

LICENSEE EVENT REPORT (LER)

Facility Name (1) QUAD-CITIES, NUCLEAR POWER STATION, UNIT TWO Docket Number (2) 0 | 5 | 0 | 0 | 0 | 2 | 6 | 5 Page (3) 1 | of | 0 | 4

Title (4) UNIT TWO TORUS/DRYWELL VACUUM BREAKER FAILED TO CLOSE DUE TO DIMPLED BUSHING OR CORRODED SOLENOID

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 Names
2	18	87	87	0 0 4	0 0	2	18	87	

OPERATING MODE (9) 4

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

<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(c)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)
<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vii)	Other (Specify
<input type="checkbox"/> 20.405(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)	in Abstract below
<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)	and in Text)
<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

Name: Suzette Walters, Technical Staff Engineer Ext. 2152 TELEPHONE NUMBER: 3 | 0 | 9 | 6 | 5 | 4 | - | 2 | 2 | 4 |

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS
X	B F	V A C B	A S 8 S	Y					

SUPPLEMENTAL REPORT EXPECTED (14)

Expected Submission Date (15) _____

Yes (If yes, complete EXPECTED SUBMISSION DATE) X | NO

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

On February 18, 1987, Unit Two was in the RUN mode at 100 percent of core thermal power. At 0118 hours, while performing QOS 1600-1, "Suppression Chamber to Drywell Vacuum Breakers Monthly Exercise", vacuum breaker 2-1601-33A would not return to its normal closed position after being tested. Based on Technical Specification 3.7.A.4.b., a separation test between the drywell and suppression chamber was performed and this confirmed that the vacuum breaker was stuck open. A Generating Station Emergency Plan (GSEP) Unusual Event was declared and appropriate notifications were completed. Subsequently it was determined that Technical Specification 3.0.A should also be considered to assure that no set of equipment outages be allowed to persist that would result in the facility being in an unprotected condition. Therefore, Unit Two was placed in hot SHUTDOWN at 1147 hours and cold SHUTDOWN at 1645 hours on February 18, 1987. The GSEP Unusual Event was then terminated.

The cause for this failure was determined to be the result of either a slightly dimpled valve bushing or a rusted and corroded solenoid associated with the air operated testing mechanism. Both of these problems were corrected and the vacuum breaker was retested successfully. This report is submitted to comply with the requirements of 10CFR50.73(a)(2)(i).

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specification 3.7.A.4.b. also was applicable. Therefore, Technical Specification 3.0.A. was implemented which states that the unit should be in a hot SHUTDOWN condition within twelve hours and cold SHUTDOWN within the following twenty-four hours. This specification assures that no set of equipment outages would be allowed to persist that would result in the facility being in an unprotected condition. A hot SHUTDOWN condition was achieved at 1147 hours on February 18, 1987 and a cold SHUTDOWN condition was achieved at 1645 on the same day. Both hot and cold SHUTDOWN were completed within the required time limits set by Technical Specification 3.0.A. The GSEP Unusual Event was terminated at 1645 hours.

C. APPARENT CAUSE OF EVENT:

Following the Unit Two shutdown, the vacuum breaker was lubricated and additionally, as part of a more thorough investigation the vacuum breaker was disassembled, inspected, and reassembled. During the inspection, a slightly dimpled bushing was discovered. This is believed to have been caused during installation. In addition, the solenoid used in the air-operated testing mechanism of the vacuum breaker was found to be rusted and corroded which could have prevented the air from exhausting, thereby keeping the vacuum breaker in the open position. It had been field tested prior to disassembly and bench tested after disassembly, and in both cases results were found acceptable. However, when tested in the field following reassembly the solenoid did not always work properly. Therefore, the solenoid or the bushing, singularly or together, could theoretically have caused the vacuum breaker failure.

This report is submitted in accordance with the requirements of the Code of Federal Regulations 10CFR50.73(a)(2)(i) which requires the reporting of the completion of any nuclear plant shutdown required by the plant's Technical Specifications and any operation or condition prohibited by the plant's Technical Specifications.

D. SAFETY ANALYSIS OF EVENT:

The vacuum breaker in question along with eleven other operable vacuum breakers are used to equalize pressure between the drywell and the suppression chamber to prevent a vacuum from being created in the drywell. With the vacuum breaker stuck in the open position, the designed differential pressure between the Suppression Chamber and the Drywell could not be maintained. As a result, there was an increased volume of water in the downcomers between the drywell and suppression chamber. In a worse case scenario, during a loss of coolant accident (LOCA), steam would force large amounts of water through the downcomers. This could damage the suppression chamber. In addition, with the vacuum breaker stuck open, steam could bypass directly to the suppression chamber during a LOCA and less effective steam condensation and energy dissipation would result. Since the other eleven vacuum breakers were operable and the 2-1601-33A vacuum breaker was only stuck open a brief period of time before shutting down, the safety consequences were minimal.

