



UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D. C. 20555

NOV 13 1979

LER MONTHLY REPORT

The enclosed computer listing, as identified on the attached sheet, provides information concerning Licensee Event Reports (LERs) entered into the data base during the month of October.

If you desire additional information or special searches, please feel free to contact me on 301/492-7724.

Sincerely,

A handwritten signature in cursive script that reads "Eugenia L. Boyle".

Eugenia L. Boyle
Licensee Operations Evaluation Branch, DTS
Office of Management and Program Analysis

Enclosures:
As Stated

1543 022

7912130 083

NOV 08, 1979

LER MONTHLY REPORT SORTED BY FACILITY
 PROCESSED DURING OCTOBER, 1979 FOR POWER REACTORS

PAGE 1

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
ARKANSAS-1 CIRCULATING WATER SYS + CON COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR LICENSED & SENIOR OPERATORS ITEM NOT APPLICABLE	05000313 79-001/04L-0 026766	021679 031679 30-DAY	DURING STEADY STATE OPERATION, 4 CIRC. WATER PUMPS RUNNING, MAX. DIFFERENTIAL TEMP. ACROSS THE CONDENSER EXCEEDED ETS 15 DEG. F. LIMIT. EVENT LASTED 2.5 HRS WITH MAX. RISE OF 15.26 DEG. F. COMPUTER LOG REVIEW INDICATED ANOTHER ETS VIOLATION OCCURRED FOR APPROX. 49 HRS ON 2/9-2/11/79 WITH A MAX. TEMP. RISE OF 15.45 DEG. F. NO IMPACT FROM THERMAL STRESS EXPECTED ON ENVIRONMENT.
ARKANSAS-1 RESIDUAL HEAT REMOV SYS + CONT PIPES, FITTINGS LESS THAN 4 INCHES COMPONENT FAILURE OTHER ITEM NOT APPLICABLE	05000313 79-003/04T-0 026812	042579 042679 2-WEEK	EXCESSIVE IMPINGEMENT OF THREADFISH SHAD ON CIRC. WATER INTAKE SCREENS PLUGGED INLET TUBE SHEETS, RESTRICTING COOLING WATER FLOW. INLET WATER BOX VALVES WERE CYCLED TO CLEANSE SHEETS. MONITORING OF CONDENSER & DIFF. TEMP. IMPROVED BY USE OF COMPUTER TREND RECORDER. AT 0100 HOURS ON 4/25/79 WITH REACTOR IN COLD SHUTDOWN, A LEAK WAS DISCOVERED IN "B" DECAY HEAT LOOP DISCHARGE LOCATED IN REACTOR BLDG. (INSERT A) DUE TO PLANT CONDITION AND SMALL MAGNITUDE OF LEAK. THERE WAS NO HAZARD TO HEALTH AND SAFETY OF PUBLIC. ((A) LEAK WAS IN A 1 INCH DRAIN LINE SOCKET WELD TO AN 8 INCH CROSS CONNECT LINE TO THE "A" DECAY HEAT LOOP.) THE 1 INCH DRAIN LINE WILL BE REPLACED. CAUSE FOR THE FAILURE IS UNKNOWN AT THIS TIME.
ARKANSAS-1 RESIDUAL HEAT REMOV SYS + CONT COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR OTHER ITEM NOT APPLICABLE	05000313 79-013/03L-0 026695	080879 082879 30-DAY	DURING NORMAL COLD SHUTDOWN OPERATION, DECAY HEAT BORON CONCENTRATION WAS NOT MONITORED DURING PRESCRIBED INTERVAL AS REQUIRED BY T.S.4.16, TABLE 4.1-3, ITEM 1F. INSERVICE DECAY HEAT LOOP WAS SWITCHED WITHOUT SWITCHING SAMPLE LINEUP, RESULTING IN SAMPLING OF OUT OF SERVICE LOOP. THERE HAVE BEEN NO SIMILAR OCCURRENCES. THIS OCCURRENCE IS REPORTABLE PER T.S. 6.12.3.2B. CAUSE WAS A BREAKDOWN IN COMMUNICATIONS BETWEEN OPERATIONS & RADIOCHEMISTRY DEPARTMENTS. RADIOCHEMISTS WERE INSTRUCTED TO VERIFY SAMPLE LINEUP THROUGH OPERATIONS. A DESIGN CHANGE IS BEING EVALUATED TO ADD CHECK VALVES IN SAMPLE LINES TO PREVENT INADVERTANT SAMPLING OF OUT OF SERVICE LOOP.
ARKANSAS-1 REACTOR VES. + APPURTENANCES COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR MAINTENANCE & REPAIR PERSONNEL ITEM NOT APPLICABLE	05000313 79-011/01T-0 026699	080979 082379 2-WEEK	DURING A NRC PERFORMANCE APPRAISAL TEAM INTERVIEW, IT WAS DISCOVERED THAT PRESSURIZER SAFETY RELIEF VALVE, PSV-1002, WAS NOT PROPERLY TESTED IN MAR, 1978. DOCUMENTATION REVEALED ACCEPTANCE CRITERIA OF PROCEDURE 401.03, REQUIRING TWO CONSECUTIVE LIFTS AT 2500 +/- 1% PSI, WAS NOT MET. AN NRC PLANT SAFETY COMMITTEE (PSC) RULED TEST WAS NOT PERFORMED SATISFACTORILY. THERE HAVE BEEN NO SIMILAR OCCURRENCES. THIS OCCURRENCE REPORTABLE PER T.S. 6.12.3.1.F. TEST ACCEPTABILITY WAS INITIALLY JUSTIFIED BASED ON HIGH PRESSURE GAGE INDICATION DUE TO EXCEEDINGLY HOT AMBIENT TEMPERATURE. VALVE WAS RETESTED ON 8/12/79, SUCCESSFULLY, WITH NO ADJUSTMENT NECESSARY.

1543 023

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTRO' NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
ARKANSAS-1 OTHER AUX SYSTEMS + CONTROLS VALVES GATE COMPONENT FAILURE MECHANICAL PRATT, HENRY CO.	05000313 79-012/03L-0 026900	081079 083179 30-DAY	DURING COLD SHUTDOWN OPERATION, LEAK RATE TESTING OF REACTOR BUILDING PENETRATION V-1, PER PROCEDURE 1304.23, REVEALED A LEAK RATE IN EXCESS OF 50,000 CC/MIN. IT WAS DETERMINED TO BE CAUSED BY THE OUTSIDE ISOLATION VALVE, CV-7402. THE INSIDE ISOLATION VALVE, CV-7404, DID NOT LEAK. THIS OCCURRENCE IS SIMILAR TO LER 50-313/79-005 AND 77-15. REPORTABLE PER T.S. 6.12.3.2B.
ARKANSAS-1 REACTOR TRIP SYSTEMS RELAYS SWITCHGEAR, PROTECTIVE COMPONENT FAILURE ELECTRICAL WESTINGHOUSE ELECTRIC CORP.	05000313 79-014/99X-0 026910	081379 091279 OTHER	INVESTIGATION REVEALED THAT THE VALVE REQUIRED AN ADJUSTMENT OF ITS SHIMS ON THE VALVE SEAT TO MATCH THE SURFACE OF THE BUTTERFLY. ADJUSTMENTS WERE MADE AND THE LEAK RATE RETESTED, MEETING THE 60% LA REQUIREMENT OF T.S. 4.4.1.2.3. TEST FREQUENCY INCREASED FROM QUARTERLY TO AFTER EVERY R.B. PURGE. WHILE INCREASING POWER, AT APPROXIMATELY 75% REACTOR POWER, SWITCHYARD RELAY, 21Z1, FAILED, CAUSING A TURBINE TRIP. TURBINE LOCK-OUT RELAY, 286-T, FAILED TO OPERATE, DEFEATING THE GENERATOR LOCK-OUT & THE RECENTLY ADDED "REACTOR TRIP ON TURBINE TRIP". THE DEGRADED FREQUENCY DURING COASTDOWN RESULTED IN BUSES A2 AND H1 UNDERVOLTAGE, CAUSING SLOW AUXILIARY POWER TRANSFER WHEN GENERATOR LOCK-OUT WAS RECEIVED FROM REACTOR TRIP (ON HIGH RC PRESSURE). INVESTIGATION REVEALED THAT THE TURBINE LOCK-OUT RELAY, 286-T, HAD LOOSE TERMINALS ON THE LEADS TO THE TURBINE, WITH ONE LUG FAILED. THE FAILED LUG WAS REPLACED AND THE TERMINALS WERE TIGHTENED. THE TURBINE LOCK-OUT AND "REACTOR TRIP ON TURBINE TRIP INTERLOCKS WERE TESTED WITH SATISFACTORY RESULTS.
ARKANSAS-1 OTHER SYSTEMS HANGERS,SUPPORTS,SHOCK SUPPRSS HANGERS DESIGN/FABRICATION ERROR CONSTRUCTION/INSTALLATION BECHTEL CORP.	05000313 79-015/99X-0 026893	081779 091479 OTHER	AS A RESULT OF THE ANALYSIS OF SEISMIC CATEGORY I PIPE SUPPORTS FOR BASE PLATE FLEXIBILITY AS REQUESTED IN NRC IE BULLETIN 79-02, THIRTY-SEVEN RESTRAINTS HAVE BEEN IDENTIFIED AS HAVING A SAFETY FACTOR OF LESS THAN TWO. REFER TO THE RESPONSE TO IE BULLETIN 79-02 FOR IDENTIFICATION. THERE HAVE BEEN NO SIMILAR OCCURRENCES. REPORTABLE PER T.S. 6.12.
ARKANSAS-1 EMERG GENERATOR SYS + CONTROLS ENGINES,INTERNAL COMBUSTION SUBCOMPONENT NOT APPLICABLE COMPONENT FAILURE MECHANICAL STEWART & STEVENSON SERV INC.	05000313 79-016/03L-0 026894	082779 091479 30-DAY	ALL PIPE SUPPORTS WITH A SAFETY FACTOR OF LESS THAN TWO HAVE BEEN MODIFIED. REFER TO THE RESPONSE TO THE IE BULLETIN 79-02 FOR DETAILS. DURING THE MONTHLY SURVEILLANCE OPERATIONAL TEST, DIESEL GENERATOR #2 TRIPPED ON LOW OIL PRESSURE AFTER APPROXIMATELY THREE MINUTES OF OPERATION. DIESEL GENERATOR #1 WAS DEMONSTRATED OPERABLE IMMEDIATELY PER SURVEILLANCE PROCEDURE 1104.36 SUPPLEMENT I. UNIT POWER OPERATION WAS CONTINUED BASED ON MEETING THE REQUIREMENTS OF T.S. 3.7.1C. LER 50-313/75-009 INVOLVED THE LUBE OIL COOLER, BUT WAS NOT SIMILAR IN NATURE. REPORTABLE PER T.S. 6.12.3.2B. THE DIESEL LUBE OIL COOLER WAS LEAKING ALLOWING WATER TO ENTER THE OIL SYSTEM. THE WATER VAPORIZED ON UNIT OPERATION CAUSING A HIGH CRANKCASE PRESSURE, WHICH ULTIMATELY CAUSED THE OIL SWITCHES TO TRIP THE ENGINE. THE OIL COOLER WAS REPLACED AND THE DIESEL GENERATOR SUCCESSFULLY TESTED WITHIN THE 7 DAYS ALLOWED BY T.S. 3.7.1C.

