

LICENSEE EVENT REPORT

CONTROL BLOCK: (1)

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 | FIL | T | P | SI 4 | 2 | 0 | 10 | -10 | 10 | 00 | 10 | -10 | 0 | 3 | 4 | 11 | 1 | 11 | 4 | 1 | 5
7 3 9 LICENSEE CODE 14 15 25 26 28 LICENSE NUMBER 57 CAT 58

CCN'T REPORT SOURCE 1 1 6 0 1 5 1 0 1 0 1 2 1 5 1 1 7 1 1 2 1 1 9 1 7 1 8 1 8 1 1 1 1 8 1 7 1 9 1 9
7 50 61 53 53 74 75 30
30 30

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

012 During normal operation, process radiation monitors R-11 and R-12 were out of service for about 18 hours. Operation in this mode is allowed for 48 hours by Technical Specification 3.1.3.f provided two other redundant means of RCS leak detection (not sensitive to radiation) are available. The redundant RCS leak detection capability was available, so this event had no adverse affect on public health and safety. A similar occurrence was reported as IER 251-78-2.

SYSTEM CAUSE CAUSE COMP. VALVE

0 9 7 8	CODE B B (11) 9 10	CODE E (12) 11	SUBCODE B (13) 12	COMPONENT CODE B L I O W I E I R (14) 13	COMP. SUBCODE Z (15) 19	VALVE SUBCODE Z (16) 20
LSP/R0 [17] REPORT		EVENT YEAR 17 8	SEQUENTIAL REPORT NO. 10116	OCCURRENCE CODE 10131	REPORT TYPE H	REVISION NO. 101

NUMBER 21 22 23 24 25 26 27 28 29 30 31 32
 ACTION TAKEN FUTURE EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED VPRO-4 FORM SUB. PRIME COMP. SUPPLIER COMPONENT MANUFACTURER
 C 13 Z 19 Z 20 Z 21 10 101 010 N N N N T 216 10
 23 34 35 36 37 38 39 40 41 42 43 44 45
 CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

110 An air sampling blower which supplies monitors R-11 and R-12 failed due to
111 normal wear. The blower was replaced and the monitors were returned to
112 service.

1 | 3

1 4
7 3 3
FACILITY METHOD OF

STATUS **1** POWER **2** OTHER STATUS **3** DISCOVERY **4** DISCOVERY DESCRIPTION **5**
 1 5 E 23 0 1 5 10 29 NA A 31 Operator Observation
 7 3 9 10 12 13 14 45 45 30
 ACTIVITY CONTENT RELEASED OR RELEASED AMOUNT OF ACTIVITY LOCATION OF RELEASE
 1 2 1 2 1 2 35 36

1 15 4 33 4 34 NA NA
7 3 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

NUMBER TYPE DESCRIPTION (3) NA

7 3 9 11 12 13 PERSONNEL INJURIES 30
NUMBER DESCRIPTION

1 3 0 0 1 0 40 NA

LOSS OF OR DAMAGE TO FACILITY 43
TYPE DESCRIPTION NA

119 42 NA 30
7 8 9 10 PUBLICITY

ISSUED TO **N** (44) DESCRIPTION (45) NA NRC USE ONLY
2 0 7 3 9 10 63 59 39

NAME OF PREPARED M. A. Schoppman

PHONE: (305) 552-3802



January 17, 1979

PRN-LI-79-18

Mr. James P. O'Reilly, Director, Region II
Office of Inspection and Enforcement
U. S. Nuclear Regulatory Commission
101 Marietta Street, Suite 3100
Atlanta, Georgia 30303

Dear Mr. O'Reilly:

REPORTABLE OCCURRENCE 250-78-17
TURKEY POINT UNIT 3
DATE OF OCCURRENCE: DECEMBER 18, 1978

TECHNICAL SPECIFICATION 6.9.2.b(4)
CVCS HOLDUP TANK

The attached Licensee Event Report is being submitted in accordance with Technical Specification 6.9.2 to provide 30-day notification of the subject occurrence.

