

CATEGORY 1

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 9710140233 DOC. DATE: 97/10/03 NOTARIZED: NO DOCKET #
 FACIL: 50-220 Nine Mile Point Nuclear Station, Unit 1, Niagara Powe 05000220
 AUTH. NAME AUTHOR AFFILIATION
 ABBOTT, R. E. Niagara Mohawk Power Corp.
 RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 97-009-00: on 970903, declared channel 12 instrumentation & systems inoperable due to leakag through instrument sys drain valves. Developed work plan to identify & stop leak & closed suspect drain valve to stop-leak. W/971003 ltr.

DISTRIBUTION CODE: IE22T COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 8
 TITLE: 50.73/50.9 Licensee Event Report..(LER), Incident Rpt, etc.

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NIAGARA MOHAWK

GENERATION
BUSINESS GROUP

NINE MILE POINT NUCLEAR STATION/LAKE ROAD, P.O. BOX 63, LYCOMING, NEW YORK 13093

October 3, 1997
NMP1L 1255

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20005

RE: Docket No. 50-220
LER 97-09

Gentlemen:

In accordance with 10CFR50.73 (a)(2)(i)(B), we are submitting LER 97-09, "Technical Specification Violation Due to System Inoperability Caused by Leakage Through Drain Valves."

Very truly yours,

Richard B. Abbott
Plant Manager - NMP1

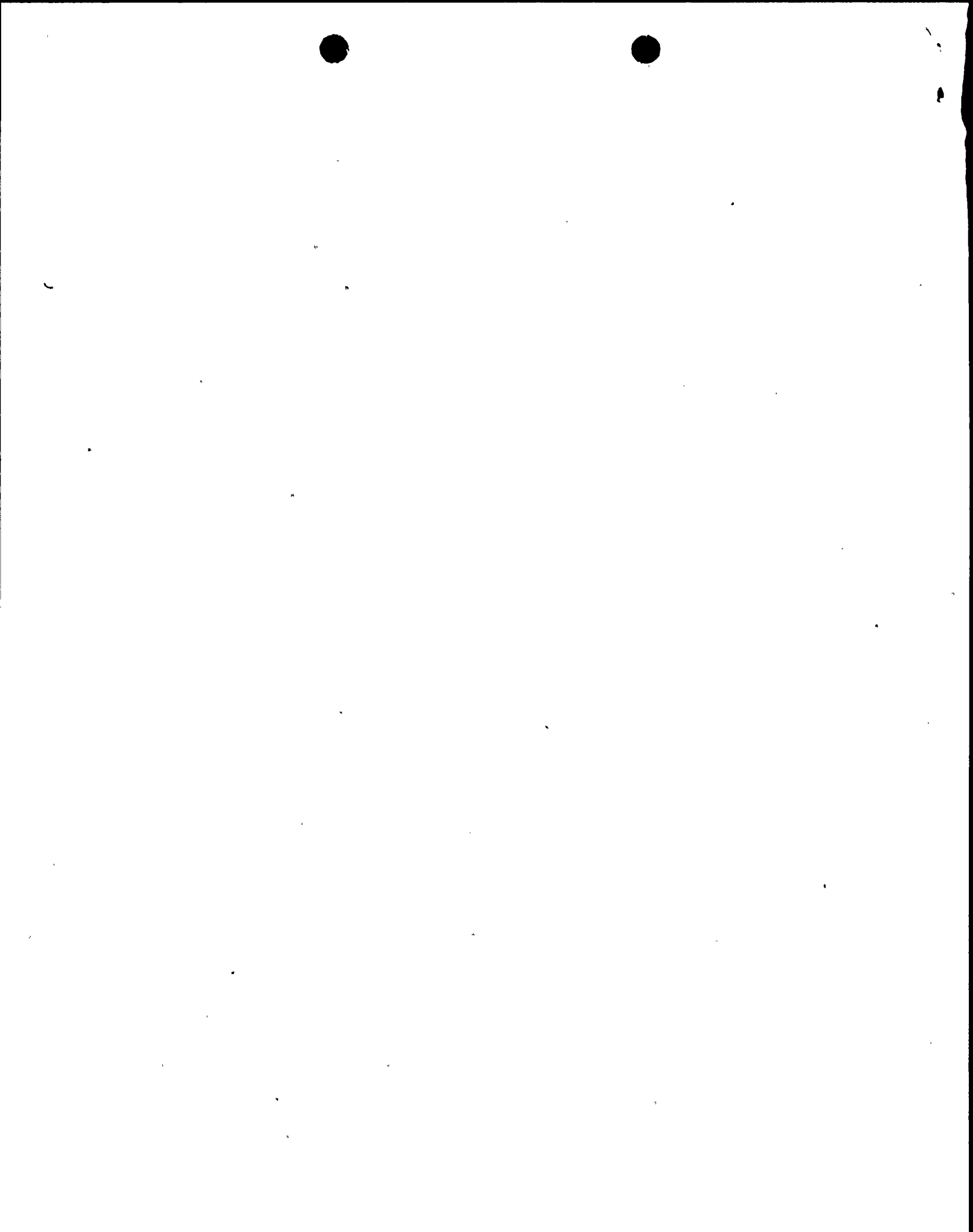
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Enclosure