1543 024

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
ARKANSAS-2 COOL SYS FOR REAC AUX + CONT VALVE OPERATORS ELECTRIC MOTOR - AC COMPONENT FAILURE MECHANICAL WESTON HYDRAULICS DIV.	05000368 78-068/03L-0 026703	081278 090579 30-DAY	DURING MODE 2 OPERATION, EMERGENCY FEEDWATER FLOW CONTROL VALVE, 2CV-102 5-1, FROM THE ELECTRIC DRIVEN EFW PUMP, 2P7B, TO THE "A" STEAM GENERATOR, FAILED TO FULLY CLOSE FROM A CONTROL ROOM DEMAND SIGNAL. THE REDUNDANT EFW VALVES WERE SUCCESSFULLY STROKED FROM THE CONTROL ROOM. THIS OCCURRENCE IS SIMILAR TO LER 50-368/79-051, 79-043, 79-035, AND 78-28. REPORTABLE PER T.S. 6.9.1.9B. INVESTIGATION REVEALED THAT THE LIMIT STOP SWITCH WAS OUT OF ALIGNMENT. REALIGNMENT WAS MADE AND THE VALVE WAS SUCCESSFULLY STROKE TESTED. THE VALVE WAS DECLARED OPERABLE WITHIN 7 HOURS, MEETING THE REQUIREMENT OF ACTION STATEMENT T.S. 3.7.1.2.
ARKANSAS-2 OTHER SYSTEMS HANGERS, SUPPORTS, SHOCK SUPPRESS HANGERS DESIGN/FABRICATION ERROR CONSTRUCTION/INSTALLATION BECHTEL CORP.	05000368 79-058/03X-1 026702	072479 052079 OTHER	AS A RESULT OF THE ANALYSIS OF SEISMIC CATEGORY I PIPE SUPPORTS FOR BASE PLATE FLEXIBILITY AS REQUESTED IN NRC IE BULLETIN 79-02, NINE RESTRAINTS HAVE BEEN IDENTIFIED AS HAVING A SAFETY FACTOR OF < 2. REFER TO RESPONSE OF IE BULLETIN 79-02 FOR IDENTIFICATION. IT WAS REQUIRED TO DECLARE THE R.B. SUMP DRAIN, OUTSIDE CONTAINMENT ISOLATION VALVE, 2CV-2061, INOPERABLE DUE TO THE INADEQUATE PIPE RESTRAINTS. THERE HAVE BEEN SIMILAR OCCURRENCES. REPORTABLE PER T.S. 6.9.1.9B. ALL PIPE SUPPORTS WITH A SAFETY FACTOR OF LESS THAN TWO HAVE BEEN MODIFIED. REFER TO THE RESPONSE TO THE IE BULLETIN 79-02 FOR DETAILS.
ARKANSAS-2 AREA MONITORING SYSTEMS INSTRUMENTATION + CONTROLS SENSOR/DETECTOR/ELEMENT COMPONENT FAILURE INSTRUMENT WESTINGHOUSE ELECTRIC CORP.	05000368 79-059/03L-0 026694	073079 082879 30-DAY	DURING MODE 1 OPERATION, CONTROL ROOM RADIATION MONITOR, 2RITS-8750-1, POWER SUPPLY FAILED, RESULTING IN A FALSE HIGH INDICATION, CAUSING ISOLATION OF CONTROL ROOM VENTILATION. THERE WERE NO HIGH RADIATION EVENTS; THEREFORE, PUBLIC & OPERATING PERSONNEL SAFETY WAS NOT ENDANGERED. OTHER OCCURRENCES INVOLVING RADIATION MONITORS ARE: LER 50-368/79-047 & 79-057. THIS OCCURRENCE REPORTABLE PER T.S. 6.9.1.9B. INVESTIGATION REVEALED +/- 15 VOLT POWER SUPPLY INOPERABILITY WAS DUE TO A CIRCUITRY FAILURE. POWER SUPPLY WAS REPAIRED, OPERATIONALLY CHECKED, & RADIATION MONITOR WAS RETURNED TO SERVICE. CONTROL ROOM EMERGENCY VENTILATION SYSTEM WAS PUT IN SERVICE WHILE MONITOR WAS OUT OF SERVICE.
ARKANSAS-2 REACTIVITY CONTROL SYSTEMS CONTROL ROD DRIVE MECHANISMS SUBCOMPONENT NOT APPLICABLE COMPONENT FAILURE INSTRUMENT COMBUSTION ENGINEERING, INC.	05000368 79-062/03L-0 026891	080479 083079 30-DAY	DURING MODE 1, POWER ESCALATION TESTING, IT WAS DISCOVERED THAT FULL LENGTH CEA #39 WOULD NOT MOVE. WITH THE CEA INOPERABLE DUE TO CAUSES OTHER THAN THAT CAUSING MECHANICAL INTERFERENCE, AND BEING WITHIN ITS ALIGNMENT REQUIREMENTS, OPERATION IN MODE 1 CONTINUED PER T.S. 3.1.3.1.C. THERE HAVE BEEN NO SIMILAR OCCURRENCES. REPORTABLE PER T.S. 6.9.1.9B. INVESTIGATION REVEALED A FAILED CEA ENABLE CARD. THE CARD WAS REPLACED AND CEA #39 WAS SUCCESSFULLY STROKE TESTED. THE CEA WAS DECLARED OPERABLE WITHIN APPROXIMATELY ONE HOUR OF THE FAILURE DETECTION.

1543 025

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER I.D./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
ARKANSAS-2 CONTAINMENT ISOLATION SYS + CONT VALVE OPERATORS SOLENOID - AC COMPONENT FAILURE MECHANICAL TARGET ROCK CORPORATION	05000368 79-063/03L-0 026905	080679 083179 30-DAY	DURING MODE 1 OPERATION, THE CONTAINMENT ATMOSPHERE SAMPLE REACTOR BUILDING PENETRATION OUTSIDE ISOLATION VALVE, 2SV-8263-2, WOULD NOT INDICATE CLOSED DURING A STROKE TEST. THE INSIDE VALVE, 2SV-8265- , AT PENETRATION 2P58, WAS VERIFIED OPERABLE. THIS OCCURRENCE IS SIMILAR TO LER 50-368/79-044, 79-060, AND 79-061. OCCURRENCE IS REPORTABLE PER T.S. 6.9.1.9B. INVESTIGATION REVEALED THAT THE LIMIT SWITCH WAS OUT OF ADJUSTMENT. THE LIMIT WAS ADJUSTED AND THE VALVE WAS PROVEN OPERABLE PER T.S. 4.6.3.1.1, TABLE 3.6-1. THE VALVE WAS RETURNED TO SERVICE IN LESS THAN TWO HOURS, MEETING THE REQUIREMENT OF ACTION STATEMENT T.S. 3.6.1A.
ARKANSAS-2 REACTOR TRIP SYSTEMS INSTRUMENTATION + CONTROLS COMPUTATION MODULE COMPONENT FAILURE INSTRUMENT COMBUSTION ENGINEERING, INC.	05000368 79-064/03L-0 026705	080779 090579 30-DAY	DURING MODE 1 OPERATION, THE CPC TRIPS IN "D" PPS WERE PLACED IN BYPASS TO INVESTIGATE OSCILLATIONS IN THE "DELTA-T" POWER INDICATION. POWER OPERATION WAS CONTINUED BASED ON MEETING THE REQUIREMENTS OF ACTION STATEMENT #2 OF T.S. TABLE 3.3.-1. THIS OCCURRENCE IS SIMILAR TO LER 50-368/79-015. REPORTABLE PER T.S. 6.9.1.9B. THE "DELTA-T" POWER CALCULATION OSCILLATION WAS DUE TO A COLD LEG TEMPERATURE INDICATION OSCILLATION. AN UNRELATED PLANT TRIP OCCURRED DURING THE INVESTIGATION. THE INVESTIGATION CONTINUED DURING THE OUTAGE. ALL RELATED SIGNAL CONNECTIONS WERE TIGHTENED AND THE CONDITION DID NOT REAPPEAR.
ARKANSAS-2 PROCESS + EFF RADIOL MONITOR SYS INSTRUMENTATION + CONTROLS SENSOR/DETECTOR/ELEMENT COMPONENT FAILURE MECHANICAL WESTINGHOUSE ELECTRIC CORP.	05000368 79-067/04L-0 026704	080879 090579 30-DAY	DURING MODE 1 OPERATION, THE AUXILIARY BUILDING RADWASTE AREA RADIATION MONITOR, 2RE-E542, SAMPLE PUMP WAS FOUND WITH A BROKEN COUPLING. GASEOUS RELEASES WHICH UTILIZE THE SUBJECT MONITOR WERE SAMPLED AND ANALYZED WITH LESS THAN MINIMUM DETECTABLE RESULTS. THIS OCCURRENCE IS SIMILAR TO LER 50-368/79-057. REPORTABLE PER E.T.S. 5.6.2B. APPROPRIATE GRAB SAMPLES WERE TAKEN WHILE THE MONITOR WAS OUT OF SERVICE, ONCE PER SHIFT, AS REQUIRED BY E.T.S. 2.2.2.7. THE PLASTIC COUPLING WAS REPLACED WITH A METAL COUPLING.
ARKANSAS-2 PROCESS SAMPLING SYSTEMS VALVES BALL COMPONENT FAILURE MECHANICAL E. B. V. SYSTEMS, INC.	05000368 79-066/03L-0 026903	080979 083179 30-DAY	DURING MODE 1 OPERATION, FOLLOWING ROUTINE DRAINING OPERATION OF THE REACTOR DRAIN TANK, CONTAINMENT ISOLATION VALVE, 2CV-2201-2, WOULD NOT FULLY CLOSE. THE AFFECTED PENETRATION WAS ISOLATED WITHIN ONE HOUR BY DEACTIVATING 2CV-2202-1 IN THE CLOSED POSITION, MEETING THE REQUIREMENTS OF ACTION STATEMENT T.S. 3.6.3.1B. OTHER OCCURRENCES ON CONTAINMENT PENETRATIONS ARE 50-368/79-063, 79-061, 79-060, 79-044, & 78-19. REPORTABLE PER T.S. 6.9.1.9B. INVESTIGATION REVEALED FOREIGN MATERIAL HAD DAMAGED SEATS AND BALL CAUSING VALVE TO LEAK THROUGH. THE VALVE WAS DISASSEMBLED, CLEANED AND REASSEMBLED. NO REPLACEMENT PARTS WERE AVAILABLE, THE INSIDE CONTAINMENT ISOLATION VALVE, 2CV-2201-1 REMAINS DEACTIVATED IN THE CLOSED POSITION.

