NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

0 1	LICENSEE CODE: I L Q A D 1 (2) · LICENSE NUMBER: 0 0 0 - 0 0 0 - 0 0 0 (3) · LICENSE TYPE: 4 1 1 1 1 (4) · CAT (5)
CON'T 0 1	REPORT SOURCE: L (6) · DOCKET NUMBER: 0 5 0 0 0 2 5 4 (7) · EVENT DATE: 0 6 2 1 8 0 (8) · REPORT DATE: 0 7 2 1 8 0 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 On June 21, 1980, with Unit 1 in startup and on July 3, 1980, with Unit 1 in shut-
0 3 down, valve 1-203-2C failed to close while testing. Consequences were minimal
0 4 because valve 1-203-1C would have supplied the required isolation had the need
0 5 risen.
0 6
0 7
0 8

SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
C D (11)	A (12)	C (13)	V A L V 0 P (14)	D (15)	Z (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 0	—	0 1 6	/	0 3	L	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
E (18)	G (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	N (25)	A 6 1 3 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of both occurrences was an improper adjustment of the exhaust restrictor
1 1 on the pilot valve resulting in a pneumatic lock which prevented the main valve
1 2 from closing. The pilot valve was dismantled and properly adjusted. Procedures
1 3 are being revised to detect this type of failure.
1 4

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1 5	F (28)	0 0 0 (29)	NA	A (31)	Shutdown to Hot Standby

	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
1 6	Z (33)	Z (34)	NA	NA

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION (39)
1 7	0 0 0 (37)	Z (38)	NA

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
1 8	0 0 0 (40)	NA

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
1 9	Z (42)	NA

PUBLICITY

	ISSUED	DESCRIPTION (45)
2 0	N (44)	NA

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NRC USE ONLY

K. Kopacz 309-654-2241, ext. 178

I. LER NUMBER: 80-16/03L

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 June 21, 1980, Unit One was in startup and in the process of maintaining a hot standby condition. While attempting to close valve 1-203-2C the valve gave a dual indication. Upon further investigation it was found that the valve had not closed Work Request Q06091 was written to correct the problem.

On July 3, 1980, Unit One was shutdown for a minor maintenance outage. While attempting to close the outboard main steam isolation valves as part of a Out-Of-Service procedure it was found valve 1-203-2C did not close. Work Request Q06354 was written to correct the problem. In both cases, the valve closed when the air supply to the valve was shut.

VI. PROBABLE CONSEQUENCES OF THE OCCURRENCE:

The consequences of this occurrence are minimal because valve 1-203-1C which is an in-line isolation valve, would have supplied the required isolation had the need risen.

VII. CAUSE:

The cause of both occurrences was an improper adjustment of the exhaust restrictor on the pilot valve. This blocked the exhaust flow resulting in a pneumatic lock on the pilot valve which prevented the main valve from closing. The valves have closing time requirement of three to five seconds and are adjusted externally to meet this requirement. It seems an operator closed down on this exhaust restrictor when he was sent to reset the valve closure timing. The valve would work as required until it was exercised using the test switch. This locked up the operator pilot and prevented closure. After the June 21 incident maintenance was done replacing the 4-way control valve. The valve was then tested and proven operable. Later after using the test switch the second occurrence of July 3 took place.

VIII. CORRECTIVE ACTION:

Following the July 3 incident the proper maintenance was performed. The pilot valve was dismantled from the valve and the exhaust restrictor was adjusted to the proper setting. A similar incident of the type occurred February 24, 1980, on valve 1-203-1B. Procedures are being revised to detect this type of failure. The valve will be operated using the control switch following operation by the test switch.