xc: Mr. H. J. Miller, Regional Administrator, Region I
Mr. B. S. Norris, Senior Resident Inspector
Records Management

9710140233 971003
PDR ADOCK 05000220
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IC 22



LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 30.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20535, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503

FACILITY NAME (1)

Nine Mile Point Unit 1

DOCKET NUMBER (2)

05000220

PAGE (3)

1 OF 7

TITLE (4)

Technical Specification Violation Due to System Inoperability Caused by Leakage Through Drain Valves

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	DOCKET NUMBER(S)	
09	03	97	97	009	00	10	03	97	N/A	05000	
									N/A	05000	

OPERATING MODE (9)

1

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

POWER LEVEL (10) 100	<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)	<input type="checkbox"/> OTHER
	<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)	<i>(Specify in Abstract below and in Text, NRC Form 366A)</i>
	<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)	
	<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

Richard E. Abbott - Acting Operations Manager NMP1

TELEPHONE NUMBER

(315) 349-2608

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

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE)

NO

EXPECTED SUBMISSION DATE (15)

MONTH

DAY

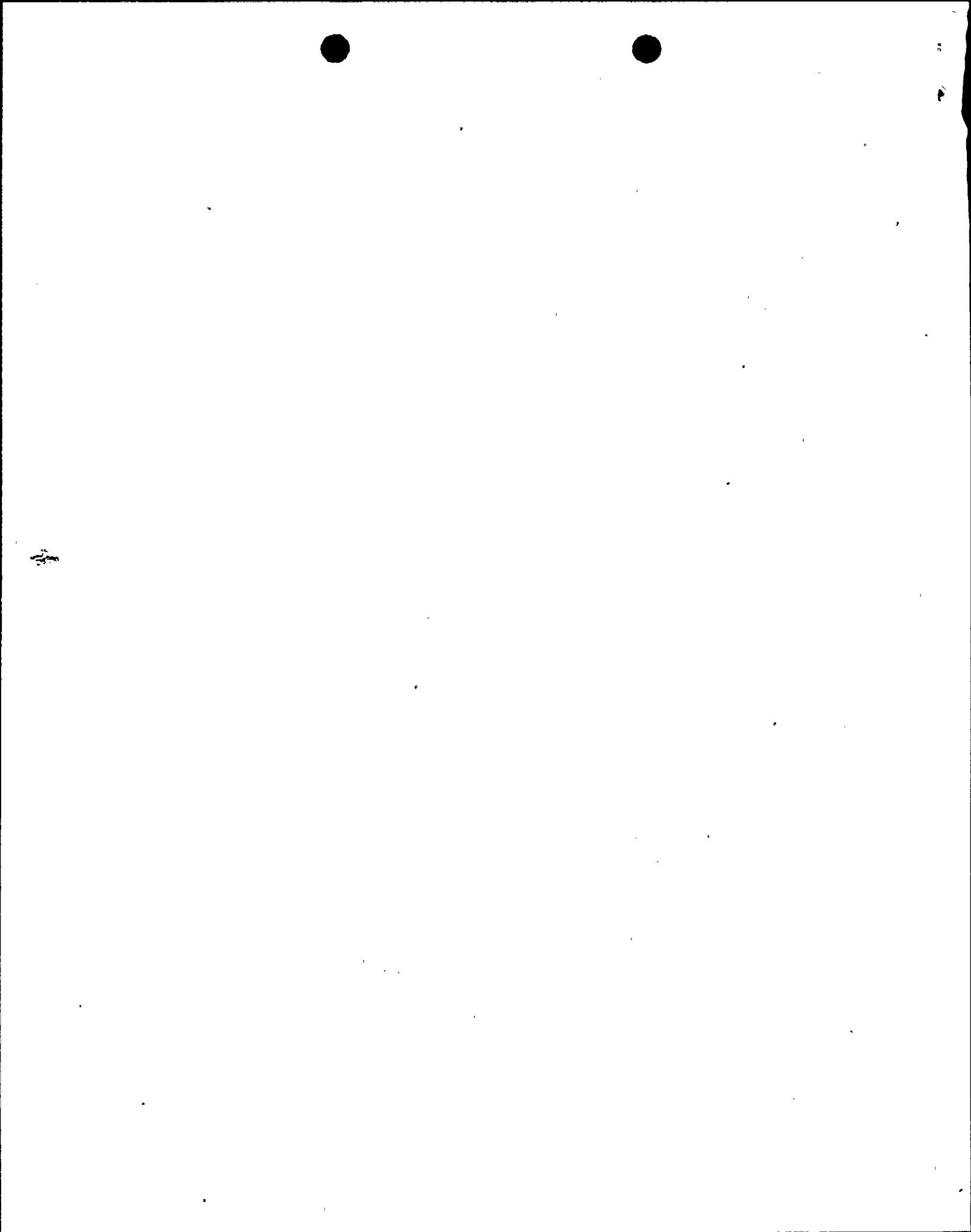
YEAR

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

On September 3, 1997, during corrective maintenance on the channel 12 reactor water level reference leg back-fill system, a divergence between the channel 11 and channel 12 GEMAC narrow range level indicators was observed in the control room. The channel 12 instrumentation and the systems affected by it were declared inoperable, which resulted in multiple Technical Specification (TS) Limiting Conditions for Operation (LCO) entries. Troubleshooting revealed that the level divergence was due to water loss from the instrument column 12 reference leg through system drain valves that were not tightly closed. Since this condition has existed since startup from the last refueling outage in May 1997, the LCO action times for the affected systems were exceeded.

The cause of this event was leakage through the instrument system drain valves. The exact cause of the leakage is unknown, but most likely is either inadequate force applied to tightly close the valves or valve degradation. When additional force was applied to the valves, the leakage stopped.

The drain valves will be inspected to determine if any degradation exists and repairs will be completed, if required. Procedure changes will be implemented to heighten awareness of drain valve operation and leakage on instrumentation. A procedure will be developed to periodically check the instrumentation system for leakage. Training will be provided to Operations, Engineering and Technical Support personnel regarding this event.



LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
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Nine Mile Point Unit 1	05000220	97	- 09	- 00	02 OF 07

TEXT (If more space is required, use additional NRC Form 366A's) (17)

I. DESCRIPTION OF EVENT

On September 3, 1997, corrective maintenance was initiated on the channel 12 reactor water level reference leg back-fill system to stop a leak at the channel 12 back-fill flow indicator. During this maintenance, a divergence between channel 11 and channel 12 GEMAC narrow range indicators was observed in the control room. Over a period of several hours, the divergence between the channels continued to increase while plant personnel attempted to confirm the cause and evaluate the potential impact. At 1030 hours on September 3, 1997, the channel 12 instrumentation and the systems affected by it were declared inoperable and the appropriate Technical Specification (TS) Limiting Conditions for Operation (LCOs) were entered. These included the following:

- TS 3.1.5, Automatic Depressurization System (ADS)
- TS 3.1.8, High Pressure Coolant Injection (HPCI) system redundant component (channel 12 HPCI level control)
- TS 3.6.11, Accident Monitoring Instrumentation (Reactor Water level - Fuel Zone channel 12)

It was believed that the cause of the level divergence was a small leak from the instrument column reference leg back through the isolated and vented back-fill system that was undergoing maintenance. Discussions between Operations and Maintenance personnel indicated there had been some leakage from the system following issuance of the tagout. When the back-fill system integrity was broken to repair the leak, Maintenance personnel reported that they had more water in the line than expected. At the approximate time when the line was disconnected, a distinct increase in the rate of level divergence was noted, further suggesting that the maintenance activity on the back-fill system was the cause of the level discrepancy. Operations personnel had recently been trained on the affect that a minimal amount of leakage could have on level transmitters and indication, and deduced that leakage through the tagged maintenance valves and open system was the cause of the level discrepancy.

The maintenance was completed and the back-fill system was restored to normal. Shortly after the restoration (approximately twenty minutes), the channel 12 GEMAC level indicator returned to normal. Walkdowns were performed to check for leaks and to verify proper system lineup. No discrepancies were noted. Following discussion and evaluation by Operations, Operations management and Technical Support personnel, the channel 12 GEMAC level instrument and the associated equipment were declared operable at 1110 hours on September 3, 1997. Operations used an equipment operability determination checklist to



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TEXT (If more space is required, use additional NRC Form 366A's) (17)