1543 026

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
ARKANSAS-2 DC ONSITE POWER SYS + CONTROLS BATTERIES + CHARGERS SUBCOMPONENT NOT APPLICABLE COMPONENT FAILURE ELECTRICAL POWER CONVERSION PRODUCTS, INC	05000368 79-065/03L-0 026904	080979 083179 30-DAY	DURING MODE 1 OPERATION, BATTERY CHARGER, 2D31, FAILED RENDERING THE "A" DC BUS INOPERABLE PER T.S. 3.8.2.3B. BATTERY CHARGER, 2D32, REMAINED OPERABLE AND 2D34 WAS PLACED IN SERVICE, RESTORING THE "A" BUS TO AN OPERABLE STATUS WITHIN 10 MINUTES OF THE FAILURE DETECTION PER T.S. 3.8.2.3B. THERE HAVE BEEN NO SIMILAR OCCURRENCES. REPORTABLE PER T.S. 6.9.1.9B.
			INVESTIGATION REVEALED THE D.C. OUTPUT LAMP SOCKET BURNED UP, CAUSING THE OUTPUT BREAKER TO TRIP. THE FAILURE WAS CAUSED BY HIGHER VOLTAGE DUE TO HEAT AND INCREASED RESISTANCE IN LAMP CIRCUIT. DUST IN THE UNIT WAS HAMPERING ITS VENTILATION. THE UNIT WAS CLEANED AND REPAIRED.
ARKANSAS-2 EMERG GENERATOR SYS + CONTROLS CIRCUIT CLOSERS/INTERRUPTERS SWITCH (OTHER THAN SENSOR) COMPONENT FAILURE ELECTRICAL GENERAL ELECTRIC CO.	05000368 79-069/03L-0 026706	081479 090579 30-DAY	DURING MODE 2 OPERATION, FOLLOWING THE COMPLETION OF THE SURVEILLANCE TEST RUN ON DIESEL GENERATOR #2, THE DIESEL COULD NOT BE STOPPED FROM THE CONTROL ROOM HANDSWITCH, 2HS-2829-2. THE DIESEL WAS STOPPED FROM THE LOCAL HANDSWITCH.
			INVESTIGATION REVEALED THAT THE INTERNAL SPRING ON THE HANDSWITCH CONTACT WAS OUT OF ADJUSTMENT. THE SPRING AND SWITCH CONTACTS WERE ADJUSTED AND TESTED SATISFACTORILY. THE SURVEILLANCE TEST WAS COMPLETED AND THE DIESEL GENERATOR DECLARED OPERABLE MEETING REQUIREMENTS OF ACTION STATEMENT T.S. 3.8.1.1A.
ARKANSAS-2 ONSITE POWER SYSTEM + CONTROL RELAYS OTHER COMPONENT FAILURE ELECTRICAL WESTINGHOUSE ELECTRIC CORP.	05000368 79-070/03L-0 026911	081679 091279 30-DAY	DURING MODE 1 OPERATION, BATTERY ELIMINATOR, 2D35, FAILED, CAUSING REACTOR TRIP BREAKERS, TCB3 AND TCB7, TO OPEN, RENDERING ONE CHANNEL INOPERABLE PER T.S. 3.3.1.1 TABLE 3.3-1 ITEM #14. THIS PUT THE BREAKERS IN THE TRIPPED CONDITION AS REQUIRED BY ACTION STATEMENT T.S. TABLE 3.3-1 ACTION #4. ALL OTHER REACTOR TRIP BREAKERS REMAINED CLOSED AND OPERABLE. THERE HAVE BEEN NO SIMILAR OCCURRENCES. REPORTABLE PER T.S. 6.9.1.9B.
			INVESTIGATION REVEALED THAT 2D35 HAD A RELAY COIL FAILED DUE TO A STICKING PLUNGER. THE REACTOR TRIP BREAKERS OPENED ON UNDERVOLTAGE. THE RELAY WAS REPLACED AND THE BREAKERS WERE RECLOSED WITHIN FOUR HOURS OF THE FAILURE DETECTION.
ARKANSAS-2 REACTOR TRIP SYSTEMS INSTRUMENTATION + CONTROLS COMPUTATION MODULE COMPONENT FAILURE INSTRUMENT SYSTEMS ENGINEER. LABS., INC.	05000368 79-071/03L-0 026912	081879 091279 30-DAY	DURING MODE 1 OPERATION, THE "B" CORE PROTECTION CALCULATOR FAILED CAUSING LOW DNBR AND HIGH LPD TRIPS IN THE "B" PPS. ALL REMAINING CPC CHANNELS REMAINED OPERABLE. THE DNBR AND LPD TRIPS IN THE "B" PPS WERE BYPASSED, PLACING THE REACTOR TRIP LOGIC IN A 2 OUT OF 3 CONDITION. THIS OCCURRENCE IS SIMILAR TO LER 50-368/79-052. REPORTABLE PER T.S. 6.9.1.9B.
			INVESTIGATION REVEALED A MEMORY FAILURE. THE MEMORY MODULE WAS REPLACED, SOFTWARE LOADED, CPC FUNCTIONALLY TESTED, AND RETURNED TO SERVICE WITHIN 7 HOURS MEETING ACTION STATEMENT T.S. TABLE 3.3-1 ACTION 2A.

1543 027

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
ARKANSAS-2 COOL SYS FOR REAC AUX + CONT TURBINES SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE TERRY STEAM TURBINE COMPANY	05000368 79-072/03L-0 026913	081879 091279 30-DAY	IMMEDIATELY FOLLOWING A PLANT TRIP, THE EMERGENCY FEEDWATER PUMP TURBINE DRIVER, 2K3, FOR PUMP 2P7A TRIPPED ON OVERSPEED UPON RECEIPT OF EFAS SIGNAL. THE ELECTRIC DRIVEN PUMP, 2P7B, WAS STARTED MANUALLY AT APPROXIMATELY THE SAME TIME AS THE ACTUATION SYSTEM, RATHER THAN DELAYED AS PROGRAMMED WITH AUTO ACTUATION. THIS OCCURRENCE IS SIMILAR TO LER 50-368/79-055. REPORTABLE PER T.S. 6.9.1.9B. THE APPARENT CAUSE WAS STICKY LINKAGE ON THE TURBINE GOVERNOR; AND THE SIMULTANEOUS START OF 2P7B DROPPING THE SUCTION PRESSURE, THUS REDUCING THE PUMPING RESISTANCE. PROCEDURE CHANGED TO CAUTION AGAINST SIMULTANEOUS STARTS.
ARKANSAS-2 REACTIVITY CONTROL SYSTEMS INSTRUMENTATION + CONTROLS COMPUTATION MODULE COMPONENT FAILURE INSTRUMENT SYSTEMS ENGINEER. LABS., INC.	05000368 79-073/03L-0 026914	082079 091279 30-DAY	DURING MODE 1 OPERATION, ALL CEA CALCULATOR INPUTS TO THE CPC'S WERE PLACED IN THE INOP FOR DIAGNOSTIC TESTING OF CEAC OUTPUTS FOLLOWING SPURIOUS PENALTY FACTOR OUTPUTS WHICH CAUSED A REACTOR TRIP. CONTINUATION OF MODE 1 OPERATION WAS ALLOWED BY MEETING THE REQUIREMENTS OF T.S. ACTION STATEMENT T.S. TABLE 3.3-1, ACTION 5B. THERE HAVE BEEN NO SIMILAR OCCURRENCES. THIS OCCURRENCE IS REPORTABLE PER T.S. 6.9.1.9B. REPORTING OF MAINTENANCE ACTIVITY CAUSED BY NECESSITY OF ENTERING A T.S. ACTION STATEMENT. THE HIGH CEAC PENALTY FACTORS WERE CAUSED BY DIRTY INPUT CARD CONTACTS. THE EDGE CONNECTOR WAS CLEANED AND CEAC'S VERIFIED OPERABLE PER PROCEDURES 2304.108 AND 2304.109.
ARKANSAS-2 AIR COND.HEAT.COOL.VENT SYSTEM HEAT EXCHANGERS COOLER COMPONENT FAILURE MECHANICAL CVI CORP.	05000368 79-076/03L-0 026897	082179 092079 30-DAY	DURING MODE 1 OPERATION, THE CONTROL ROOM EMERGENCY AIR CONDITIONING UNIT 2VE1B, FAILED TO START ON DEMAND FROM THE CONTROL ROOM. THE REDUNDANT EMERGENCY AIR CONDITIONING SYSTEM WAS VERIFIED OPERABLE. OTHER OCCURRENCES INVOLVING THE EMERGENCY CONTROL AIR CONDITIONING ARE LER 50-368/79-050. THIS OCCURRENCE IS REPORTABLE PER T.S. 6.9.1.9B. IMMEDIATE CORRECTIVE ACTION WAS TO RESET THE LOW DISCHARGE OIL PRESSURE SWITCH AND PROVE OPERABLE PER PROCEDURE 2104.34. INVESTIGATION REVEALED A CRANKCASE OIL LEAK. THE LEAK WAS REPAIRED, OIL AND FREON WERE ADDED, AND THE UNIT WAS OPERATIONAL CHECKED OUT.
ARKANSAS-2 OTHER INST SYS REQD FOR SAFETY INSTRUMENTATION + CONTROLS POWER SUPPLY COMPONENT FAILURE INSTRUMENT LAMBDA ELECTRONICS	05000368 79-074/03L-0 026907	082179 091279 30-DAY	DURING MODE 1 OPERATION, THE "A" CPC TRIPS WERE BYPASSED TO ALLOW THE CHANGE OUT OF THE RSPT POWER SUPPLIES WHICH WERE CAUSING ERRONEOUS POSITION INDICATION INPUTS TO THE CPC. THE PULSE COUNTER FROM CEAC #2 AND THE UPPER ELECTRICAL LIMITS WERE AVAILABLE FOR CEA POSITION INDICATIONS. THERE HAVE BEEN NO SIMILAR OCCURRENCES. THIS OCCURRENCE IS RELATED TO LER 50-368/79-073. REPORTABLE PER T.S. 6.9.1.9B. THE "A" CPC WAS TAKEN OUT OF SERVICE AS A PRECAUTIONARY STEP DURING THE MAINTENANCE ACTIVITY IN THE CPC CABINET. THE RSPT POWER SUPPLIES WERE CHANGED OUT AND THE "A" CPC WAS RETURNED TO SERVICE WITHIN THREE HOURS MEETING THE REQUIREMENTS OF ACTION STATEMENT T.S. TABLE 3.3-1 ACTION 2A.

1543 028

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
ARKANSAS-2 REACTOR TRIP SYSTEMS INSTRUMENTATION + CONTROLS COMPUTATION MODULE COMPONENT FAILURE INSTRUMENT OTHER	05000368 79-075/03L-0 026906	082279 091279 30-DAY	DURING MODE 1 OPERATION, THE DATA LINK FROM CEAC #1 TO THE "B" CPC DROPPED A BIT CAUSING AN INACCURATE OUTPUT INDICATION, RESULTING IN THE "B" CPC CHANNEL TRIPPING. THE DATA LINK FAILED IN THE CONSERVATIVE DIRECTION AND THE REMAINING CEAC DATA LINKS WERE OPERABLE. THERE HAVE BEEN NO SIMILAR OCCURRENCES. REPORTABLE PER T.S. 6.9.1.9B. THE DATA LINK OUTPUT ERROR WAS CAUSED BY A FAILED OPTICAL AMPLIFIER. THE DATA LINK WAS REPAIRED AND THE "B" CPC RETURNED TO SERVICE WITHIN ONE HOUR MEETING THE REQUIREMENTS OF ACTION STATEMENT T.S. TABLE 3.3-1 ACTION 2A.
ARKANSAS-2 EMERG CORE COOLING SYS + CONT VALVE OPERATORS ELECTRIC MOTOR - AC COMPONENT FAILURE ELECTRICAL E P G (DIV OF GULF-W)	05000368 79-077/03L-0 026896	082679 092079 30-DAY	DURING MODE 1 OPERATION, THE "D" SAFETY INJECTION TANK, 2T2D, LEVEL COULD NOT BE MAINTAINED ABOVE THE 80.1% INDICATED LEVEL AS REQUIRED BY T.S. 3.5.1B DUE TO MAKEUP VALVE, 2CV-5064, FAILING TO OPEN ON COMMAND. THE OTHER SAFETY INJECTION TANKS REMAINED OPERATIONAL. AN OCCURRENCE INVOLVING SAFETY INJECTION TANKS IS LER 50-368/79-16; HOWEVER, IT IS NOT SIMILAR. THIS OCCURRENCE IS REPORTABLE PER T.S. 6.9.1.9B. SAFETY INJECTION TANK MAKEUP VALVE, 2CV-5064, WAS MANUALLY OPENED AND LEVEL WAS RETURNED TO NORMAL IN LESS THAN TWO HOURS, MEETING THE REQUIREMENT OF ACTION STATEMENT T.S. 3.5.1 ACTION A. THE SPRING TENSION WAS ADJUSTED ON THE VALVE OPERATOR GATE AND IT WAS RETURNED TO OPERATIONAL STATUS. AT 1020 HOURS, THE LOOP B DELTA T-TAVG INDICATION FAILED DOWNSCALE. AT 1046 HOURS, THE INSTRUMENT LOOP BISTABLES WERE PLACED IN THE TRIPPED CONDITION. REDUNDANT INSTRUMENTATION REMAINED AVAILABLE UNTIL THE INSTRUMENT LOOP WAS RETURNED TO SERVICE AT 1940 HOURS ON 4/25/78.
BEAVER VALLEY-1 REACTOR TRIP SYSTEMS INSTRUMENTATION + CONTROLS POWER SUPPLY COMPONENT FAILURE INSTRUMENT WESTINGHOUSE ELECTRIC CORP.	05000334 78-034/03L-0 026843	042478 091879 30-DAY	THE INCIDENT RESULTED FROM THE FAILURE OF A CAPACITOR IN LOW LEVEL AMPLIFIER [TM-RC-422H] FOR LOOP B HOT LEG TEMPERATURE. THE CAPACITOR WAS REPLACED AND THE LOOP WAS TESTED AND RETURNED TO OPERATION.
BEAVER VALLEY-1 STATION SERV WATER SYS + CONT COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR OTHER ITEM NOT APPLICABLE	05000334 79-001/04T-0 026810	010479 011979 2-WEEK	PLANT SHUTDOWN WITH ALL COOLING TOWER PUMPS SECURED. ON 1/4/79, CHLORINATION WAS PERFORMED IN RIVER WATER SYSTEMS AND BOTH CONDENSER SECTIONS. AT 1520 HRS, HIGH ALARM ON THE CHLORINE ANALYZER AT THE OUTFALL STRUCTURE WAS RECEIVED. AT 1530 HRS, FREE CHLORINE RESIDUALS REACHED A MAXIMUM OF 2.0 PPM, & AT 1610 HRS, RETURNED TO <0.5 PPM. AT 1745 HRS, HIGH ALARM WAS AGAIN RECEIVED & MAXIMUM FREE CHLORINE RESIDUAL WAS 0.65 PPM. AT 1815 HOURS, IT RETURNED TO LESS THAN 0.5 PPM. WITH NO COOLING TOWER PUMPS OPERATING, FLOW THROUGH CONDENSER IS REVERSE DUE TO OPERATION OF PLANT RIVER WATER SYSTEMS. THEREFORE, ANY CHLORINE ADDITIONS INTENDED FOR CONDENSER ARE BACKWASHED TO RIVER WITHOUT PASSING THROUGH THE CONDENSER. PERSONNEL HAVE BEEN INSTRUCTED TO CHLORINATE ONLY WITH AT LEAST ONE COOLING TOWER PUMP IN OPERATION.

