Thomas J. Martin
Vice President
Engineering and Construction

Public Service Electric and Gas Company 80 Park Place Newark, N.J. 07101 201/430-8316

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August 9, 1978

Mr. Boyce H. Grier, Director
U. S. Nuclear Regulatory Commission
Office of Inspection and Enforcement
Region 1
631 Park Avenue
King of Prussia, Pennsylvania 19406

Dear Mr. Grier:

REACTOR VESSEL - INCORE INSTRUMENT TUBING
10CFR50.55(e) "SIGNIFICANT DEFICIENCY"
NO. 2 UNIT
SALEM NUCLEAR GENERATING STATION

On July 19, 1978 a verbal report was made to Region 1, Office of Inspection and Enforcement representative Mr. R. Gallo, advising that in the course of performing Preservice Mechanized examinations of the Salem No. 2 Unit Reactor Vessel on Saturday, July 15, Southwest Research Institute apparently swept ultrasonic calibration block #5-CSCL-42SAM into the vessel while manipulating their automated inspection device above the reactor flange.

The following information is hereby submitted pursuant to our initial report and in accordance with the requirements of 10CFR50.55(e):

1. Description of the Deficiency

The calibration block fell from the vessel flange hitting the core support ledge putting a shallow dent in the cladding at the 0^{o} location, then proceeded to fall into 12 ft. of water. Before coming to rest at the bottom of the vessel, the block apparently hit bottom mounted instrumentation tube #28 causing this tube to bend outwards approximately four (4) degrees, and caused two nicks in the cladding on the bottom of the vessel. While examining all bottom mounted instrumentation tubes by the rod and ball method, tube #47 was found to be slightly bowed. However, this tube apparently was not struck by the calibration block due to its location.

2. Corrective Action

PSE&G has evaluated the damage found in the vessel and the following minor repairs are anticipated:

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(1) Cosmetic blending of the dent on core support ledge.

(2) Cosmetic blending of the nicks in cladding on the bottom of the vessel.

(3) Straightening of tubes #28 and #47, if they are determined by Westinghouse to be out of tolerance.

These repairs will be performed using approved procedures developed by Westinghouse in September 1978.

Southwest Research Institute has investigated the circumstances leading up to the calibration block being swept into the vessel and is in the process of issuing a report to PSE&G. Preliminary information from Southwest Research indicates that steps during Preservice Inspection, such as physically securing calibration blocks and requiring a technician to be stationed in the vessel flange area while manipulating the mechanized inspection device are being considered.

The possibility of this type of incident occuring during Inservice Inspection has been reviewed and considered virtually non-existent since calibration is performed completely remote of the vessel flange.

Very truly yours,

T Martin

CC: Mr. Leif J. Norrholm
Resident Reactor Inspector
U. S. Nuclear Regulatory Commission
Drawer I
Hancocks Bridge, New Jersey 08033