I. DESCRIPTION OF EVENT (cont'd)

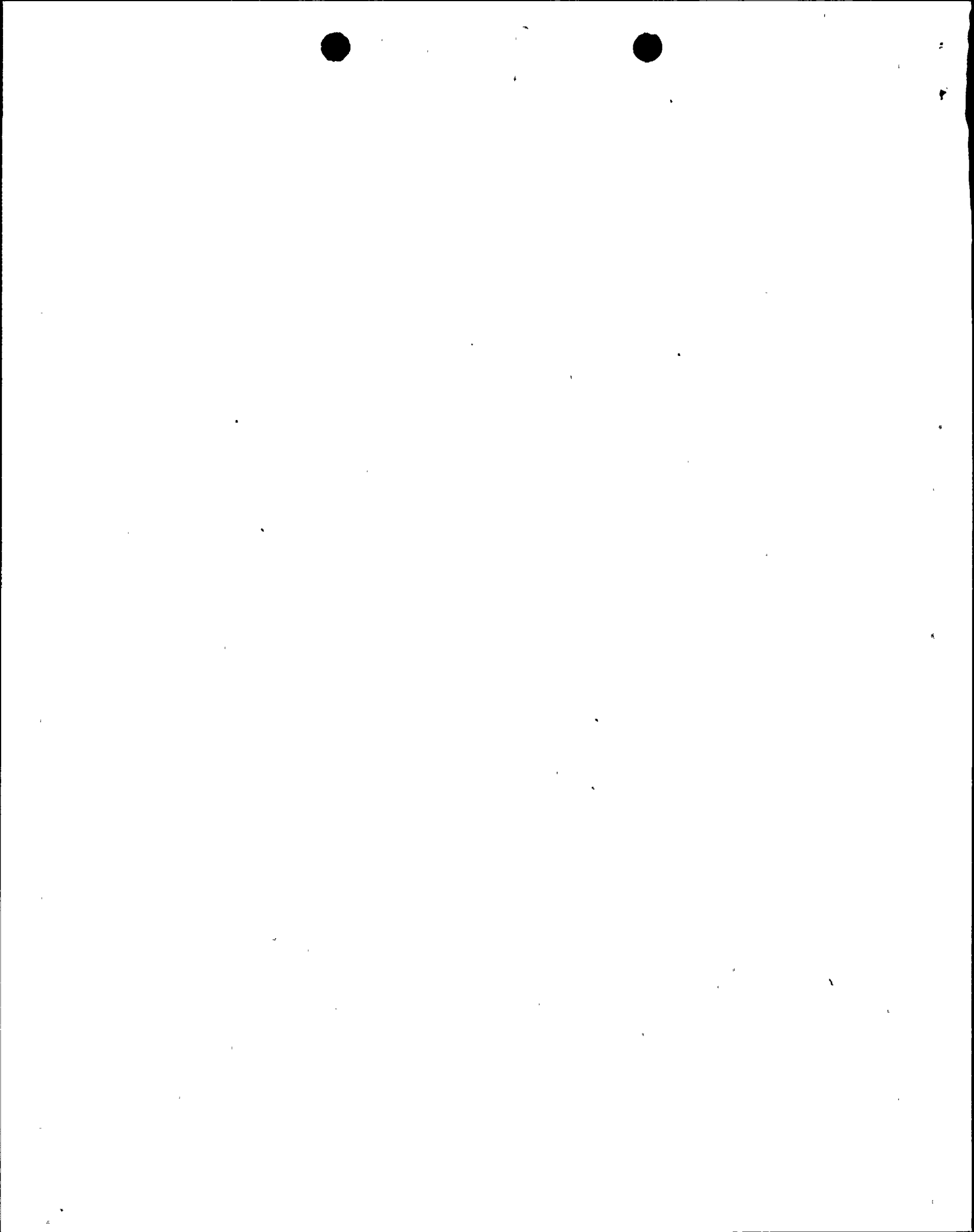
document operability. Operability was based on the fact that no work was being done on the transmitters, the level column reading before the tagout was hung and the reading after the tagout was restored were the same, and that there were no other indications of any leakage from the instrument racks. All LCOs were exited.

During the preparation of a Deviation/Event Report to document the event, an Engineering Supporting Analysis (ESA) was requested to obtain additional review of the unusual instrument behavior during maintenance. On September 4, 1997, Engineering and Technical Support personnel reviewed the data from September 3, and postulated that a reference leg leak in a location different from the maintenance activity could exist. However, it was expected that a detailed review would show that the back-fill system could be relied upon to maintain the reference leg full based on the fact that the Control Rod Drive (CRD) pumps, which provide flow to the back-fill system, are TS required equipment and in the case of a loss of offsite power, automatically restart from the diesel generators. A work plan was written as part of the Engineering evaluation to verify whether a leak existed or not. On September 5, 1997, thermography was performed on drain valves in the East Instrument Room which revealed a slightly elevated temperature (less than two degrees) on the drain valves for the instrument column 12 reference leg, indicating apparent leakage past these valves. Engineering determined that instrument column 12 was inoperable because a reference leg leak existed such that the CRD and back-fill systems were required to keep the reference column filled with water. However, the CRD and back-fill systems are not safety related and must be considered unavailable during a Loss-of-Coolant-Accident (LOCA). The previously identified TS LCOs were reentered on September 6, 1997 at 0045 hours and "backdated" to the inoperability on September 3, 1997.

To comply with TS Table 3.6.2f, Instrumentation that initiates ADS (low-low-low reactor water level), the transmitter trip cards for reactor water level low-low-low were placed in the tripped condition and TS 3.1.5 was exited at 0224 hours on September 6, 1997.