1543 029

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
BEAVER VALLEY-1 REACTOR TRIP SYSTEMS INSTRUMENTATION + CONTROLS COMPUTATION MODULE COMPONENT FAILURE INSTRUMENT WESTINGHOUSE ELECTRIC CORP.	05000334 79-025/03L-0 026970	062479 082379 30-DAY	DURING A RECORDS REVIEW ON 7/24/79, IT WAS DISCOVERED THAT THE RESULTS OF A SURVEILLANCE TEST PERFORMED ON 6/24/79 WERE UNSATISFACTORY. THE BIASING CIRCUIT FOR THE CHANNEL 2 DELTA T-AVG SIGNAL SUMMATOR WAS PRODUCING AN OUTPUT SIGNAL SETPOINT APPROXIMATELY 25 DEGREES LESS THAN REQUIRED. THIS FAILURE WAS IN THE CONSERVATIVE DIRECTION AND WOULD HAVE RESULTED IN THE CHANNEL TRIPPING SOONER THAN REQUIRED. THE INCIDENT RESULTED FROM A FAILURE OF THE INSTRUMENT LOOP SIGNAL SUMMATOR. THE SUMMATOR WAS REPLACED AND THE LOOP WAS CALIBRATED SUCCESSFULLY
BEAVER VALLEY-1 CONTAINMENT COMBUSTION GAS CONTROL SYSTEMS ELECTRICAL CONDUCTORS SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR OTHER ATOMICS INTERNATIONAL	05000334 79-022/03L-0 026995	072279 081779 30-DAY	ON JULY 2, 1979, ROCKWELL INTERNATIONAL INFORMED BVPS OF A POTENTIAL FOR FAILURE OF THE INTERCONNECTING POWER CABLES ON THE CONTAINMENT HYDROGEN RECOMBINERS. AT ANOTHER SITE, ONE OF THE POWER CONDUCTORS IN THE POWER CABLE MELTED AT THE CONNECTOR WHICH PLUGS INTO THE RECOMBINER JUNCTION BOX. WHILE DISASSEMBLING MAIN POWER CONNECTOR ON 1A RECOMBINER AT BVPS FOR INSPECTION, 3 OF THE 4 WIRES WERE LOOSE & PULLED OUT OF THE CONNECTOR. THERE WAS NO EVIDENCE OF OVERHEATING. INCIDENT RESULTED FROM INSUFFICIENT SETSCREW TORQUE ON THE WIRES IN THE PINS OF THE POWER CONNECTOR. THE WIRES WERE REINSTALLED WITH THE CORRECT SETSCREW TORQUE AND SATISFACTORILY TESTED. THE FOUR WIRES IN THE CONNECTOR OF THE 1B RECOMBINER WERE INSPECTED AND VERIFIED TO HAVE BEEN INSTALLED CORRECTLY. AS A RESULT OF A REVIEW OF SIS CABLE USED IN CONTAINMENT, IT WAS DETERMINED WIRE FROM FOUR MANUFACTURERS MAY HAVE BEEN INSTALLED. THREE OF THE FOUR VENDORS HAVE SUPPLIED DOCUMENTATION INDICATING THEIR PRODUCTION RUNS COVERING THE TIME PERIOD THAT THE SIS WIRE WAS PURCHASED AND INSTALLED WOULD HAVE QUALIFIED FOR THE HOSTILE POST LOCA CONTAINMENT ENVIRONMENT.
BEAVER VALLEY-1 OTHER INST SYS REQD FOR SAFETY ELECTRICAL CONDUCTORS SUBCOMPONENT NOT APPLICABLE DESIGN/FABRICATION ERROR DESIGN ITEM NOT APPLICABLE	05000334 79-019/01X-1 026373	072379 081779 OTHER	REVIEW OF AFFECTED EQUIPMENT IN CONTAINMENT BY ONSITE SAFETY COMMITTEE HAS DETERMINED THAT 4 VALVES REQUIRE WIRE REPLACEMENT PRIOR TO STARTUP. REMAINING VALVES THAT DO NOT HAVE QUALIFIED SIS WIRE CLOSE ON CIB & WOULD NOT BE REQ. TO BE REOPENED TO MITIGATE CONSEQUENCES OF AN ACCIDENT. CABLE FOR SAFETY RELATED EQUIP. IN CONTAINMENT TO BE REPL DURING REFUELING. AT 0315 HOURS DURING PERFORMANCE OF A SURVEILLANCE TEST, THE NO. 1 DIESEL GENERATOR OUTPUT BREAKER FAILED TO CLOSE WHEN THE CONTROL SWITCH WAS ACTUATED. IN ADDITION, AN ALARM WAS RECEIVED INDICATING A FAILURE OF THE NO. 1 AIR START MOTORS TO START THE DIESEL GENERATOR. THE DIESEL STARTED ON THE NO. 2 AIR START MOTORS. THE NO. 2 EMERGENCY DIESEL GENERATOR REMAINED OPERABLE THROUGHOUT THE PERIOD.
BEAVER VALLEY-1 EMERG GENERATOR SYS + CONTROLS COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000334 79-023/03L-0 026971	072479 082379 30-DAY	AIR START MOTOR FAILURE RESULTED FROM A STICKING PINION ON AIR MOTOR. PINION ASSEMBLY WAS CLEANED, EXERCISED, & SATISFACTORILY TESTED. TEST CIRCUIT INSTALLED TO MONITOR BREAKER CONTROL CIRCUITRY INDICATED FAILURE OCCURRED IN MANUAL START RELAYS. REPEATED CYCLING OF RELAYS DID NOT PRODUCE ANY FAILURES. DLC ENGINEERING IS INVESTIGATING REPLACEMENT OF RELAYS

1543 030

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
BEAVER VALLEY-1 REACTOR CONTAINMENT SYSTEMS VALVE OPERATORS SOLENOID - DC DESIGN/FABRICATION ERROR DESIGN ASCO	05000334 79-024/01T-1 026501	072779 081779 2-WEEK	AS A RESULT OF REVIEW OF ASCO SOLENOID VALVES PER IE BULLETIN 79-01A, IT HAS BEEN DETERMINED THAT THERE ARE 44 ASCO VALVES INSTALLED IN THE REACTOR CONTAINMENT WHICH HAVE DEFICIENCIES IN ENVIRONMENTAL QUALIFICATIONS. SEVERAL OF THESE VALVES HAVE CLASS HT OR HB HIGH TEMPERATURE COILS BUT NONE OF THE VALVES ARE OF THE NEW NUCLEAR GRADE TYPE NP-1. THE PLANT SAFETY COMMITTEE HAS DETERMINED THERE IS NO HAZARD TO THE GENERAL PUBLIC DURING THE INTERIM OPERATING PERIOD. INADEQUATE DESIGN RESULTED IN INSTALLATION OF SUBJECT SOLENOID VALVES. 44 SOLENOID VALVES WILL BE REPLACED WITH TYPE NP-1 VALVES OR OTHER QUALIFIED VALVES DURING FALL REFUELING OUTAGE. SOLENOID VALVES ON A PRESSURIZED PORV & 2 COMPONENT COOLING WATER ISOLATION VALVES TO EXCESS LETDOWN HEAT EXCHANGER HAVE BEEN REBUILT W/HI TEMP COILS & RENEWED INTERNAL PARTS. AT 0635 HOURS, THE 1C CHARGING PUMP WAS STARTED FOR AN OPERABILITY VERIFICATION FOLLOWING MAINTENANCE. AT 0738 HOURS, A HIGH TEMPERATURE ALARM WAS RECEIVED FOR THE 1C CHARGING PUMP THRUST BEARING. THE 1C CHARGING PUMP WAS SHUTDOWN AT 0742 HOURS. AN INVESTIGATION REVEALED A RIVER WATER SUPPLY VALVE TO THE CHARGING PUMP SPEED INCREASER HAD BEEN INADVERTENTLY LEFT SHUT FOLLOWING MAINTENANCE.
BEAVER VALLEY-1 EMERG CORE COOLING SYS + CONT VALVES GATE PERSONNEL ERROR MAINTENANCE & REPAIR PERSONNEL ITEM NOT APPLICABLE	05000334 79-029/03L-0 026841	081679 091479 30-DAY	THE INCIDENT RESULTED FROM A FAILURE OF MAINTENANCE AND OPERATIONS PERSONNEL TO INSURE THE CHARGING PUMP WAS RETURNED TO SERVICE SATISFACTORILY FOLLOWING MAINTENANCE ACTIVITIES. THE PERSONNEL INVOLVED RECEIVED WRITTEN REPRIMANDS FOR THEIR ACTIONS. ALL MAINTENANCE AND OPERATIONS PERSONNEL WERE APPRISED OF THE INCIDENT AND ITS CONSEQUENCES. DURING A LOAD INCREASE, AT 99 PERCENT POWER, THE CHANNEL 3 OVERPOWER DELTA TEMPERATURE ALARM WAS RECEIVED. AT 1830 HOURS, THE LOOP BISTABLES WERE TRIPPED. THE LOOP WAS CALIBRATED AND RETURNED TO SERVICE AT 1630 HOURS ON 8/29/79. THE HEALTH AND SAFETY OF THE GENERAL PUBLIC WERE NOT JEOPARDIZED AS REDUNDANT INSTRUMENT LOOPS WERE AVAILABLE AND THE LOOP WAS PROTECTING IN THE CONSERVATIVE DIRECTION.
BEAVER VALLEY-1 REACTOR TRIP SYSTEMS INSTRUMENTATION + CONTROLS POWER SUPPLY DEFECTIVE PROCEDURES NOT APPLICABLE WESTINGHOUSE ELECTRIC CORP.	05000334 79-026/03L-0 026972	082779 092779 30-DAY	INSTRUMENT LOOP WAS MISCALIBRATED AS RESULT OF NOT HAVING CURRENT RTD CALIBRATION DATA IN SURVEILLANCE TEST. HOT LEG RTD WAS REPLACED DURING PREVIOUS OUTAGE & NEW CALIBRATION DATA WAS OBTAINED. HOWEVER, NEW DATA WAS NOT INCLUDED IN LOOP CALIBRATION PROCEDURE. MAINTENANCE PROCEDURES WILL BE REVISED TO INSURE REVISIONS PLACED IN CONTROLLED PROCEDURE FILE. A CONTROL ROOM OPERATOR NOTED THAT STATIC INVERTER POWER SUPPLY FOR ONE CONTAINMENT VACUUM RELIEF LOOP WAS DE-ENERGIZED & A BLOWN INPUT FUSE WAS FOUND. FUSE WAS REPLACED & UNIT RESTORED TO OPERABILITY ON 6/16/79. BENCH CHECKING COMPLETED ON 7/10/79 DID NOT REVEAL ANY OTHER DEFECT. REDUNDANT LOOP WAS OPERABLE & NO HAZARD OCCURRED. PREVIOUS FAILURES REPORTED IN RO-78-40 & RO-79-15. REPORTABLE PER TECHNICAL SPECIFICATION 6.9.2.B.(2)
BIG ROCK POINT OTHER ENGRD SAFETY FEATR SYS INSTRUMENTATION + CONTROLS POWER SUPPLY DESIGN/FABRICATION ERROR DESIGN TOPAZ ELECTRONICS	05000155 79-021/03L-0 026880	061679 071379 30-DAY	BASED ON PREVIOUS EXPERIENCE WITH SAME TYPE INVERTER, IT IS HYPOTHESIZED THAT LIGHTLY LOADED INVERTER SHOULD HAVE A DUMMY LOAD TO PRECLUDE FAILURE ON INPUT VOLTAGE TRANSIENTS. EQUIPMENT IS BEING CHECKED ROUTINELY UNTIL THIS MODIFICATION IS COMPLETED. LOAD ADDITION IS PLANNED PRIOR TO PLANT STARTUP.

