

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)
LaSalle County Station Unit 2

DOCKET NUMBER (2)
0 5 0 0 0 3 7 4 1 OF 0 3

PAGE 15

TITLE (4)
RHR - Shutdown Cooling Isolation

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME		DOCKET NUMBER(S)
03	08	84	84	009	01	06	15	84	N/A		0 5 0 0 0
											0 5 0 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

OPERATING MODE (8) 4	20.402(b)	20.408(a)	<input checked="" type="checkbox"/>	80.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10) 01010	20.408(a)(1)(i)	80.38(a)(1)	<input type="checkbox"/>	80.73(a)(2)(v)	73.71(d)
	20.408(a)(1)(ii)	80.38(a)(2)	<input type="checkbox"/>	80.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 205A)
	20.408(a)(1)(iii)	80.73(a)(2)(i)	<input type="checkbox"/>	80.73(a)(2)(vii)(A)	
	20.408(a)(1)(iv)	80.73(a)(2)(ii)	<input type="checkbox"/>	80.73(a)(2)(vii)(B)	
	20.408(a)(1)(v)	80.73(a)(2)(iii)	<input type="checkbox"/>	80.73(a)(2)(viii)	

LICENSEE CONTACT FOR THIS LER (12)

NAME: Mark D. Schaible, extension 469

TELEPHONE NUMBER: 811 531 571 - 671 611

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC
A	BIO	ISV L	200	N					
B	BIO	ITIS R	218	N					

SUPPLEMENTAL REPORT EXPECTED (14)

YES (if you complete EXPECTED SUBMISSION DATE) NO

EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 words, i.e., approximately fifteen single-space typewritten lines) (16)

On March 8, 1984, following the completion of Work Request L34027 on Instrument 2E31N605C, RHR Equipment Area High Temp Switch, an isolation signal was generated causing the "A" Loop of RHR to isolate. The Shutdown Cooling mode of RHR was in operation on loop "A" at the time. As designed the injection valve 2E12-F053A closed, but contrary to design, the suction valve 2E12-F008 remained open. This sequence of events placed the "A" RHR pump at shut off head conditions, and the subsequent opening of the minimum flow valve 2E12-F064A allowed 60 inches of reactor water to be pumped to the suppression pool. Upon receiving a reactor vessel low level alarm, the operator tripped the "A" RHR pump and thus terminated the level decrease. The apparent cause of the problem has been determined to be as follows:

- 1) A personnel error was made leaving the breaker for the 2E12-F008 valve in the off position following some previous testing that was performed involving the 2E12-F008 valve. The breaker and valve position was logged in the U-2 NSO's log, however, the NSO involved could not recall the circumstances surrounding the log entry.
- 2) The failure of the Spare Riley alarm and trip module that was installed as a part of Work Request L34027. The spare alarm and trip module were assumed to be a working unit based on the operability check that was performed on the installed spares during the initial calibration and past experiences with using other Unit 2 installed spare modules of the same type with no apparent problems.

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		09	01	01	02	OF	03

TEXT (If more space is required, use additional NRC Form 3884's) (17)

I. EVENT DESCRIPTION

On March 8, 1984, following the completion of Work Request L34027 on Instrument 2E31N605C, RHR Equipment Area High Temp Switch (JM), an isolation signal was generated causing the "A" Loop of RHR (B0) to isolate. The Shutdown Cooling mode of RHR was in operation on Loop "A" at the time. As designed the injection valve 2E12-F053A closed, but contrary to design, the suction valve 2E12-F008 remained open. This sequence of events placed the "A" RHR Pump at shut off head conditions, and the subsequent opening of the minimum flow valve 2E12-F064A allowed 60 inches of reactor water to be pumped to the suppression pool. Upon receiving a reactor vessel low level alarm, the Operator tripped the "A" RHR pump and thus terminated the level decrease. Upon examination, the breaker for motive power to the 2E12-F008 valve was found in the off position. When the breaker was closed-in the F008 valve closed as designed.

II. CAUSE

The apparent cause of the problem has been determined to be as follows:

- 1) A personnel error was made leaving the breaker for the 2E12-F008 valve in the off position following some previous testing that was performed involving the 2E12-F008 valve. The breaker and valve position was logged in the U-2 NSO's log, however, the NSO involved could not recall the circumstances surrounding the log entry.
- 2) The inadvertant group 6 isolation of the RHR system on Unit 2 on 3/8/84 was initiated by an improper jumper configuration on a newly installed Riley T.I.S. in the Leak Detection system as a part of Work Request L34027. This T.I.S. had the correct part number but the improper jumper configuration. It was discovered that this and two other T.I.S.'s had been supplied by General Electric with improper jumper configurations. The spare alarm and trip module was assumed to be a working unit based on the operability check that was performed on the installed spares during the initial calibration and past experiences with using other Unit 2 installed spare modules of the same type with no apparent problems. FDDR HA-2-1630 has been issued to document changing these T.I.S.'s to the proper jumper configuration.

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TEXT (if more space is required, use additional NRC Form 388A (9/177))

III. PROBABLE CONSEQUENCES

The probable consequences of this event were mitigated by the fact that the Operator secured the running RHR pump "A" upon receipt of the reactor water low level alarm, along with the fact that the redundant suction valve 2E12-F009 was, in fact, energized and fully operational to provide an isolation and terminate the level decrease in the event that reactor water level reached the Level 3 trip point of +12.5 inches.

IV. CORRECTIVE ACTION

1. Review the incident with the personnel involved to emphasize the seriousness of the event (AIR #01-84-67042).
2. LIS-RH-208 and LIS-RH-108 have been revised to specifically require sign-off steps for alarm and relay actuation states (AIR #01-84-67043).
3. Consider the possibility of adding motive power breaker indication for valve 2E12-F008 in the Control Room (AIR #01-84-67044).
4. Inspect the T.I.S.'s in Stores to verify conformance with station requirements and review the procurement documentation to assure the correct part number (164C5687P008) is specified on future orders (AIR #01-84-67094).

V. PREVIOUS OCCURRENCES

None.

VI. NAME AND TELEPHONE NUMBER OF PREPARER

Mark Schaible, (815)357-6761, extension 469.



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LaSalle County Nuclear Station
Rural Route #1, Box 220
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Telephone 815/357-6761

June 15, 1984

U.S. Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

Dear Sir:

Reportable Occurrence Report #84-009-01, Docket #050-374 is being submitted to your office to supercede previously submitted Reportable Occurrence Report 84-009-00.

G. J. Diederich
G. J. Diederich ^{6/25}
Superintendent
LaSalle County Station

GJD/MLD/kg

Enclosure

xc: NRC, Regional Director
INPO-Records Center
File/NRC

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