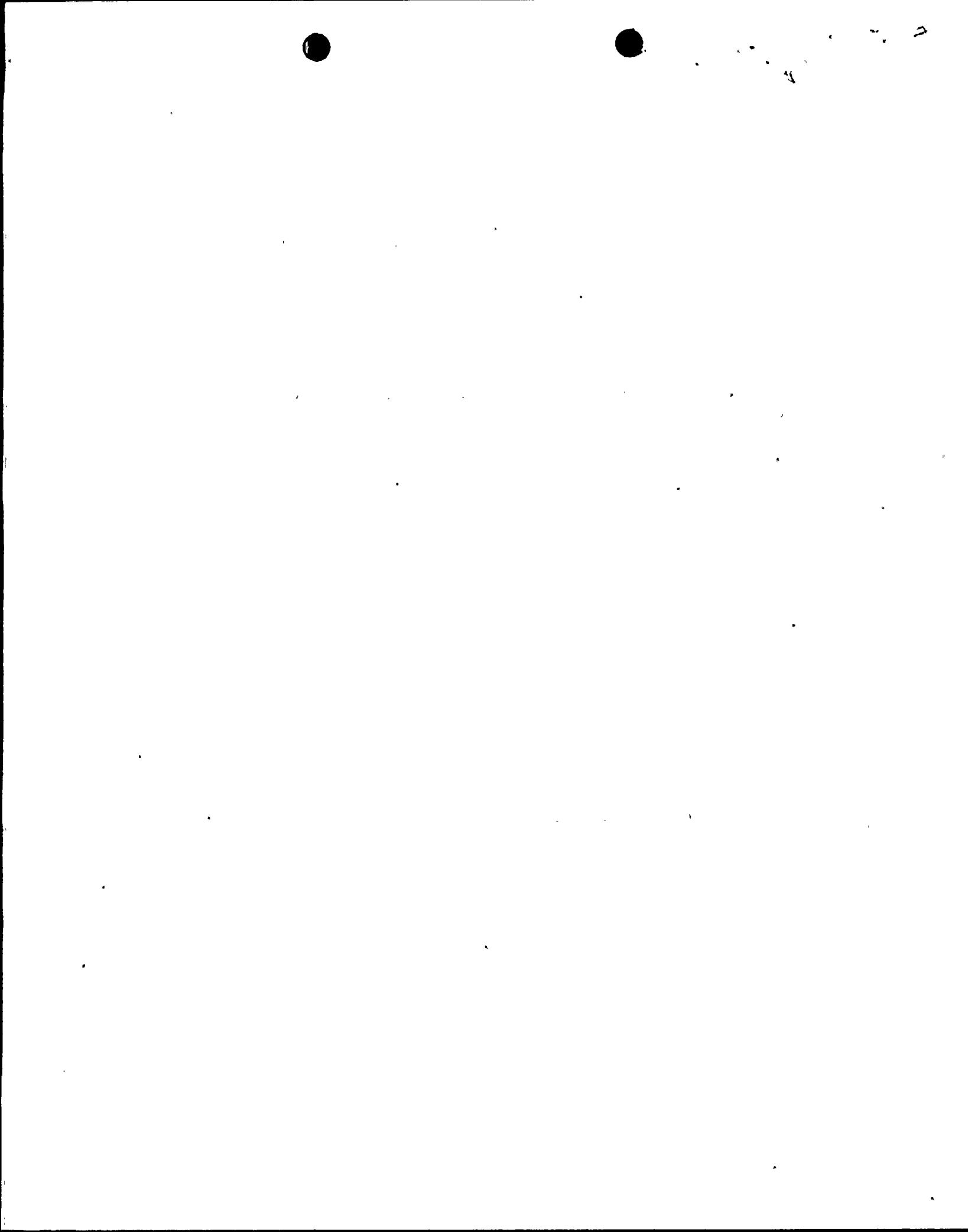
Very truly yours,

JR Benson
for A. D. Schmidt
Vice President
Power Resources

MAS/cpc

Attachment

cc: Director, Office of Inspection and Enforcement (30)
Director, Office of Management-Information and Program Control (3)
Robert Lowenstein, Esquire
File 933.1TP



LICENSEE EVENT REPORT

CONTROL BLOCK: | | | | | | | ①

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CCN

REPORT SOURCE L 5 0 1 5 1 0 1 0 0 1 2 1 5 1 0 7 1 1 2 1 1 8 1 7 1 8 3 0 1 3 1 1 1 7 1 7 9 9
7 3 60 61 COCKET NUMBER 52 53 EVENT DATE 74 75 REPORT DATE 30

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

- 012 During normal operation, efforts were being made to determine the source of
013 an intermittent radioactive gas leak. It was determined that the leak could
014 be associated with reactor coolant letdown to CVCS holdup tank A, but not
015 to tanks B and C: After further investigation and inspection, a small
016 through-wall defect was found near the top of the A tank. CVCS holdup tank
017 rupture is discussed in FSAR section 14.2.2 and would not adversely affect
018 public health and safety. This is the first LFR of this type.