1543 031

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
BIG ROCK POINT EMERG CORE COOLING SYS + CONT INSTRUMENTATION + CONTROLS SENSOR/DETECTOR/ELEMENT DESIGN/FABRICATION ERROR DESIGN YARWAY CORP.	05000155 79-022/01T-0 026881	082279 090579 2-WEEK	DESIGN REVIEW OF REACTOR VESSEL LEVEL INSTRUMENT SYSTEM, LE RE09 & LS RE 09 REVEALED THAT DURING POSTULATED LOSS OF COOLANT ACCIDENT CONDITIONS, AUTOMATIC INITIATION OF REACTOR SCRAM, CONTAINMENT ISOLATION, & CORE SPRAY ACTUATIONS THAT ARE INITIATED BY THIS SYSTEM MIGHT NOT FUNCTION DUE TO FLASHING THAT COULD OCCUR IN REFERENCE LINE DURING RAPID DEPRESSURIZATION OF PRIMARY SYSTEM. REPORTABLE PER TECH. SPEC. 6.9.2.A (9). THIS ITEM REPRESENTS A GENERIC DESIGN SHORTCOMING THAT WAS IDENTIFIED BY THE N.S.S.S. VENDOR. THE RESOLUTION IS STILL UNDER STUDY TO DETERMINE CORRECTIVE ACTION PRIOR TO PLANT START-UP.
BIG ROCK POINT CNTNMNT ISOLATION SYS + CONT VALVES GATE COMPONENT FAILURE MECHANICAL BLACK-SIVALS-BRYSON	05000155 79-023/03L-0 027093	091179 101079 30-DAY	DURING ROUTINE LEAK RATE TESTS OF AUTOMATIC ISOLATION VALVES IN REACTOR & FUEL PIT DRAIN LINE, VALVE CV/4027 EXHIBITED LEAKAGE OF 80 MILLILITER PER MIN. WHICH IS IN EXCESS OF LIMIT DEFINED IN TECH SPEC 3.7(B). REDUNDANT VALVE CV/4117 WAS OPERABLE & THUS CONTAINMENT INTEGRITY WAS MAINTAINED. SIMILAR LEAKAGE OF THIS VALVE HAS BEEN REPORTED IN RO-73-33 & A0-15-75 DATED 6/10/75. INVESTIGATION REVEALED THAT SEATING SURFACE NEEDED TO BE MACHINED TO REDUCE DISC CONTACT AREA TO PROVIDE TIGHT SHUT-OFF CAPABILITY. NEW SEATS WILL BE INSTALLED ON BOTH VALVES DURING A FUTURE OUTAGE. SEAT WAS MACHINED & A VALVE RETEST WAS SATISFACTORY. REPORTABILITY IS BASED ON TECH SPEC 6.9.2B(2).
BIG ROCK POINT OTHER ENGNRD SAFETY FEATR SYS INSTRUMENTATION + CONTROLS SWITCH COMPONENT FAILURE OTHER STATIC-O-RING	05000155 79-024/03L-0 027092	091379 101079 30-DAY	DURING ROUTINE TESTING OF REACTOR DEPRESSURIZING SYSTEM PUMP DISCHARGE PRESSURE SWITCHES PS789, PS790, PS791, & PS792, SET POINTS WERE FOUND TO BE BETWEEN 1.0 & 3.5 PSI BELOW TECH SPEC REQUIREMENT OF ≥ 100 PSI IN TABLE 3.5.2H. THIS DEFECT WOULD NOT PREVENT ADEQUATE OPERATION OF SYSTEM & NO HAZARD TO PUBLIC EXISTED. INCIDENT IS NOT REPETITIVE. REPORTABLE BASED ON TECH SPEC 6.9.2.B(1). EXACT CAUSE OF INSTRUMENT DRIFT IS NOT KNOWN. A TRENDING HISTORY WILL BE ESTABLISHED FOR THIS SWITCH. THE PRESSURE SWITCHES WERE RESET TO TRIP AT 105 PSIG. SWITCH IS MADE BY STATIC-O-RING AND IS MODEL GHN-G5-M2CIS SX.
BROWNS FERRY-1 SYSTEM CODE NOT APPLICABLE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR CONSTRUCTION PERSONNEL ITEM NOT APPLICABLE	05000259 79-013/01X-1 026456	072379 091279 OTHER	WITH UNIT 1 AT 1035 MWE, UNIT 2 AT 1095 MWE, & UNIT 3 IN OUTAGE, TVA'S FIELD INSPECTION & EVALUATION PROGRAM OF SELF-DRILLING EXPANSION ANCHORS IS CONTINUING IN ACCORD WITH IE BULLETIN 79-02, 79-02 R1, & 79-02 R1 SUPPL 1. TO DATE 875 ANCHORS HAVE BEEN INSPECTED IN SAFETY-RELATED PIPING SYS. 71 DEVIATIONS FOUND. ON NON-SAFETY-RELATED PIPING, 18 BOLT ANCHORS PULL-TESTED, 2 SLIPPED, & 2 PULLED OUT. NO EFFECT TO HEALTH OR SAFETY OF PUBLIC. EVENT REPORTED UNDER T.S. 6.7.2.A.(9). DEVIATIONS DURING INSTALLATION DUE TO REBAR INTERFERENCE SHORTBOLTS & IMPROPERLY SEATED ANCHORS. ANCHORAGES WITH DEVIATIONS BEING EVALUATED BY TVA'S DIVISION OF ENG. DESIGN AS FOUND. DIV OF ENG DESIGN CONTINUING TO EVALUATE RESULTS OF ONGOING INSPECTION PROGRAM. REPAIR PROG TO IMMEDIATELY CORRECT IMPROPERLY INSTALLED ANCHORS IS ONGOING WITH THE INSPECTION EFFORT

1543 032

NOV 08, 1979

LER MONTHLY REPORT SORTED BY FACILITY
PROCESSED DURING OCTOBER, 1979 FOR POWER REACTORS

PAGE 11

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
BROWNS FERRY-1 AC ONSITE POWER SYS + CONTROLS CIRCUIT CLOSERS/INTERRUPTERS SWITCHGEAR COMPONENT FAILURE ELECTRICAL GENERAL ELECTRIC CO.	05000259 79-016/03L-0 026741	080479 083179 30-DAY	DURING NORMAL OPERATION BREAKER CLOSURE SPRING FOR START BUS "1B" NORMAL FEEDER BREAKER WAS FOUND TO BE DISCHARGED. THIS MADE THE BREAKER INOPERABLE FOR CLOSURE WHICH PLACED START BUS "1B" IN AN ABNORMAL CONDITION CONTRARY TO T.S. 3.9.B. THE DIESEL GENERATORS WERE VERIFIED OPERABLE. THERE WAS NO EFFECT ON PUBLIC HEALTH AND SAFETY. THERE HAVE BEEN NO PREVIOUS OCCURRENCES. THE START BUS "1B" NORMAL FEEDER BREAKER SPRING CHARGING MOTOR COMMUTATOR HAD A HOLE BURNED IN IT. THIS CAUSED THE CLOSE CIRCUIT CONTROL FUSES TO BLOW AND ALSO LEFT THE CLOSURE SPRING IN A DISCHARGE CONDITION. THE MOTOR, G.E. 105C9393 P3, WAS REPLACED AND THE BREAKER RETURNED TO SERVICE. DURING NORMAL OPERATION A SMOKE DETECTOR FOR THE AUXILIARY INSTRUMENT ROOM ALARMED AND WOULD NOT CLEAR. THE ALARM WOULD HAVE MASKED SIGNALS FROM DETECTORS WHICH ARE REQUIRED TO BE OPERATIONAL BY T.S. 3.11.C.1. THERE WERE NO EFFECTS ON PUBLIC HEALTH OR SAFETY. THERE ARE NO REDUNDANT SYSTEMS. SIMILAR EVENTS: 296/77-2, 259/78-01, 259/78-09, 296/78-09, 296/78-17, 296/78-23, 296/78-26, 296/78-28.
BROWNS FERRY-1 FIRE PROTECTION SYS + CONT INSTRUMENTATION + CONTROLS SENSOR/DETECTOR/ELEMENT COMPONENT FAILURE NATURAL END OF LIFE KIODE, WALTER & CO	05000259 79-015/03L-0 026742	080579 090479 30-DAY	THE SMOKE DETECTOR WENT INTO ALARM STATE DUE TO INCREASED DETECTOR SENSITIVITY. THE KIDDE FT-200 DETECTOR WAS REPLACED. A FIRE WATCH WAS ESTABLISHED UNTIL REPAIRS WERE MADE.
BROWNS FERRY-1 REACTOR TRIP SYSTEMS COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE GENERAL ELECTRIC CO.	05000259 79-017/03L-0 026740	080979 090779 30-DAY	DUE TO G.E. REEVALUATION OF POST-LOCA CONDITIONS, GE SIL 299, HIGH DRYWELL TEMPERATURE EFFECT ON REACTOR VESSEL WATER LEVEL INSTRUMENTATION, THE REACTOR WATER LEVEL INDICATIONS CAN BE 29 INCHES LESS THAN INDICATED BY PRESENT PROCEDURES. THERE WAS NO HAZARD TO THE PUBLIC HEALTH OR SAFETY. THERE HAVE BEEN NO PREVIOUS OCCURRENCES. REDUNDANT SYSTEMS ARE NOT APPLICABLE. THE REEVALUATION OF HIGH DRYWELL TEMPERATURE EFFECTS ON THE REACTOR VESSEL WATER LEVEL INSTRUMENTATION HAS RESULTED IN A DESIGN CHANGE REQUEST 1875 SUBMITTED REQUESTING A SETPOINT CHANGE FOR LIS-3-58A-D.
BROWNS FERRY-1 DEMIN WATER MAKE-UP HANGERS,SUPPORTS,SHOCK SUPPRS OTHER OTHER NOT APPLICABLE TENNESSEE VALLEY AUTHORITY	05000259 79-018/01T-0 026778	082379 090679 2-WEEK	WITH UNIT IN NORMAL OPERATION AT 95% POWER, INSPECTIONS WERE MADE IN ACCORDANCE WITH IE BULLETIN 79-14. DURING THIS INSPECTION IT WAS FOUND THAT RESTRAINTS ON CERTAIN CSSC SYSTEMS WERE INOPERABLE IN THAT THEIR CONFIGURATION DID NOT CONFORM TO THE DESIGN SPECIFICATIONS. THERE WERE NO RESULTING SIGNIFICANT OCCURRENCES, NO PREVIOUS SIMILAR EVENTS AND NO DANGER TO HEALTH OR SAFETY OF THE PUBLIC. THIS EVENT WAS REPORTED UNDER T.S. 6.7.2.A.9. PIPE VIBRATION AND/OR IMPROPER INSTALLATION DURING CONSTRUCTION CAUSED THE INOPERABILITY. SIMILAR RESTRAINTS IN UNITS 1, 2, AND 3 ARE BEING INSPECTED AND A FOLLOWUP REPORT WILL BE ISSUED.