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TEXT							

E. CORRECTIVE ACTIONS:

Three Work Requests (Q55458, Q55492, Q55494) were written on the failed vacuum breaker. These Work Requests had the vacuum breaker lubricated and exercised, the dimpled bushing filed smooth, and the solenoid replaced. When the work was completed, the Monthly Surveillance was reperformed and found acceptable. This is considered an isolated incident, because no recent License Event Reports (LER) have been written at Quad Cities Station describing a similar failure. No further corrective action is deemed necessary at this time.

F. PREVIOUS EVENTS:

There were no recent LERs written that reflected the cause of the vacuum breaker being stuck in the open position due to a failed solenoid or dimpled bushing. However, there were two LERs written due to the vacuum breakers being stuck in the open position: 265/82-22/03L (due to the stainless steel packing and stuffing box bushing being bound to the shaft) and 265/82-06/03L (due to the counterweight being mispositioned).

G. COMPONENT FAILURE DATA:

The vacuum breaker is an 18 inch swing-check valve manufactured by the Atwood and Morrill Company, Inc. The solenoid was manufactured by AZCO, type HT 8317-30.



Commonwealth Edison

DEVIATION REPORT

DVR NO. 04 - 02 - 87 - 014
STA UNIT YEAR NO.

PART 1 TITLE OF DEVIATION OCCURRED
U2 TORUS/DRYWELL VACUUM BREAKER FAILED TO CLOSE 2-18-87 0118
DATE TIME

SYSTEM AFFECTED 1600 PRIMARY CONT. PLANT STATUS AT TIME OF EVENT
MODE RUN POWER(%) 100 TESTING YES NO
WORK REQUEST NO.

DESCRIPTION OF EVENT
WHILE PERFORMING QOS 1600-1, SUPPRESSION CHAMBER TO DRYWELL VACUUM BREAKERS
MONTHLY EXERCISE, VACUUM BREAKER 2-1601-33A FAILED TO RECLOSE AFTER THE TEST
PUSHBUTTON WAS RELEASED. SEVERAL ATTEMPTS WERE MADE TO CLOSE THE VALVE, BUT
IT REMAINED FULL OPEN. UNIT 2 BEGAN SHUTTING DOWN PER T.S. 3.7.A.6.a(3) AND
GSEP UNUSUAL EVENT DECLARED AT 0320 HOURS. NARS NOTIFICATIONS COMPLETED AT 0325 HOURS.

POTENTIALLY SIGNIFICANT EVENT PER NSD DIRECTIVE A-07 YES NO

10CFR50.72 NRC RED PHONE NOTIFICATION MADE 1 HOUR 0355 4 HOUR NO
PAUL D. KNOESPEL 2-18-87
RESPONSIBLE SUPERVISOR DATE

PART 2 OPERATING ENGINEER'S COMMENTS
SINCE THE VACUUM BREAKER IS STUCK OPEN, THIS LER WAS RE-CLASSIFIED TO FALL UNDER
T.S. 3.0.A, REQUIRING A HOT SHUTDOWN CONDITION WITHIN 12 HOURS AND COLD SHUTDOWN
WITHIN 24 HOURS.

NON REPORTABLE EVENT
 30 DAY REPORTABLE/10CFR 50.73 (a) (2) (1) A & B
 5 DAY REPORT PER 10CFR21
 ANNUAL/SPECIAL REPORT REQUIRED
A.I.R. #
L.E.R. # 87-004
NOTIFICATION REGION III DATE TIME
NSD DATE TIME
 CECD CORPORATE NOTIFICATION MADE IF ABOVE NOTIFICATION IS PER 10CFR21
TELECOPY CECD CORPORATE OFFICER DATE TIME

PRELIMINARY REPORT COMPLETED AND REVIEWED B. STRUB 2-18-87
OPERATING ENGINEER DATE

INVESTIGATION REPORT & RESOLUTION ACCEPTED BY STATION REVIEW
RESOLUTION APPROVED AND AUTHORIZED FOR DISTRIBUTION
STATION MANAGER 3-17-87
DATE



Commonwealth Edison

Quad Cities Nuclear Power Station
22710 206 Avenue North
Cordova, Illinois 61242
Telephone 309/654-2241

RLB-87-71

March 9, 1987

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

Reference: Quad-Cities Nuclear Power Station
Docket Number 50-265, DPR-30, Unit Two

Enclosed please find Licensee Event Report (LER) 86-004, Revision 00, for Quad-Cities Nuclear Power Station.

This report is submitted to you in accordance with the requirements of the Code of Federal Regulations, Title 10, Part 50.73(a)(2)(1), which requires the reporting of the completion of any nuclear plant shutdown required by the plant's Technical Specifications and any operation or condition prohibited by the plant's Technical Specifications.

Respectfully,

COMMONWEALTH EDISON COMPANY
QUAD-CITIES NUCLEAR POWER STATION

RLB

R. L. Bax
Station Manager

kLB/MSK/clr

Enclosure

cc: I. Johnson
A. Morrongiello
INPO Records Center
NRC Region III

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