On September 6, 1997 at approximately 0500, the suspect drain valves were tightened. The back-fill system was later valved out of service and back into service to look for indications of additional leakage. None were found. Thermography was also completed to confirm that the leakage was stopped.

On September 8, 1997, an ESA was completed to document operability of the HPCI system and Accident Monitoring Instrumentation, and the respective LCOs were exited at 2315 hours. An additional ESA was completed on September 9, 1997, to document that the low-low-low reactor water level instrumentation was operable. Post maintenance testing was performed to demonstrate operability to allow restoring the reactor water level low-low-low trip cards to normal. The LCO for Table 3.6.2f (ADS instrumentation) was exited after satisfactory testing on September 10, 1997 at 0143 hours.



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TEXT (If more space is required, use additional NRC Form 366A's) (17)

I. DESCRIPTION OF EVENT (cont'd)

The instrument system drain valves that were leaking were manipulated during the last refueling outage as part of excess flow check valve testing on May 1, 1997. The valves were closed after the testing and were rechecked closed as part of a pre-startup lineup on May 5, 1997. Since it is believed that this condition has existed since startup from the refueling outage on May 9, 1997 when the systems were required to be operable, the LCO action times for the affected systems were exceeded.

II. CAUSE OF EVENT

The cause of this event was leakage through the instrument system drain valves. The exact cause of the leakage is unknown, but most likely is either inadequate force applied to tightly close the valves or valve degradation. When additional force was applied to the valves, the leakage stopped.

There were two contributing causes to being in violation of the TS for an extended duration: a) a lack of periodic testing to confirm no leakage, and b) inadequate evaluation of the change in water level indication during maintenance.

During the design and installation of the back-fill system, the possibility of a small leak being masked by the make-up from the back-fill system and the impact on the rest of the instrumentation system was not adequately evaluated. Post-modification leakage testing was performed, but a periodic leakage test was not developed.

An opportunity to identify the leaking drain valves was missed on September 3, 1997 when the back-fill system was restored and the level instruments were incorrectly declared operable. Attention was focused on the technical aspects of the maintenance and the consensus that the maintenance activity had to be the cause of the divergent level indication. Although the available data supported the belief that the leak was through the tagged section of open piping, other possible explanations were not evaluated, including problems with the system that were unrelated to the maintenance.



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TEXT (If more space is required, use additional NRC Form 366A's) (17)

III. ANALYSIS OF EVENT

This event is reportable in accordance with 10CFR50.73 (a)(2)(i)(B), "any operation or condition prohibited by the plant's Technical Specifications."

The various systems affected by the level instrumentation were ADS, HPCI and Fuel Zone water level indication. The impact of the inoperability will be discussed for each.

The reactor water level low-low-low signal along with high drywell pressure provides the necessary logic to open the ADS valves to depressurize the reactor in the case of a small break LOCA. This allows the Core Spray system to inject water to the reactor vessel to restore and maintain level and ensures adequate core cooling. The ADS logic is arranged such that the low-low-low water level transmitters connected to either GEMAC instrument column 11 or 12 will input the required low-low-low water level signals to the ADS logic to initiate a complete depressurization. The instrument column 11 low-low-low water level signals were available during the period that instrument column 12 was inoperable and not tripped. Thus, the ADS function was available throughout this period.

A separate water level transmitter on this instrument column also provides water level input to the fuel zone compensated water level instrumentation which is used for post-LOCA monitoring per Regulatory Guide (RG) 1.97. The instrument column 11 fuel zone water level indication was available throughout this period, thus fuel zone level indication would have been available if an accident had occurred. In addition, wide range level instruments were available. These wide range instruments have separate reference legs and also meet RG 1.97 requirements.