1543 033

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
BROWNS FERRY-1 REACTOR CONTAINMENT SYSTEMS COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000259 79-020/03L-0 026943	083179 092879 30-DAY	DURING NORMAL OPERATION, CONTAINMENT OXYGEN CONCENTRATION EXCEEDED 4% (T.S. 3.7.A.5.A) AND DRYWELL-SUPPRESSION CHAMBER DIFFERENTIAL PRESSURE DECREASED BELOW 1.0 PSID (T.S. 3.7.A.6). THERE ARE NO REDUNDANT SYSTEMS. THERE WAS NO HAZARD TO THE PUBLIC HEALTH OR SAFETY, AND THERE WERE NO PREVIOUS OCCURRENCES.
BROWNS FERRY-1 REAC CORE ISOL COOL SYS + CONT VALVE OPERATORS ELECTRIC MOTOR - DC COMPONENT FAILURE ELECTRICAL OTHER	05000259 79-021/03L-0 026954	090279 100179 30-DAY	THE PRIMARY CONTAINMENT OXYGEN CONCENTRATION HAD BEEN INCREASED AND DRYWELL-SUPPRESSION CHAMBER DIFFERENTIAL PRESSURE DECREASED IN PREPARATION FOR OR A PLANNED REACTOR SHUTDOWN. THE SHUTDOWN WAS DEFERRED DUE TO A FORCE MAJEURE SHUTDOWN OF UNIT 2. CONTAINMENT REINERTED & DIFFERENTIAL PRESSURE RESTABLISHED WITHIN 24 HRS. NO RECURRENCE CONTROL ACTION IS REQUIRED. WITH UNIT IN HOT STANDBY AT LESS THAN 25 PSIG CONTAINMENT ISOLATION VALVE FCV-71-3 WOULD NOT CLOSE AND WAS INOPERABLE. CONTRARY TO TECHNICAL SPECIFICATION 3.7.D.1, FCV 71-2 IN THE SAME LINE WAS CLOSED TO PROVIDE ISOLATION. THERE WAS NO HAZARD TO THE PUBLIC'S HEALTH OR SAFETY. THERE WERE NO PREVIOUS OCCURRENCES.
BROWNS FERRY-2 REAC CORE ISOL COOL SYS + CONT MECHANICAL FUNCTION UNITS SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR OTHER WOODWARD GOVERNOR CO.	05000260 79-013/03L-1 026166	053079 092479 30-DAY	PEERLESS ELECTRIC MOTOR, S/N GV 79985 HAD A MOTOR FAILURE. THE CAUSE OF THE PROBLEM IS NOT KNOWN. THE MOTOR WAS REPLACED. THE OPERATING LIMITS OF THE VALVE WERE RESET AND THE VALVE WAS OPERATIONALLY TESTED. THE FAILURE WAS RANDOM AND NO RECURRENCE CONTROL IS NECESSARY.
BROWNS FERRY-3 REACTOR TRIP SYSTEMS INSTRUMENTATION + CONTROLS OTHER OTHER NOT APPLICABLE BARKSDALE VALVE COMPANY	05000296 79-012/03L-0 026776	081579 091479 30-DAY	WITH REACTOR AT RATED TEMPERATURE AND PRESSURE, THE RCIC TRIPPED ON OVER SPEED DURING FLOW TEST. DURING THE INVESTIGATION, THERE WAS A LOSS OF SPEED SIGNAL IN THE CONTROL ROOM. THERE WERE NO SIGNIFICANT RESULTING EVENTS AND NO DANGER TO HEALTH OR SAFETY OF THE PUBLIC. PREVIOUS OCCURRENCES: BFRO 50-296/78-32, BFRO 50-259/76-15. TECHNICAL SPECIFICATION 3.5.F WAS INVOLVED.
			IMPROPER INITIAL ASSEMBLY ALLOWED TURBINE WHEEL NUT TO LOOSEN DESTROYING THREADS AND CAUSING AXIAL LOADING OF BEARINGS. BEARING WEAR ALLOWED SHAFT TO STRIKE PICK-UP CAUSING SPEED CONTROL MALFUNCTION, THUS THROTTLE VALVE REMAINED OPEN. WHEEL NUT, BEARINGS, AND ACTUATOR REPLACED. WOODWARD GOVERNOR, SN 968510. TERRY TURBINE, MODEL A8250 TYPE GS-1.
			DURING NORMAL OPERATION WHILE PERFORMING SI 4.1.A-14, TURBINE FIRST STAGE PRESSURE PERMISSIVE, PRESSURE SWITCH 1-81A SETPOINT WAS FOUND TO EXCEED THE T.S. LIMIT SPECIFIED IN TABLE 3.1.A. BY 8 PSIG. THERE WAS NO HAZARD TO THE PUBLIC HEALTH OR SAFETY. THERE ARE NO REDUNDANT SYSTEMS. PREVIOUS OCCURRENCES: 259/79-8, 259/78-16, 260/79-16 AND 296/79-7.
			THE MODEL B2TA1250 SETPOINT HAD DRIFTED OUT OF THE SPECIFIED LIMIT. THE SWITCH WAS RECALIBRATED AND SATISFACTORILY FUNCTIONALLY TESTED. THE FREQUENCY OF TESTING HAS BEEN INCREASED TO TRY TO DETERMINE THE CAUSE OF THE SETPOINT DRIFT. THESE WILL BE REPLACED WITH ANALOG TRIP UNITS IN THE FUTURE.

1543 034

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
BROWNS FERRY-3 FIRE PROTECTION SYS + CONT COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE DESIGN/FABRICATION ERROR CONSTRUCTION/INSTALLATION ITEM NOT APPLICABLE	05000296 79-013/03L-0 026774	081679 091479 30-DAY	DURING NORMAL OPERATION WHILE CORE DRILLING IN THE U-3 DIESEL GENERATOR BUILDING THE CARBON DIOXIDE PILOT VALVE LINE FOR FCV-39-36 AND FCV-39-27 WAS CUT. THE CARBON DIOXIDE SYSTEM FOR BOARD ROOMS 3EA AND 3EB WAS MADE INOPERABLE T.S. 3.11.B.1. THERE WAS NO HAZARD TO THE PUBLIC HEALTH OR SAFETY. THERE HAVE BEEN NO PREVIOUS OCCURRENCES. THERE ARE NO REDUNDANT SYSTEMS.
			THE EMBEDDED PIPING DRAWING WAS IN ERROR. THE EMBEDDED PIPE DID NOT APPEAR ON THE DRAWING. THE SAFETY ENGINEER WAS NOTIFIED AND A FIRE WATCH ESTABLISHED WHILE THE SYSTEM WAS INOPERABLE. THE DAMAGED PIPE WAS REPAIRED. THE DRAWING WILL BE CORRECTED TO PREVENT RECURRENCE.
BROWNS FERRY-3 MAIN STEAM ISOL SYS + CONTROLS VALVES GLOBE COMPONENT FAILURE MECHANICAL ATWOOD & MORRILL CO., INC.	05000296 79-014/03L-0 026942	083179 092779 30-DAY	DURING REFUELING WHILE PERFORMING LOCAL LEAK RATE TESTING, 5 MSIV'S EXCEEDED LEAKAGE LIMITS OF 11.5 SCFH CONTRARY TO T.S. 4.7.A.2.I. REDUNDANT SYSTEMS WERE NOT APPLICABLE SINCE REACTOR WAS IN REFUELING MODE. THERE WAS NO SIGNIFICANT RESULTING CHAIN OF EVENTS AND NO DANGER TO HEALTH OR SAFETY OF THE PUBLIC. PREVIOUS OCCURRENCES BFWO-50-296/78-25, 259/78-3, 4 259/77-23, 259/79-03, 260/79-13, 260/79-7, 260/78-9.
			EVENT WAS CAUSED BY AGE AND USE OF SEATING SURFACES. VALVE SEATING SURFACES WILL BE REPAIRED AND MSIV'S RETESTED TO MEET TECHNICAL SPECIFICATIONS PRIOR TO RETURN TO UNIT STARTUP. ATWOOD AND MORRILL 26-INCH GLOBE, VALVE MODEL 20851 H, 1250 PSIG.
BRUNSWICK-1 SAFETY RELATED DISPLAY INSTRUMENTATION + CONTROLS SWITCH COMPONENT FAILURE ELECTRICAL GENERAL ELECTRIC CO.	05000325 79-043/03X-1 026160	060979 092879 OTHER	WHILE PERFORMING A NORMAL REACTOR STARTUP, CONTROL ROD 18-23 HAD NO INDICATION AT NOTCH 30. TECHNICAL SPECIFICATION 3.1.3.7, 6.9.1.9B.
			THE REED SWITCH FOR NOTCH 30 INDICATION WAS FOUND DEFECTIVE AND REPLACED. THE SYSTEM WAS TESTED AND RETURNED TO SERVICE SATISFACTORILY. DUE TO AN INCREASING NUMBER OF INDICATING PROBLEMS, AN ENGINEERING WORK REQUEST HAS BEEN WRITTEN TO DETERMINE IF THERE IS A GENERIC PROBLEM WITH THE POSITION INDICATING SYSTEM.
BRUNSWICK-1 SAFETY RELATED DISPLAY INSTRUMENTATION + CONTROLS SWITCH COMPONENT FAILURE ELECTRICAL GENERAL ELECTRIC CO.	05000325 79-052/03X-1 026517	072879 092879 OTHER	DURING A NORMAL REACTOR STARTUP, ROD 26-15 HAD NO POSITION INDICATION AT NOTCH 38 AND ROD 18-23 HAD NO POSITION INDICATION AT NOTCH 30. TECHNICAL SPECIFICATION 3.1.3.7, 6.9.1.9B.
			BOTH ROD POSITIONS HAD DEFECTIVE REED SWITCHES WHICH WERE REPLACED. BOTH INDICATING SYSTEMS WERE TESTED AND RETURNED TO SERVICE SATISFACTORILY. DUE TO THE INCREASING NUMBER OF INDICATING PROBLEMS, AN ENGINEERING WORK REQUEST HAS BEEN WRITTEN TO DETERMINE IF THE POSITION INDICATING SYSTEM FAILURES ARE GENERIC.

