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REGION 2, ATLANTA, OFFICE OF THE DIRECTOR

SUBJECT: LER 79-011/03L-0 ON 790319:CONTAINMENT ISOLATION VALVE ON GASEOUS RADIATION MONITOR INLET LINE WAS DISCOVERED TO BE INOPERABLE.CAUSED BY LOOSE WIRE ON VALVE MOTOR CONTACTOR WHICH CAUSED THERMAL OVERLOADS TO OVERHEAT.WIRE TIGHTENED.

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TITLE: INCIDENT REPORTS

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APR 26 1979

DUKE POWER COMPANY
OCONEE UNIT 1

Report Number: RO-269/79-11

Report Date: April 18, 1979

Occurrence Date: March 19, 1979

Facility: Oconee Unit 1, Seneca, South Carolina

Identification of Occurrence: Penetration Isolation Valve Inoperable

Conditions Prior to Occurrence: 99% Full Power

Description of Occurrence:

At 1700 on March 19, 1979, valve PR-7, the containment isolation valve inside the Reactor Building (RB) on the RB gaseous radiation monitoring inlet line, was determined to be inoperable. A computer alarm had been received indicating an overload on the valve motor. Attempts were made to reset the valve breaker, but each time the thermal overloads on the valve motor contactor tripped. Valve PR-8, the redundant isolation valve outside the Reactor Building, was closed, effecting containment isolation of the monitoring line. Closing valve PR-8 removed the gaseous radiation monitors, RIA-47, -48 and -49, from service. These monitors provide a radiation-sensitive means for detecting reactor coolant system (RCS) leakage. According to Oconee Nuclear Station Technical Specification 3.1.6.8, the monitors may be removed from service for up to 48 hours, provided that at least two other leak detection systems are operable. At 1830 on March 19, valve PR-7 was examined, and a loose wire on the valve motor contactor was discovered to be causing the thermal overloads to overheat. The wire connection was tightened, and at 2015 the valve was tested and verified to be operating properly. Valves PR-7 and PR-8 were then opened, returning the gaseous radiation monitors to service. Therefore, Technical Specifications 3.1.6.8 and 3.6.3.b, which requires that an inoperable containment isolation valve be restored to operable status within four hours, were satisfied.

Apparent Cause of Occurrence:

The valve failure was due to overheating of the thermal overloads in the valve motor contactor when operation of the valve was attempted. The overheating of the overloads was the result of a loose wire on the motor contactor.

Analysis of Occurrence:

When valve PR-7 was discovered to be inoperable, the redundant isolation valve was closed in order to assure containment integrity. This resulted in the removal from service of the RB radiation monitors, but RB normal sump level and RCS inventory volume measurements were available to detect any leakage. Therefore, although the failure of valve PR-7 and the subsequent removal of the gaseous monitoring system from service constituted operation of the unit in a degraded mode permitted by a limiting condition for operation, the incident was of no significance with respect to safe operation of the unit. The valve was restored to operability in less than four hours, thus returning the gaseous monitoring system to service. Therefore, safe operation of the unit was not affected, and the health and safety of the public were not endangered.

NRC FORM 366
(7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

EXHIBIT A

CONTROL BLOCK: [| | | | | |] (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

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CON'T 0 1 | REPORT SOURCE L (6) | 0 5 0 0 0 2 6 9 (7) | 0 3 1 9 7 9 (8) | 0 4 1 8 7 9 (9)
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EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 On March 19, 1979 the containment isolation valve on the Reactor Building
0 3 gaseous radiation monitor inlet line was discovered to be inoperable. The
0 4 redundant valve was closed to assure that containment integrity would be main-
0 5 tained. This caused the gaseous monitors to be removed from service, but two
0 6 other methods of detecting RCS leakage were operable. Since containment
0 7 integrity and adequate leakage detection systems were maintained, safe opera-
0 8 tion of the unit was not affected, and the health and safety of the public were
not endangered.

0 9 | SYSTEM CODE: B B (11) | CAUSE CODE: E (12) | CAUSE SUBCODE: A (13) | COMPONENT CODE: V A L V E X (14) | COMP. SUBCODE: X (15) | VALVE SUBCODE: D (16)

(17) LER/RO REPORT NUMBER | EVENT YEAR: 7 9 | — | SEQUENTIAL REPORT NO.: 0 1 1 | / | OCCURRENCE CODE: 0 3 | REPORT TYPE: L | — | REVISION NO.: 0

ACTION TAKEN: B (18) | FUTURE ACTION: Z (19) | EFFECT ON PLANT: Z (20) | SHUTDOWN METHOD: Z (21) | HOURS (22): 0 0 0 0 | ATTACHMENT SUBMITTED: Y (23) | NPRD-4 FORM SUB.: Y (24) | PRIME COMP. SUPPLIER: L (25) | COMPONENT MANUFACTURER: L 2 0 0 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The valve failure was due to a loose wire on the valve motor contactor which
1 1 caused the thermal overloads to overheat. The wire contact was tightened, and
1 2 the valve was tested to verify its operability. Both isolation valves were
1 3 opened, returning the gaseous monitoring system to service within four hours of
1 4 discovering the valve's inoperability.

1 5 | FACILITY STATUS: E (28) | % POWER: 0 9 9 (29) | OTHER STATUS (30): NA | METHOD OF DISCOVERY: A (31) | DISCOVERY DESCRIPTION (32): Operator Observation

1 6 | ACTIVITY RELEASED: Z (33) | CONTENT OF RELEASE: Z (34) | AMOUNT OF ACTIVITY (35): NA | LOCATION OF RELEASE (36): NA

PERSONNEL EXPOSURES
1 7 | NUMBER: 0 0 0 (37) | TYPE: Z (38) | DESCRIPTION (39): NA

PERSONNEL INJURIES
1 8 | NUMBER: 0 0 0 (40) | DESCRIPTION (41): NA

LOSS OF OR DAMAGE TO FACILITY (43)
1 9 | TYPE: Z (42) | DESCRIPTION: NA

PUBLICITY
2 0 | ISSUED: N (44) | DESCRIPTION (45): NA | NRC USE ONLY

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