

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 7911130309 DOC. DATE: 79/11/06 NOTARIZED: NO DOCKET #
 FACIL: ~~50-276 Georgia Tech Research Reactor, Georgia Institute of T~~ 05000276
 AUTH. NAME: LEWIS, S. R. AUTHOR AFFILIATION: Duke Power Co. 50-270
 RECIP. NAME: RECIPIENT AFFILIATION: Region 2, Atlanta, Office of the Director

Reportable Occurrence

SUBJECT: LER 79-007/01T-0: on 791024, 1 over power injection outlet valves discovered in improper positions. Low pressure svc water outlet valves were not available. Caused by improper procedures. Procedures were revised.

DISTRIBUTION CODE: A002S COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 3+1
 TITLE: Incident Reports

NOTES:

ACTION:	RECIPIENT	COPIES		RECIPIENT	COPIES	
	ID CODE/NAME	LTR	ENCL		ID CODE/NAME	LTR
	05 BC <u>ORB#4</u>	4	4			
INTERNAL:	<u>01 REG FILE</u>	1	1	02 NRC PDR	1	1
	09 I&E	2	2	11 MPA	3	3
	14 TA/EDO	1	1	15 NOVAK/KNIEL	1	1
	16 EEB	1	1	17 AD FOR ENGR	1	1
	18 PLANT SYS BR	1	1	19 I&C SYS BR	1	1
	20 AD PLANT SYS	1	1	22 REAC SAFT BR	1	1
	23 ENGR BR	1	1	24 KREGER	1	1
	25 PWR SYS BR	1	1	26 AD/SITE ANAL	1	1
	27 OPERA LIC BR	1	1	28 ACIDENT ANLYS	1	1
	29 AUX SYS BR	1	1	E JORDAN/IE	1	1
	HANAUER, S.	1	1	STS GROUP LEADR	1	1
	TMI-H STREET	1	1			
EXTERNAL:	03 LPDR	1	1	04 NSIC	1	1
	29 ACRS	16	16			

NOV 14 1979

NOV 14 1979

CB
104

LICENSEE EVENT REPORT

EXHIBIT A

CONTROL BLOCK: _____ (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 | S | C | N | E | E | 2 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 4 | 1 | 1 | 1 | 1 | 4 | _____ | 5
7 8 9 14 15 25 28 30 37 40 47 50 57 64

CONT
01 | REPORT SOURCE | L | 6 | 0 | 5 | 0 | 0 | 0 | 2 | 7 | 0 | 7 | 1 | 1 | 0 | 2 | 4 | 7 | 9 | 3 | 1 | 1 | 1 | 0 | 6 | 7 | 9 | 9
7 8 9 60 61 68 75 82 89 96 103 110 117 124 131 138 145 152 159 166 173 180

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 | During operation at 49% full power on October 24, 1979, it was discovered
03 | that the LPI cooler outlet valves were not in the proper positions. Since
04 | the pneumatically operated outlet control valves were closed rather than 50%
05 | open, LPSW flow for the LPI cooler would not have been automatically avail-
06 | able if required. In the unlikely event of a LOCA, sufficient time would
07 | have been available to open the valves from the control room. Thus, the
08 | incident is considered not to have affected safe operation of the unit or
09 | the health and safety of the public.

09 | S | F | 11 | D | 12 | Z | 13 | H | T | E | X | C | H | 14 | C | 15 | Z | 16
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22

17 | LER/RO REPORT NUMBER | 7 | 9 | _____ | SEQUENTIAL REPORT NO. | 0 | 1 | 7 | OCCURRENCE CODE | 0 | 1 | REPORT TYPE | T | REVISION NO. | 0

ACTION TAKEN | FUTURE ACTION | EFFECT ON PLANT | SHUTDOWN METHOD | HOURS | ATTACHMENT SUBMITTED | NPRO-4 FORM SUB. | PRIME COMP. SUPPLIER | COMPONENT MANUFACTURER
X | 18 | G | 19 | Z | 20 | Z | 21 | 0 | 10 | 0 | 0 | Y | 23 | N | 24 | L | 25 | B | 0 | 1 | 5 | 28

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 | The LPI procedure had been revised, with a number of valve alignments deleted
11 | from the body of the procedure and placed in an attached checklist. These
12 | valves were left in the body but should have been included in the checklist.
13 | The procedure has been revised and personnel reinstructed, and an audit of
14 | procedural controls and their implementation will be conducted.

15 | FACILITY STATUS | E | 28 | % POWER | 0 | 4 | 9 | 29 | OTHER STATUS | NA | 30 | METHOD OF DISCOVERY | A | 31 | DISCOVERY DESCRIPTION | Operator observation | 32

16 | ACTIVITY RELEASED OF RELEASE | Z | 33 | Z | 34 | AMOUNT OF ACTIVITY | NA | 35 | LOCATION OF RELEASE | NA | 36

17 | PERSONNEL EXPOSURES NUMBER | 0 | 0 | 0 | 37 | TYPE | Z | 38 | DESCRIPTION | NA | 39

18 | PERSONNEL INJURIES NUMBER | 0 | 0 | 0 | 40 | DESCRIPTION | NA | 41

19 | LOSS OF OR DAMAGE TO FACILITY TYPE | Z | 42 | DESCRIPTION | NA | 43

20 | PUBLICITY ISSUED DESCRIPTION | N | 44 | DESCRIPTION | NA | 45

7911130309

NRC USE ONLY