1543 035

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
BRUNSWICK-1 PRCS5 + EFF RADIOL MONITOR SYS INSTRUMENTATION + CONTROLS COMPUTATION MODULE OTHER NOT APPLICABLE GENERAL ELECTRIC CO.	05000325 79-056/03L-0 026739	080879 090679 30-DAY	WHILE PERFORMING PT 1.1.13P, HIGH STEAMLINE RADIATION CHANNEL ALIGNMENT AND FUNCTION TEST, MAIN STEAM LINE HI RAD MONITOR "B" WAS FOUND TO BE AC TUATING AT 3.95 X BACKGROUND WHILE THE ALLOWABLE LIMIT IS <=/= 3.5 X BACK GROUND. TECHNICAL SPECIFICATIONS 2.2.1, 6.9.1.9A.
			OUT OF TOLERANCE READING WAS ATTRIBUTED TO INSTRUMENT DRIFT. MONITOR WAS RECALIBRATED & RETURNED TO SERVICE. GENERAL ELECTRIC WILL BE REQUESTED TO PROVIDE TECHNICAL ASSISTANCE IN DETERMINING CAUSE OF INSTRUMENT DRIFT & DETERMINING CORRECTIVE ACTION. A SUPPLEMENT REPORT WILL BE ISSUED WHE N REQUIRED CORRECTIVE ACTION HAS BEEN DETERMINED.
BRUNSWICK-1 SAFETY RELATED DISPLAY INSTR INSTRUMENTATION + CONTROLS SENSOR/DETECTOR/ELEMENT COMPONENT FAILURE ELECTRICAL GENERAL ELECTRIC CO.	05000325 79-051/03L-0 026822	082079 091779 30-DAY	DURING A NORMAL STARTUP AND FOLLOWING POWER INCREASE, THE OPERATOR NOTIC ED THAT POSITION 12 ON ROD 06-43 WAS NOT INDICATING. TECHNICAL SPECIFIC ATIONS 3.1.3.7, 6.9.1.9B.
			AN INVESTIGATION DETERMINED THAT THE PROBLEM WAS PROBABLY A SHORT IN THE PIP PROBE OF THE NOTCH 12 REED SWITCH. THIS PROBLEM WILL BE CORRECTED DURING THE FIRST OUTAGE OF SUFFICIENT LENGTH TO ENTER THE DRYWELL.
BRUNSWICK-1 REACTOR CORE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE DEFECTIVE PROCEDURES NOT APPLICABLE ITEM NOT APPLICABLE	05000325 79-063/03L-0 026823	082479 092079 30-DAY	AFTER REACHING 99% POWER FOLLOWING REDUCED POWER OPERATION DUE TO CONDEN SER BACK PRESSURE, A DAILY CORE PARAMETER CHECK REVEALED THAT THE LHGR W AS 13.69 KW/FT., OR GREATER THAN THE MLHGR OF 13.4 KW/FT. THE NUCLEAR EN GINEER HAD ESTIMATED AT 96% POWER THAT SUFFICIENT MARGIN EXISTED IN LHGR TO ALLOW FULL POWER OPERATIONS. POWER WAS IMMEDIATELY REDUCED AND LHGR RETURNED WITHIN SPECIFICATIONS. TECHNICAL SPECIFICATIONS 3.2.4, 6.9.1. 9B.
			THE CAUSE OF THIS EVENT WAS OPERATING WITHOUT A MARGIN TO THE MLHGR AND NOT MONITORING THE APPROACH TO THE MLHGR LIMIT WHILE INCREASING REACTOR POWER. THIS WAS CAUSED BY NOT HAVING COMPLETED ALL PREVENTATIVE MEASURE S OF LER 1-79-022, DATED 8-21-79. OPERATING RESTRICTIONS WERE PLACED IN THE DAILY INSTRUCTIONS AND AT THE NUCLEAR ENGINEER'S DESK.
BRUNSWICK-1 REACTOR CORE FUEL ELEMENTS SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR OTHER GENERAL ELECTRIC CO.	05000325 79-062/01T-0 026738	082879 091179 2-WEEK	DURING A REVIEW OF UNIT 1 CORE LOAD VIDEOTAPES, IT WAS DISCOVERED THAT B UNDL E 29-10, SERIAL NUMBER LJO 197, HAD BEEN PLACED IN CORE 180 DEG FROM REQUIRED ORIENTATION. THIS WAS VERIFIED BY CHANNEL FASTENER LOCATION & SERIAL NUMBER ALIGNMENT. PRELIMINARY ANALYSIS BY G.E. INDICATED THAT C ONTINUED OPERATION OF THE UNIT CAN BE SUPPORTED WITH THIS CONDITION. TEC HNICAL SPECIFICATION 6.9.1.8I.
			A REVIEW OF REFUELING RECORDS INDICATED THAT BUNDLE LJO 197 WAS MOVED DU RING 1979 REFUELING OUTAGE FROM POSITION 33-02 TO POSITION 29-10 WITH NO CHANGE IN ORIENTATION REQUIRED. AN EVALUATION OF FUEL MOVEMENT PLAN IND ICATES NO APPARENT CAUSE FOR THE BUNDLE ROTATION. CORE VERIFICATION BY A SPO, A NUCLEAR ENG, & A Q.A. TECHNICIAN FAILED TO DETECT ROTATED BUNDLE

1543 036

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
BRUNSWICK-1 CNTNMT COMBUS GAS CONTROL SYS INSTRUMENTATION + CONTROLS COMPUTATION MODULE COMPONENT FAILURE ELECTRONIC BECKMAN INSTRUMENTS, INC.	05000325 79-050/03L-0 026941	090479 100179 30-DAY	DURING NORMAL PLANT OPERATION, THE OPERATOR NOTICED THAT THE DRYWELL OXYGEN/HYDROGEN MONITOR, CAC-1263. MADE A STEP INCREASE FOR NO APPARENT REASON. DRYWELL OXYGEN CONCENTRATION DID NOT EXCEED 4%. TECHNICAL SPECIFICATIONS 3.6.6.4, 6.9.1.9B.
BRUNSWICK-1 EMERG CORE COOLING SYS + CONTROLS RELAYS CONTROL, GENERAL PURPOSE COMPONENT FAILURE ELECTRICAL GENERAL ELECTRIC CO.	05000325 79-038/03L-0 026950	090579 100279 30-DAY	CALIBRATION CHECK FOUND INSTRUMENT "ZERO" SHIFTED APPROX 40% FOR NO APPARENT REASON, GIVING ABOUT A 2% SHIFT IN MONITOR. INSTRUMENT RECALIBRATED & RETURNED TO SERVICE SATIS. AS THIS IS FIRST TIME INSTRUMENT HAS BEEN OUT OF CALIBRATION SINCE GOING TO A BIWEEKLY CALIBRATION, THIS IS CONSIDERED AN ISOLATED EVENT AND NO FURTHER ACTION IS REQUIRED. DURING A ROUTINE SURVEILLANCE OF THE CONTROL PANEL, THE OPERATOR NOTICED THAT HE DID NOT HAVE ANY INDICATION OF THE VALVE POSITION FOR E41-F006, HPCI INJECTION VALVE, ON THE RTGB OR AT THE LOCAL MOTOR CONTROL CENTER. THE HPCI SYSTEM WAS DECLARED INOPERABLE. TECHNICAL SPECIFICATIONS 3.5.1, 6.9.1.9B.
BRUNSWICK-1 SAFETY RELATED DISPLAY INSTRUMENTATION + CONTROLS INDICATOR OTHER NOT APPLICABLE GENERAL ELECTRIC CO.	05000325 79-064/03L-0 026940	090879 100179 30-DAY	THE CONTROL POWER FUSE WAS FOUND BLOWN DUE TO A SHORTED RELAY COIL. THE FUSE AND THE RELAY COIL WERE REPLACED. A REASON COULD NOT BE DETERMINED FOR THE SHORTED COIL. AS THIS IS A FIRST TIME OCCURRENCE, THIS IS CONSIDERED AN ISOLATED EVENT AND NO FURTHER ACTION IS REQUIRED.
BRUNSWICK-1 STATION SERV WATER SYS + CONTROLS INSTRUMENTATION + CONTROLS TRANSMITTER COMPONENT FAILURE ELECTRONIC ROSEMOUNT, INC.	05000325 79-060/03L-0 026955	091679 100270 30-DAY	WHILE PERFORMING PT 14.1, CONTROL ROD OPERABILITY CHECK, ROD 02-35 HAD NO POSITION INDICATION AT NOTCH 46 WHEN THE ROD WAS DRIVEN IN. NO PROBLEM WAS EXPERIENCED AT THE NORMAL ROD POSITION, NOTCH 43. TECHNICAL SPECIFICATION 3.1.3.7, 6.9.1.9B. AN OPERATIONAL CHECK OF ROD 02-35 AND A CHECK OF THE CIRCUITRY REVEALED NO PROBLEM. PT 14.1 WAS RUN AGAIN ON 9/17/79 WITH NORMAL INDICATION AT NOTCH 46 ON ROD 02-35. THE POSITION INDICATION OF ALL RODS WILL BE CONTINUALLY MONITORED DURING OPERATION AND DURING ROD MOVING PT'S.
BRUNSWICK-1 STATION SERV WATER SYS + CONTROLS INSTRUMENTATION + CONTROLS TRANSMITTER COMPONENT FAILURE ELECTRONIC ROSEMOUNT, INC.	05000325 79-060/03L-0 026955	091679 100270 30-DAY	WHILE PERFORMING PT 55.9 PC, SHUTDOWN PANEL RHR SERVICE WATER D/P CALIBRATION, DIFFERENTIAL PRESSURE TRANSMITTER 1E11-PDT-H002DX FAILED TO RESPOND TO A TEST SIGNAL. TECHNICAL SPECIFICATIONS 3.3.5.2, 6.9.1.9B. THE TRANSMITTER CAPSULE FAILED CAUSING NO OUTPUT SIGNAL FOR THE INDICATOR. A NEW TRANSMITTER HAS BEEN ORDERED AND IS TO ARRIVE BY OCTOBER 10, 1979. WHEN THE TRANSMITTER IS RECEIVED, IT WILL BE INSTALLED, CALIBRATED, AND RETURNED TO SERVICE. AS THIS IS THE FIRST FAILURE OF THIS INSTRUMENT, THIS IS CONSIDERED AN ISOLATED EVENT.

