LICENSEE EVENT REPORT (LER)									U.S. NUCLEAR REGULATORY COMMISSION								
	NAME (1										DOCKET NUMBER	(2)		PAC	E (3)		
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Fail	ure o	of Is	olatio	on Valve	to Close	9											
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20.406(a)(1)(iv) 20.406(a)(1)(iv)			05(a)(1)(iv)	F	80.73(a)(2)(ii) 80.73(a)(2)(iii)												
						ICENSEE	CONTACT	FOR THIS	LER (12)								
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				COMPLETE	ONE LINE FOR	EACH C	OMPONEN	T FAILURE	DESCRIBE	D IN THIS REPO		1-1					
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ABSTRACT (Limit to 1400 abeces, i.e., approximately fifteen single-space typewritten lines) (16)

During the performance of Startup Test 2-31, "Loss of Offsite Power Test", containment isolation valve 2B33-F019 did not close upon receipt of a containment isolation signal. Upon investigation, it was discovered that the solenoid valve was improperly positioned preventing the air pressure from venting off that holds valve 2B33-F019 open. Outboard containment isolation valve 2B33-F020 did close, thus maintaining containment integrity. Valve 2B33-F019 was repaired by repositioning its solenoid valve properly. Subsequently other safety related valves were found with mispositioned solenoid pilot valves and were repaired or removed from service.

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FACILITY NAME (1)	DOCKET NUMBER (2)	DOCKET NUMBER (2)				PAGE (3)		
		YEAR		NUMBER	REVISION NUMBER			
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EXT Iff more space is required, use additional NRC Form 385A's) (17)

I. EVENT DESCRIPTION

During the performance of Startup Test 2-31, "Loss of Offsite Power Test", the Reactor Water Sample (KN) containment isolation valves 2B33-F019 and 2B33-F020 did not go full closed per their position indicating lights at Control Room panel 2H13-P601. Upon investigation, it was determined that outboard containment isolation valve 2B33-F020 was physically full closed but required a limit switch adjustment. Inboard containment isolation valve 2B33-F019 appeared to be full open with its solenoid deenergized.

11. CAUSE

Offsite power was purposely interrupted to Unit 2 causing a reactor scram from approximately 20% power on 6/8/84 at approximately 11:25 AM. An expected simultaneous loss of the Reactor Protection System (JC) buses caused a containment isolation signal (JM). Upon receipt of the signal, all containment isolation valves indicated closed with the exception of Reactor Water Sample containment isolation valves 2B33-F019 and 2B33-F020. Physical inspection of the valves indicated 2B33-F020 full closed with a position indicating limit switch out of adjustment. Valve 2B33-F019 appeared to be stuck full open, however, the solenoid pilot valve was deenergized. Both valves are solenoid air operated, fail-closed valves manufactured by A.C.F. Industries.

Work Request L37604 and L37605 were generated to repair both valves. 2B33-F020 required a limit switch adjustment; 2B33-F019 required repositioning the solenoid pilot valve so that the coil of the solenoid is in the vertical position. Proper positioning of the solenoid valve is required because the coil assembly drops to the vent position by means of spring pressure assisted by gravity.

The solenoid pilot valve is manufactured by ASCO, model number 206832-3F. No automatic or manually initiated safety system responses were affected.

111. PROBABLE CONSEQUENCES OF THE OCCURRENCE

With only one containment isolation valve not closed, consequences of the occurrence are minimal. Containment isolation would still be maintained regardless of the severity of an accident by proper operation of the outboard containment isolation valve 2B33-F020.

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IV. CORRECTIVE ACTION

Action Statement 3.6.3.a.1.b. was implemented until inboard containment isolation valve 2B33-F019 had been repaired. Valve 2B33-F019 was repaired by properly positioning the pilot solenoid so that the coil assembly is in a vertical plane.

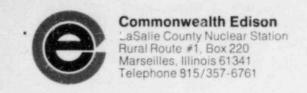
On July 13, 1984, it was verified that the manufacturer of the pilot solenoid valve (ASCO) required that the valve be mounted in the vertical position only. All accessible valves which have safety related functions were immediately inspected to determine the valve position. 19 Primary Containment Isolation and RCIC (BN) valves were remounted by July 15, 1984. This report was upgraded to an LER at that time because of the potential impact on several systems. No problems of valve operation of the 19 valves mispositioned were reported and the valves were always considered operational. Other inaccessible valves were verified in their "fail safe" position as a conservative measure and will be inspected to determine their orientation when access is possible. (AIR 1-84-67109)

V. PREVIOUS OCCURRENCES

None.

VI. NAME AND TELEPHONE NUMBER OF PREPARER

John Bruciak, (815)357-6761, extension 323.



July 23, 1984

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

Dear Sir:

Reportable Occurrence Report #84-033-00, Docket #050-374 is being submitted to your office in accordance with 10 CFR 50.73.

G. J. Diederich Superintendent LaSalle County Station

GJD/MLD/kg

Enclosure

xc: NRC, Regional Director INPO-Records Center

File/NRC

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