

# LICENSEE EVENT REPORT

CONTROL BLOCK: \_\_\_\_\_ ①

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 | 1 | L | Q | A | D | 2 | 2 | 0 | 0 | 0 | - | 0 | 0 | 0 | - | 0 | 0 | 0 | 3 | 4 | 1 | 1 | 1 | 1 | 4 | \_\_\_\_\_ | 5  
 7 8 | 9 | 14 | 15 | 25 | 26 | 30 | 57 CAT 58

CON'T  
 0 1 | REPORT SOURCE | L | 6 | 0 | 5 | 0 | 0 | 0 | 2 | 6 | 5 | 7 | 0 | 6 | 3 | 0 | 8 | 3 | 8 | 0 | 7 | 1 | 2 | 8 | 3 | 9  
 7 8 | 60 | 61 | DOCKET NUMBER | 68 | 69 | EVENT DATE | 74 | 75 | REPORT DATE | 80

### EVENT DESCRIPTION AND PROBABLE CONSEQUENCES ⑩

0 2 | On June 30, 1983, while performing the monthly instrument isolation valve audit,  
 0 3 | the isolation valves to the Core Spray discharge pressure switches, PS-2-1462C and  
 0 4 | PS-2-1462D, for the Automatic Depressurization System (ADS) low pressure pump  
 0 5 | running permissive were found isolated and sealed. This is contrary to the require-  
 0 6 | ments specified in Technical Specification 3.2.B, Table 3.2-2. The RHR pump  
 0 7 | pressure switches were all operable and would have sent the pump running permissive  
 0 8 | signal to the ADS logic circuit; therefore, the safety consequences of this  
 0 8 | occurrence were minimal.

0 9 | SYSTEM CODE | S | F | 11 | CAUSE CODE | A | 12 | CAUSE SUBCODE | C | 13 | COMPONENT CODE | I | N | S | T | R | U | 14 | COMP SUBCODE | S | 15 | VALVE SUBCODE | Z | 16  
 7 8 | 9 | 10 | 11 | 12 | 13 | 18 | 19 | 20  
 17 | LER/RO REPORT NUMBER | 8 | 3 | 21 | 22 | SEQUENTIAL REPORT NO. | 0 | 0 | 9 | 24 | 26 | OCCURRENCE CODE | / | 0 | 1 | 28 | 29 | REPORT TYPE | T | 30 | REVISION NO. | 0 | 32  
 ACTION TAKEN | X | 18 | FUTURE ACTION | G | 19 | EFFECT ON PLANT | Z | 20 | SHUTDOWN METHOD | Z | 21 | HOURS | 0 | 0 | 0 | 0 | 37 | 40 | ATTACHMENT SUBMITTED | Y | 23 | 41 | NRPD-4 FORM SUB. | N | 24 | 42 | PRIME COMP. SUPPLIER | Z | 25 | 43 | COMPONENT MANUFACTURER | Z | Z | Z | Z | 26 | 44 | 47

### CAUSE DESCRIPTION AND CORRECTIVE ACTIONS ⑳

1 0 | On June 23, 1983, while performing the calibration and functional test on these  
 1 1 | pressure switches, the Instrument Mechanic inadvertently left the isolation valves  
 1 2 | closed and sealed them. The valves were opened immediately upon discovery. A  
 1 3 | memorandum was issued requiring immediate verification of valve positions following a  
 1 4 | surveillance test. The Technician was disciplined for failure to adhere to Station  
 1 4 | procedures. Discussions were held with the remaining mechanics as to the seriousness  
 1 4 | of such errors. An investigation is being performed as to the feasibility of using  
 1 4 | valves with immediate visual position indication.

1 5 | FACILITY STATUS | E | 28 | 8 | 9 | % POWER | 0 | 6 | 9 | 29 | 10 | 12 | 13 | OTHER STATUS | NA | 30 | 44 | METHOD OF DISCOVERY | B | 31 | 45 | 46 | DISCOVERY DESCRIPTION | Instrument Valve Audit | 32 | 80

1 6 | ACTIVITY CONTENT | Z | 33 | 8 | 9 | RELEASED OF RELEASE | Z | 34 | 10 | 11 | AMOUNT OF ACTIVITY | NA | 35 | 44 | LOCATION OF RELEASE | NA | 36 | 45 | 80

1 7 | PERSONNEL EXPOSURES | 0 | 0 | 0 | 37 | 8 | 9 | TYPE | Z | 38 | 10 | 11 | DESCRIPTION | NA | 39 | 12 | 13 | 80

1 8 | PERSONNEL INJURIES | 0 | 0 | 0 | 40 | 8 | 9 | DESCRIPTION | NA | 41 | 10 | 11 | 12 | 80

1 9 | LOSS OF OR DAMAGE TO FACILITY | Z | 42 | 8 | 9 | TYPE | NA | 43 | 10 | 11 | DESCRIPTION | NA | 44 | 12 | 13 | 80

2 0 | PUBLICITY | N | 44 | 8 | 9 | DESCRIPTION | \_\_\_\_\_ | 45 | 10 | 11 | 12 | 13 | ISSUED | S | 46 | 14 | 15 | 16 | 17 | 18 | 19 | NRC USE ONLY | \_\_\_\_\_ | 68 | 69 | 80

