

LICENSEE EVENT REPORT

Rev 2

Date March 12, 1983

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CONTROL BLOCK: | | | | | 1

L I L S I C | | 2 | 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | - | 0 | 0 | 3 | 4 | 1 | 0 | 0 | 0 | 4 | | 5

REPORT SOURCE | L | 6 | 0 | 5 | 10 | 0 | 0 | 13 | 7 | 13 | 7 | 0 | 16 | 12 | 1 | 18 | 2 | 2 | | | | | | | | 9

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES 10
During an audit of instrument stop valve positions the stop valves for Main Steam Line A High Flow instrument were found to be in the lockwired closed position. Three redundant instruments were available to provide the necessary trip function. At the time of the event no nuclear steam was being produced and the Main Steam Isolation Valves were closed. Under these circumstances this event had no impact on the safe operation of the plant.

SYSTEM CODE | C | D | 11
CAUSE CODE | A | 12
CAUSE SUBCODE | C | 13
COMP. SUBCODE | Z | 15
VALVE SUBCODE | Z | 16
EVENT YEAR | 8 | 2 | 21
SEQUENTIAL REPORT NO. | 0 | 4 | 9 | 24
OCCURRENCE CODE | 0 | 3 | 28
REPORT TYPE | L | 31
REVISION NO. | 0 | 33
ACTION TAKEN | X | 18
FUTURE ACTION | H | 19
EFFECT ON PLANT | Z | 20
SHUTDOWN METHOD | Z | 21
HOURS | 0 | 0 | 0 | 0 | 22
ATTACHMENT SUBMITTED | Y | 23
NPRD-FORM SUBM. | N | 24
PRIME COMP. SUPPLIER | Z | 25
COMPONENT MANUFACTURER | Z | 9 | 9 | 9 | 26

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27
This event was caused by the improper return to service of the instrument upon completion of the last routine surveillance performed for this instrument. The instrument was immediately returned to service and the Master Instrument Mechanic conducted a discussion with all instrument shop personnel to reemphasize the importance of attentiveness during surveillances that require valve operations.

FACILITY STATUS | B | 28
% POWER | 0 | 0 | 0 | 29
OTHER STATUS | NA | 30
METHOD OF DISCOVERY | A | 31
DISCOVERY DESCRIPTION | AUDIT | 32
ACTIVITY RELEASED | Z | 33
CONTENT OF RELEASE | Z | 34
AMOUNT OF ACTIVITY | NA | 35
LOCATION OF RELEASE | NA | 36
PERSONNEL EXPOSURES NUMBER | 0 | 10 | 10 | 37
TYPE | Z | 38
DESCRIPTION | NA | 39
PERSONNEL INJURIES NUMBER | 0 | 10 | 10 | 40
DESCRIPTION | NA | 41
LOSS OF OR DAMAGE TO FACILITY TYPE | Z | 42
DESCRIPTION | NA | 43

PUBLICITY ISSUED | N | 44
DESCRIPTION | NA | 45
NRC USE ONLY
258

B207300341 B20720
PDR ADOCK 05000373 PDR

M. Schaible

- I. LER NUMBER: 82-049/03L-0
- II. LASALLE COUNTY STATION: Unit 1
- III. DOCKET NUMBER: 050-373/374
- IV. EVENT DESCRIPTION:

During an audit of instrument stop valve positions conducted on 6/21/82 the high and low side stop valves of Main Steam Line A High Flow Instrument 1E31-N008C were in the lockwired closed position. Upon further examination it was found that the high and low side vent valves were in the lockwired open position, this condition made the instrument inoperable.

V. PROBABLE CONSEQUENCES:

Three redundant instruments were available to provide the necessary trip function. At the time of the event the reactor was being operated for low power physics testing, no nuclear steam was being produced and the Main Steam Isolation Valves were closed. This event had no impact on the safe operation of the plant.

VI. CAUSE:

The cause of this event was improper return to service of instrument 1E31-N008C upon completion of LIS-MS-02 and failure to properly implement the second verification system to detect the improper valve positions.

VII. CORRECTIVE ACTION:

- A. Immediate: The instrument was placed in normal operation and lockwires were installed accordingly.
- B. Long term: The Master Instrument Mechanic has conducted a discussion with all shop personnel to reemphasize the importance of attentiveness during surveillances that require this type of valve operation. Also the second verification system will be reviewed to insure these checks are made independently and that not only the presence of a lockwire be verified but also the actual physical position of the valve be verified.

The valving error in this LER and LER's 82-052/03L-0 and 82-053/03L-0 were reviewed by an On Site Review Committee. The findings of that review were satisfactory and were reported to the Station Superintendent in LaSalle On Site Review Number 82-20.

PREPARED BY: M. Schiable