Instrument column 12 also provides input to the 3-element feedwater level control system and the HPCI feedwater level control system, as well as a narrow range level indication in the control room during normal reactor operation. The affect on Feedwater and HPCI level control would have been minimal. Feedwater level control may have controlled water level below the normal level if instrument column 12 was selected as the level input. The Reactor Protection System (RPS) low water level scram comes from separate instrument columns and both RPS channels were available to initiate a scram if water level fell below the scram setpoint. HPCI water level control is designed with an alternate level control system (channel 11) which controls level at a slightly lower water level than channel 12 (65 inches vs. 72 inches) and automatically assumes control if water level drops below this point. Therefore, HPCI would have controlled water level within the EOP operating band and per design. Channel 11 water level control was available for the above functions throughout this period.

The leak on the reference leg was very small and caused the level divergence over a several hour period. Although the back-fill system is assumed to not be available during a LOCA, the divergence over a short period of time due to the leak would have had a negligible affect on the reference leg water level and



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III. ANALYSIS OF EVENT (cont'd)

therefore on the affected systems. These systems would have essentially responded in a normal manner in the short term. As described above, the instrument column 11 controls and indication were available throughout this period. In addition, the CRD system was in service throughout this period of time. The back-fill system was in service as well, with the exception of the maintenance period previously described.

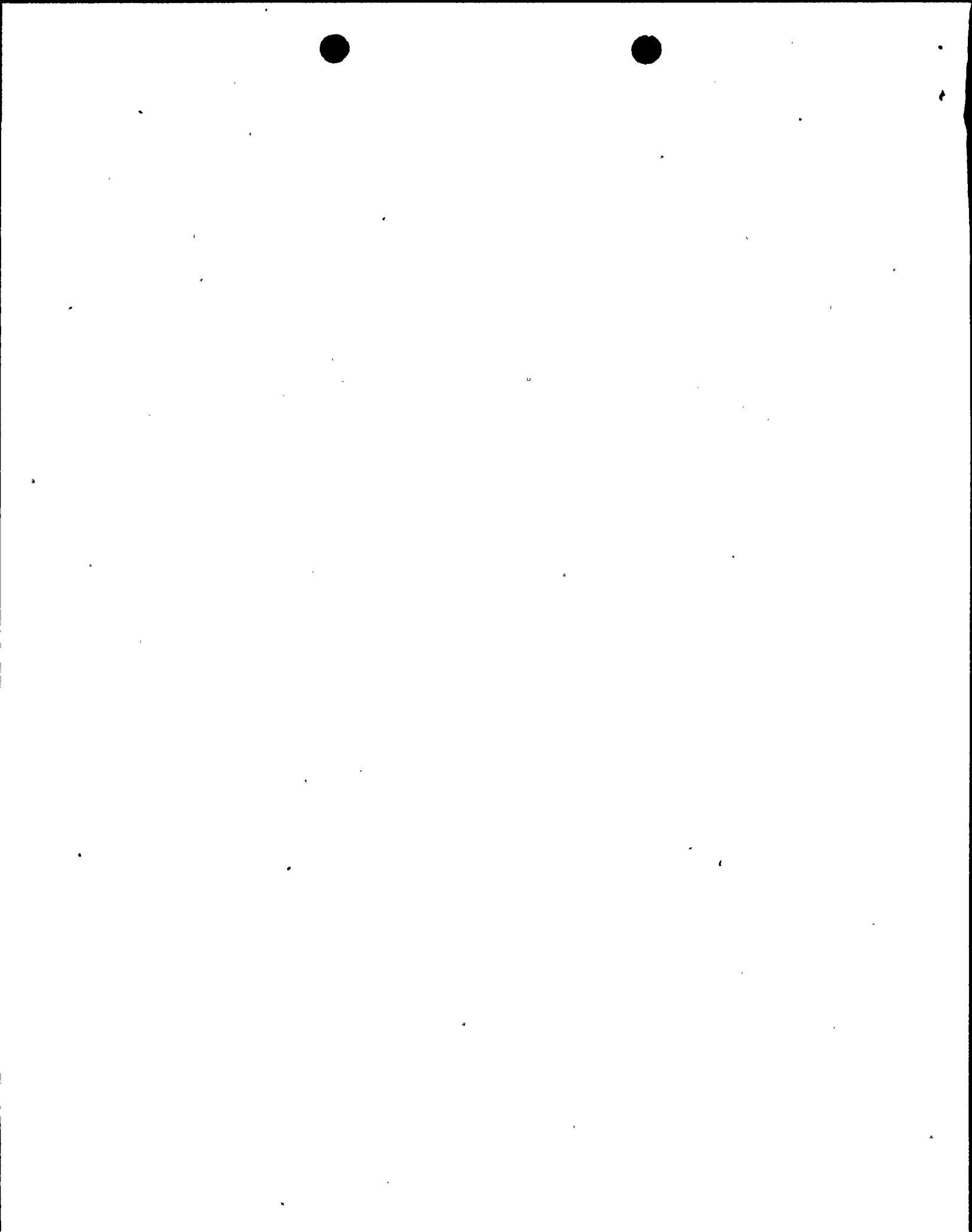
There were periods of time since the refueling outage that surveillance testing was performed on the channel 11 instruments. These time periods were for short durations only (a matter of a few hours). As described above, the channel 12 instruments would have essentially responded normally in the short term. Even with some level divergence in the non-conservative direction, ADS would still have responded, although not at the setpoints described in the Safety Analysis Report. For example, ADS might have initiated below its normal setpoint, but depressurization would have occurred and the Core Spray system would have restored and maintained reactor water level. HPCI would have controlled reactor water level within its designed band, and would have maintained level well above the top of active fuel. In addition, operators would have recognized these conditions and are provided adequate guidance in the Emergency Operating Procedures (EOPs) to take manual actions as necessary. This could have included restoring channel 11 functions to normal or manually controlling the appropriate systems, including EOP actions to manually inhibit ADS. Thus, the affects of testing the other channel would have been minimal.