NAME OF PREPARER H Lihou PHONE 309-654-2241, ext 170

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 PDR ADOCK 05000265  
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- I. LER NUMBER: LER/RO 83-9/01T-0
- II. LICENSEE NAME: Commonwealth Edison Company  
Quad-Cities Nuclear Power Station
- III. FACILITY NAME: Unit Two
- IV. DOCKET NUMBER: 050-265
- V. EVENT DESCRIPTION:

On June 30, 1983, an Instrument Maintenance Department Foreman was performing the monthly audit of isolation valve positions for all instruments which are required to have the isolation valves closed in order to perform scheduled calibration. This audit is performed on a routine basis, following completion of all the monthly instrument surveillances, and verifies that these valves are left wire sealed in the appropriate position. At approximately 0800 hours, while checking the Core Spray Pump discharge pressure switches for the Automatic Depressurization System (ADS) low pressure pump running permissive, the Foreman found two pressure switches, PS-2-1462C and PS-2-1462D, isolated. This combination of inoperable pressure switches prevented Core Spray pump operation from providing a low pressure pump running permissive to the ADS logic. Thus, the requirements as specified in Technical Specification Section 3.2.B and Table 3.2-2 were not met. The wire seals were immediately broken and the instrument isolation valves were opened. This returned the instrument logic circuit to its required status.

VI. PROBABLE CONSEQUENCES OF THE OCCURRENCE:

In the event of a loss of coolant accident which could not be handled by the High Pressure Coolant Injection (HPCI) System and yet would not cause rapid Reactor depressurization, the ADS provides pressure relief to allow for low pressure ECCS pump coolant injection. Prior to an ADS initiation, the following requirements must be met: high Drywell pressure (>2 psig), low-low water level (-59 inches), a 120 second time delay and a low pressure pump running, as sensed by pressure switches on the pump's discharge line. The pump running permissive signal can be initiated by either the Core Spray or the Residual Heat Removal System logic circuitry. Inoperability of pressure switches PS-2-1462C and PS-2-1462D would have prevented the Core Spray System pump operation from providing the ADS pump running permissive, but the RHR System logic was fully operable and capable of providing the required ADS initiation signal. The pressure switches in no way affected the low pressure pumps from performing their function. Thus, there was no significant affect on safe plant operation as a result of this occurrence.

VII. CAUSE:

This occurrence was the result of a personnel error. On June 23, 1983, the Instrument Mechanic had performed the quarterly low pressure Core Spray Pump Discharge Pressure Calibration and Functional Test, QIS-23. Upon

VII. CAUSE: (Continued)

completion of calibration, the Instrument Mechanic inadvertently failed to open the PS-2-1462C and PS-2-1462D isolation valves before they were wire sealed.

VIII. CORRECTIVE ACTION:

Upon discovery of this occurrence, the pressure switches were immediately unisolated, thereby returning the instrument logic circuit to its required status. Completion of the Instrument Foreman's monthly valve audit verified that no other Instrumentation had been left inoperable. A subsequent check of this instrumentation was again performed to assure proper valving.

On June 30, 1983, Quad-Cities Station Maintenance Memorandum No. 32 was issued requiring that instrument repair and testing work be verified by a completely independent and qualified reviewer and documented, as such, on the original surveillance form. This memorandum was later revised to require immediate verification, on July 1, 1983. A Station procedure will be initiated, prior to August 1, 1983, to reflect these new requirements.

The Instrument Mechanic responsible for this error was disciplined for failure to follow Station procedures. In addition, this event was discussed between the Instrument Maintenance Department personnel and Station Management as to the seriousness and potential repercussions of such errors. Immediate actions, procedural changes and managerial controls taken as a result of this occurrence are deemed adequate. However, further investigations as to the feasibility of using instrument isolation valves which provide immediate visual position indication are presently being performed.



**Commonwealth Edison**

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NJK-83-241

July 12, 1983

J. Keppler, Regional Administrator  
Office of Inspection and Enforcement  
Region III  
U. S. Nuclear Regulatory Commission  
799 Roosevelt Road  
Glen Ellyn, IL 60137

Reference: Quad-Cities Nuclear Power Station  
Docket Number 50-265, DPR-30, Unit Two  
Appendix A, Section 3.2.B, Table 3.2-2

Enclosed, please find Reportable Occurrence Report Number RO 83-9/01T-0 for Quad-Cities Nuclear Power Station. This occurrence was previously reported to Region III, Office of Inspection and Enforcement, by telephone on June 30, 1983, and by telecopy on June 30, 1983.

This report is submitted to you in accordance with the requirements of Technical Specification 6.6.B.1.f; personnel error which could prevent, by itself, the fulfillment of the functional requirements of systems used to cope with accidents analyzed in the SAR. This occurrence reduced redundancy and did not result in loss of system function. Although the Technical Specifications allow reporting this event under Section 6.6.B.2.c, based on the seriousness of this occurrence, and the decision to provide prompt notification, it is being reported under Section 6.6.B.1.

Respectfully,

COMMONWEALTH EDISON COMPANY  
QUAD-CITIES NUCLEAR POWER STATION

*L. J. Hermer for*  
N. J. Kalivianakis  
Station Superintendent

NJK:DGC/bb

Enclosure

cc B. Rybak  
A. Morrongiello  
INPO Records Center

JUL 18 1983

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