)	NA
16	Location of Release (36)	NA
17	Personnel Exposures Number (37)	0 0 0
17	Type (38)	Z
17	Description (39)	NA
18	Personnel Injuries Number (40)	0 0 0
18	Description (41)	NA
19	Loss of or Damage to Facility Type (42)	Z
19	Description (43)	NA
20	Publicity Issued (44)	N
20	Description (45)	NA

MAY 5 - 1980

NRC USE ONLY

NAME OF PREPARER J. Eagle PHONE: 309-654-2241, ext. 182

I. LER NUMBER: LER/RO 80-09/03L-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 10, 1980, while performing the LPCI Motor Operated Valve Operability Test, procedure QOS 1000-3, the thermal overload relay for the B-loop suppression chamber cooling valve (MO-1-1001-36B) tripped while attempting to open the valve. The relay was reset and upon actuation, the thermal overload relay tripped again. The relay was reset a second time, and when attempting to open the valve the third time, the valve functioned properly. On the same day, while performing the RHRS Pump Operability Test, procedure QOS 1000-2, the thermal overload relay tripped when attempting to open the same valve. The relay was reset and the valve functioned properly. Work Request QO-4581 was written to investigate and repair the problem.

Unit One was in the RUN mode at 787 MWe and 2355 MWt

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 "B" RHR loop and for suppression chamber cooling. The valve could have been manually operated if needed. The "A" 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 probable cause of the thermal overload relay trip is attributed to high motor starting currents caused by a torque switch setting which was too high.

The valve is a 14 inch globe valve manufactured by Crane Company. The motor operator is a SMB-3 type operator made by Limitorque.

VIII. CORRECTIVE ACTION

The immediate corrective action was to reset the thermal overload relay and continue attempting to operate the valve from the control room. Later, the torque switch was adjusted down from a setting of 2-1/4 to 2. The valve was then successfully stroked three times and declared operable.

MAY 5 - 1980