Overall, adequate controls and indications were available to ensure that reactor water level inventory would have been maintained. Therefore, there were no adverse consequences to the health and safety of the public or NMPC personnel.

IV. CORRECTIVE ACTIONS

The immediate corrective action was to declare the affected systems inoperable and enter the appropriate TS action statements. A work plan to continue troubleshooting the back-fill system was developed to identify and stop the leak. Tightly closing the suspect drain valves stopped the leak. Subsequent evaluations and post-maintenance testing were performed to establish operability and allow exiting the respective TS LCOs. The remaining instrument drain valves associated with reference legs fed from the back-fill system were also verified tightly closed.

The drain valves will be inspected during the current forced outage to determine if any degradation exists and repairs will be completed, if required. Additionally, procedure changes will be implemented to heighten awareness of drain valve operation and the significance of drain valve leakage on instrumentation. These actions will be completed by December 31, 1997.



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IV. CORRECTIVE ACTIONS (cont'd)

A procedure will be developed to periodically check the instrumentation system for leakage. This procedure will be performed under steady state conditions after startup from the current forced outage on the three reference legs which are fed from the back-fill system.

Training will be provided to Operations, Engineering, and Technical Support personnel regarding this event and will specifically address the failure to fully evaluate the affects of the modification on the instrumentation system and the lack of thoroughness in the initial operability determination. This action will be completed by December 31, 1997.

V. ADDITIONAL INFORMATION

- A. Failed components: none.
- B. Previous similar events: none.
- C. Identification of components referred to in this LER:

COMPONENT	IEEE 803 FUNCTION	IEEE 805 SYSTEM ID
Reactor Level Indication	LI	N/A
Reactor Level Transmitter	LT	N/A
Isolation/Drain Valve	ISV	N/A
Control Rod Drive System	N/A	AA
High Pressure Coolant Injection System	N/A	BJ