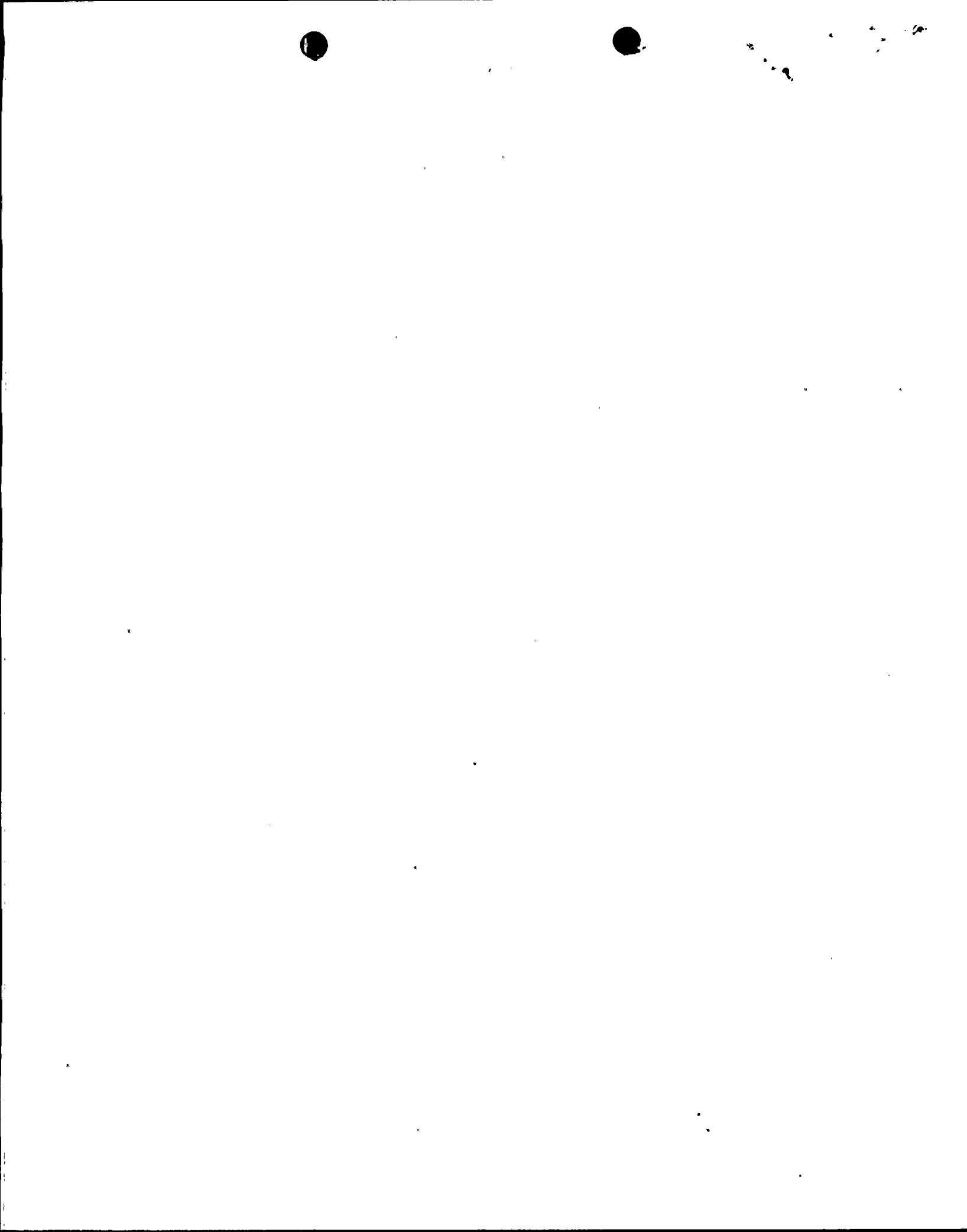
7	8	9	SYSTEM CODE 0 9 7 6	CAUSE CODE P C 9 10	CAUSE SUBCODE E 11 12	COMPONENT CODE B 13 14	COMP. SUBCODE X 15 19	VALVE SUBCODE Z 20 23	30			
17 LER/RO REPORT NUMBER [78] 21 22				EVENT YEAR [78] 23				SEQUENTIAL REPORT NO. [0117] 24 26		OCCURRENCE CODE [03] 23 29	REPORT TYPE [L] 30	REVISION NO. [0] 32
ACTION TAKEN [D] 33		FUTURE ACTION [X] 18 19		EFFECT ON PLANT [Z] 20 35	SHUTDOWN METHOD [Z] 21 36	HOURS [101000] 27 40	ATTACHMENT SUBMITTED [Y] 22 41	VPRO-4 FORMS/US [N] 24 42	POINT OF CAP. SUPER. [X] 25 43	COMPONENT MANUFACTURER [N115] 0 44	47	

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (2)

- 110 The cause has not been positively determined, but it is apparent that a
111 small section of the tank shell in the area of the defect has been deformed
112 as a result of low internal pressure. Fatigue stresses associated with the
113 deformation appear to have caused the defect.

NAME OF PREPARED M. A. Schoppman

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Additional Cause Description and Corrective Action

Corrective action will include repair of the defect and evaluation of cover pressure control and monitoring methods.

Tank Data: 13,000 ft³
15 psig internal pressure
200°F
0 psig external pressure

