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# LICENSEE EVENT REPORT (LER)

U.S. NUCLEAR REGULATORY COMMISSION APPROVED OMS NO. 3180-0104 EXPIRES 8/31/86

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TRACT (Limit to 1400 spaces, i.e., approximetary fifteen single-space typewritten lines) (18)

Shutdown cooling suction inboard isolation valve, 1E21-F009, failed to open by the motor operator or manually. The unit was in the process of going to Cold Shutdown for a planned maintenance/surveillance outage. The unit was not required to go to Cold Shutdown. The cause of the 20 inch flex wedge gate valve not opening electrically cannot be determined at this time. The manual operation was made unuseable by a broken declutch lever. Two methods of alternate decay heat removal were available. The valve was subsequently opened and shutdown cooling initiated. An investigation of the cause of failure and corrective action is proceeding.

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U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104

EXPIRES 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)		LER NUMBER (6)		PAGE (3)			
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TEXT (If more space is required, use additional NRC Form 3664's) (17)

### I. EVENT DESCRIPTION

On 9/30/84 at 0130 with the unit in Mode 3, Hot Shutdown, the Residual Heat Removal (BO, RHR) Shutdown Cooling Suction Inboard Isolation Valve, 1E12-F009, failed to open by the motor operator or manually. The unit was not required to be in Cold Shutdown during this event. A GSEP was declared at 0730 and classified as an Alert (EAL #13).

## II. CAUSE

The 1E12-F009 valve is a 20 inch flexible wedge gate valve manufactured by Anchor Darling Company. The motor operator is a Model SBO manufactured by Limitorque Corporation. When the valve could not be opened by the motor operator or manually by Operating personnel, Mechanical Maintenance personnel were sent to troubleshoot the valve. The motor operator declutch mechanism was found inoperative. After mechanically declutching the motor operator, the handwheel required 15 to 20 hard hammerblows to remove the valve disc from the body seats. (A hammerblow is accomplished by rotating the handwheel in the close direction and then in the open direction until the drive logs engage.) Once the disc was off the seats, the valve could be normally operated with the handwheel. The cause of the declutch mechanism failure is unknown but could have resulted from excess force being previously applied. The inoperability of the declutch mechanism would not affect the electrical operability of the motor operator. The motor operator was subsequently tested by Electrical Maintenance as being satisfactory (Work Request L42049). In addition, a consultant, Movats, Inc., was contracted to diagnose the operation of the valve and motor operator with the unit in Cold Shutdown. Their findings indicated that no valve/operator limitations were being exceeded.

### III. PROBABLE CONSEQUENCES OF THE OCCURRENCE

During this event, the reactor recirculation pumps (AD) remained on to assure adequate core circulation. Reactor coolant temperature and pressure were monitored once per hour. Removal of decay heat was continued during the event by depressurizing the RPV to the main condenser (SG) and making up water to the RPV via the CD/CB/FW (SD, SJ) systems in accordance with LGA-02, Cooldown. Additional alternate methods of decay heat removal included the use of the SRV's (SB) and RHR systems as delineated in UFSAR Chapter 15 and LGA-02. 1E12-F009 was opened at 1020 and RHR Shutdown Cooling started. The unit was in Mode 4, Cold Shutdown, by 1629.

Since two alternate methods of decay heat removal were available, the Reactor Recirculation System was in operation, and reactor coolant parameters monitored, the Action Statements of Technical Specification 3.4.9.1 were satisfied. The probable consequences of the event would not result in any temperature or pressure transient in excess of the criteria for which the fuel, pressure vessel, or containment were designed.

### LICENSEE EVENT REPORT (LER) TEXT CONTINUATION APPROVED OMB NO 3150-0104 EXPIRES 8/3: 85 DOCKET NUMBER (2) PAGE (3) FACILITY NAME (1) LER NUMBER (6) SEQUENTIAL YEAR

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U.S. NUCLEAR REGULATORY COMMISSION

LaSalle County Station Unit 1 TEXT (If more space is required, use additional NRC Form 386A's) (17)

# IV. CORRECTIVE ACTION

Station personnel, Station Nuclear Engineering Department, and Sargent & Lundy are investigating potential causes for the valve inoperability. A supplemental LER will be issued when the cause is determined. (AIR 1-84-67165)

AIR 1-84-67166 has been issued to train all Operating personnel on the correct procedure for declutching motor operators.

#### V. PREVIOUS OCCURRENCES

LER 373/83-142

#### VI. NAME AND TELEPHONE NUMBER OF PREPARER

M. A. Peters 815/357-6761, extension 245.

October 30, 1984

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

Dear Sir:

Reportable Occurrence Report #84-062-00, Docket #050-373 is being submitted to your office in accordance with 10CFR 50.73.

G. J. Diederich

Superintendent

LaSalle County Station

GJD/MLD/kg

Enclosure

xc: NRC, Regional Director

INPO-Records Center

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