1543 037

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
BRUNSWICK-1 SAFETY RELATED DISPLAY INSTR INSTRUMENTATION + CONTROLS SWITCH COMPONENT FAILURE ELECTRICAL GENERAL ELECTRIC CO.	05000325 79-067/03L-0 026956	091679 100379 30-DAY	DURING A NORMAL REACTOR STARTUP, THE OPERATOR NOTICED THAT ROD 26-15 DID NOT HAVE POSITION INDICATION AT NOTCHES 30, 31, 34, AND 35. ALL OTHER INDICATIONS WERE NORMAL. TECHNICAL SPECIFICATIONS 3.1.3.7, 6.9.1.9B.
BRUNSWICK-1 OTHER ENGRD SAFETY FEATR SYS HANGERS, SUPPORTS, SHOCK SUPPRS SNUBBERS COMPONENT FAILURE MECHANICAL BERGEN-PATTERSON PIPE SUPPORT	05000325 79-061/03L-0 026957	091779 100379 30-DAY	TROUBLESHOOTING ROD 26-15 DETERMINED THAT THE PROBLEM EXISTED IN THE PIP PROBE LOCATED IN THE DRYWELL. THIS PROBLEM WILL BE CORRECTED DURING THE NEXT OUTAGE OF SUFFICIENT LENGTH. DUE TO THE INCREASING NUMBER OF ROD POSITION INDICATION PROBLEMS, AN ENGINEERING WORK REQUEST HAS BEEN SUBMITTED TO INVESTIGATE THE PROBLEM. WHILE PERFORMING PT 19.6.0.2, VISUAL INSPECTION OF ACCESSIBLE SNUBBERS ON N SAFETY RELATED SYSTEMS, THE FOLLOWING WERE FOUND INOPERABLE: 1) 15W-1735S175, SERVICE WATER TO DISCHARGE CANAL; 2) 1E11-185547, LINE RHR HEAT EXCHANGER TO VESSEL; 3) 1G41-95527, LINE FROM SLC 1 MP5 TO VESSEL; 4) 1G41-15522, FUEL POOL COOLING LINE TO RHR; 5) 1G41-205576, FUEL POOL COOLING RECIRCULATION LINE. TECHNICAL SPECIFICATIONS 3.7.5, 6.9.1.9B.
BRUNSWICK-1 ENGRD SAFETY FEATR INSTR SYS INSTRUMENTATION + CONTROLS SENSOR/DETECTOR/ELEMENT DESIGN/FABRICATION ERROR DESIGN YARWAY CORP.	05000325 79-070/03L-0 026958	092179 100379 30-DAY	SNUBBERS 15W-1735S175, AND 1E11-185547 HAD LOW FLUID LEVEL. THESE SNUBBERS WERE REBUILT WITH NEW SEALS AND FUNC. HALL TESTED. SNUBBERS 1G41-95527, AND 1G41-15522, AND 1G41-205576 HAD LOOSE PIPE CLAMPS WHICH ALLOWED SNUBBERS TO SLIP ON THEIR PIPES. SNUBBERS WERE POSITIONED PER PLANT DRAWINGS & TIGHTENED. TESTING OF SNUBBERS WILL CONTINUE PER TECH SPEC REVIEW OF REACTOR VESSEL WATER LEVEL INSTRUMENTATION FOLLOWING RECEIPT OF GENERAL ELECTRIC SERVICE INFO LETTER # 299 RESULTS WITH IDENTIFICATION OF POTENTIAL INACCURACY WHICH COULD OCCUR UNDER HIGH DRYWELL TEMP. CHARACTERIZED BY ACCIDENT CONDITION 3. EFFECT OF INACCURACY IS ACCEPTABLE FROM A SAFETY STAND POINT, BUT IT COULD RESULT IN REDUCTION IN REDUNDANCY OF INITIATING SIGNALS OF SOME EMERG. CORE COOLING SYS & LEAD TO MISINTERPRETATION OF ACTUAL VESSEL LEVEL BY OPERATOR. LARGE INCREASES IN DRYWELL TEMP., SUCH AS THOSE THAT COULD OCCUR DURING A PIPE RUPTURE IN DRYWELL, WOULD CAUSE REF. LEG OF YARWAY LEVEL INDICATIONS TO HEAT UP. AS REF. LEG TEMP. INCREASES, ITS DENSITY WILL DECREASE CAUSING A DECREASING D/P. THIS DECREASING D/P WOULD REGISTER AS AN INCREASING VESSEL LEVEL ON D/P CELL INDICATOR & REMOTE INDICATION.
BRUNSWICK-1 EMERG CORE COOLING SYS + CONT ELECTRICAL CONDUCTORS SUBCOMPONENT NOT APPLICABLE DESIGN/FABRICATION ERROR DESIGN GENERAL ELECTRIC CO.	05000325 79-068/01T-0 026949	092779 100979 2-WEEK	DURING REVIEW OF ECCS DIVISION SEPARATION, DETERMINED THAT DIVISION II CABLES FOR HPCI INBOARD ISOLATION VLV (G41-F002), DIV. II VLV, RUN IN SECTIONS OF CABLE TRAY CONTAINING DIV. II ADS SYS CABLES. SUBSEQUENT ANALYSIS OF CABLES REVEALED IF ISOLATION VLV WAS IN WRONG POSITION, A FAILURE AT A TRAY SECT CONTAINING THESE CABLES MIGHT RESULT IN COMBINATION OF CABLE FAILURES WHICH COULD IMPAIR OPER OF HPCI (DIV. I) & ADS (DIVISION I) SYSTEMS. THIS IS COMMON TO BOTH UNITS. TECH SPEC 6.9.1.11. UNITED ENG & CONSTRUCTORS PREPARING PLANT MOD TO "SPARE" CABLES & INSTALL NEW CABLES IN ISOLATED CONDUIT TO PROVIDE SUFFICIENT ISOLATION. REVIEW OF ECCS & THEIR PRIMARY CONTAINMENT ISOLATION VLVs BEING PERFORMED TO VERIFY THAT NO OTHER CABLE SEPARATION PROB. EXISTED. CABLE SEPARATION CRITERION FOR HPCI & ADS SYS WILL BE REDEFINED IN APPROP CABLE SEP SPECS.

1543 038

NOV 08, 1979

LER MONTHLY REPORT SORTED BY FACILITY
PROCESSED DURING OCTOBER, 1979 FOR POWER REACTORS

PAGE 17

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
BRUNSWICK-2 CHTNMNT HEAT REMOV SYS + CONT PUMPS CENTRIFUGAL COMPONENT FAILURE MECHANICAL INGERSOLL-RAND CO	05000324 79-071/03L-0 026736	080879 090679 30-DAY	WHILE PERFORMING PT 8.2.4, RHRSW OPERATIONAL COMPONENT TEST, RHRSW PUMP 2D HAD A VIBRATION OF 12.5 MILS. THE MAXIMUM ALLOWABLE VALUE IS \leq 3.6 MILS. TECHNICAL SPECIFICATIONS 3.7.1.1, 6.9.1.9B. AN INVESTIGATION OF PUMP REVEALED A PART OF A SPRING LODGED IN VANE OF IMPELLER. THIS WAS REMOVED, PUMP WAS INSPECTED, TESTED, & RETURNED TO SERVICE. IT IS BELIEVED THAT THIS PARTIAL SPRING CAME FROM A CHECK VALVE DISK ASSEMBLY ON DISCHARGE OF NUCLEAR &/OR CONVENTIONAL SERVICE WATER PUMPS.
BRUNSWICK-2 PRCSS + EFF RADIOL MONITOR SYS INSTRUMENTATION + CONTROLS COMPUTATION MODULE OTHER NOT APPLICABLE GENERAL ELECTRIC CO.	05000324 79-069/03L-0 026737	081079 090779 30-DAY	WHILE PERFORMING PT 1.1.13P, HIGH STEAMLINE RADIATION CHANNEL ALIGNMENT AND FUNCTION TEST, MAIN STEAMLINE HI RAD MONITOR "D" WAS FOUND TO BE ACTUATING AT 3.66 X BACKGROUND WHILE THE ALLOWABLE LIMIT IS \leq 3.5 X BACKGROUND. TECHNICAL SPECIFICATIONS 2.2.1, 6.9.1.9A. OUT OF TOLERANCE READING WAS ATTRIBUTED TO INSTRUMENT DRIFT. MONITOR WAS RECALIBRATED & RETURNED TO SERVICE. GENERAL ELECTRIC IS BEING REQUESTED TO PROVIDE TECHNICAL ASSISTANCE IN DETERMINING THE CAUSE OF INSTRUMENT DRIFTING & DETERMINING CORRECTIVE ACTION. A SUPPLEMENT REPORT WILL BE ISSUED WHEN REQUIRED CORRECTIVE ACTION HAS BEEN DETERMINED.
BRUNSWICK-2 REAC COOL CLEANUP SYS + CONT HEAT EXCHANGERS COOLER COMPONENT FAILURE OTHER PERFEX, INC.	05000324 79-072/03L-0 026735	081279 091179 30-DAY	DURING NORMAL PLANT OPERATION, VESSEL CONDUCTIVITY EXCEEDED 2 μ MHOS FOR APPROXIMATELY 33 HOURS. POWER WAS REDUCED TO LIMIT CONDUCTIVITY BUILD UP. TECHNICAL SPECIFICATIONS 3.4.4, 6.9.1.9B. REASON FOR EXCEEDING 2 μ MHOS WAS INOPERABILITY OF RWCU SYSTEM. DUE TO LEAKS ON "B" RWCU HEAT EXCHANGER, SYSTEM WOULD ISOLATE ON "HI ROOM TEMPERATURE" OR "HI HI LEAK DIFFERENTIAL" GROUP ISOLATION. HEAT EXCHANGER WAS SEALED WITH FURMANITE & RETURNED TO SERVICE, AT WHICH TIME CONDUCTIVITY SLOWLY DECREASED TO 2 μ MHOS. MOD WILL BE PERFORMED ON ALL RWCU HEAT EXCHANGE WHILE ATTEMPTING TO PLACE "B" LOOP OF RHRSW UNDER CLEARANCE FOR MAINT, "2A" RHRSW PUMP BREAKER WAS RACKED OUT BY MISTAKE, MAKING BOTH LOOPS OF RHRSW INOPERABLE. "2A" PUMP WAS OUT OF OPERATION FOR APPROX 15 MINS. ERROR WAS DISCOVERED QUICKLY AFTER IT OCCURRED, AS A RESULT OF NORMAL CLEARANCE PROCESS WHEN AUX OPERATOR WHO HUNG TAG RETURNED TO CONTROL ROOM TO SIGN TAG SHEET & OBSERVED THAT IT DID NOT REFLECT ACTUAL EQUIPMENT CLEARANCE. TECHNICAL SPECIFICATIONS 3.7.1.1, 6.9.1.9C. "2" RHRSW PUMP WAS IMMEDIATELY RACKED IN. TAG & TAG-OUT SHEET HAD BEEN PREPARED INCORRECTLY BY CONTROL OPERATOR IN THAT "2" PUMP WAS DESIGNATED TO BE RACKED OUT VICE "2B" PUMP. THE FOLLOWING CORRECTIVE ACTION WERE OR WILL BE TAKEN: 1) AN IMMEDIATE MEETING & COUNSELING SESSION WAS HELD WITH CONTROL OP INVOLVED, SHIFT FOREMAN, ACTING OP SUPV. & SUPERINTENDENT.
BRUNSWICK-2 OTHER ENGRD SAFETY FEATR SYS CIRCUIT CLOSERS/INTERRUPTERS SWITCHGEAR PERSONNEL ERROR LICENSED & SENIOR OPERATORS GENERAL ELECTRIC CO.	05000324 79-073/03L-0 026734	081379 091179 30-DAY	

1543 039

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
BRUNSWICK-2 EMERG CORE COOLING SYS + CONT INSTRUMENTATION + CONTROLS COMPUTATION MODULE OTHER NOT APPLICABLE BARTON INSTRU CO., DIV OF ITT	05000324 79-074/03L-0 026733	081579 091179 30-DAY	WHILE PERFORMING PT 3.1.14PC, REACTOR LOW PRESSURE CHANNEL CALIBRATION AND FUNCTION TEST, B21-PS-N021D WAS FOUND TO BE OPERATING IN AN OUT OF TOLERANCE CONDITION. THE ALLOWABLE RANGE FOR THIS INSTRUMENT IS 435 + 15 PSIG AND THE AS-FOUND CONDITION WAS 395 PSIG. TECHNICAL SPECIFICATION 3.3.3, 6.9.1.9B. THE INSTRUMENT WAS RECALIBRATED AND RETURNED TO SERVICE. THE INSTRUMENT WAS OUT OF CALIBRATION DUE TO INSTRUMENT DRIFT. DUE TO THIS INSTRUMENT'S PAST RELIABILITY AND PERFORMANCE AND BECAUSE IT IS CHECKED MONTHLY, THIS IS CONSIDERED AN ISOLATED EVENT AND NO FURTHER ACTION IS REQUIRED.
BRUNSWICK-2 CONTAINMENT COMBUS GAS CONTROL SYS INSTRUMENTATION + CONTROLS SENSOR/DETECTOR/ELEMENT OTHER NOT APPLICABLE DWYER	05000324 79-075/03L-0 026771	081879 091379 30-DAY	DURING NORMAL OPERATOR SURVEILLANCE OF THE CONTROL PANELS, THE OPERATOR NOTICED A LOW FLOW INDICATED ON 2-CAC-1263. THE ALARM WOULD NOT CLEAR AND THE MONITOR COULD NOT BE STARTED. TECHNICAL SPECIFICATION 3.6.6.4, 6.9.1.9B. AN AUXILIARY OPERATOR WAS SENT TO THE -1263 PANEL TO DETERMINE THE PROBLEM & NONE WAS FOUND. ANOTHER ATTEMPT WAS MADE TO CLEAR THE ALARM & START THE UNIT AT THE END OF THE SHIFT. THE UNIT STARTED NORMALLY, & RAN SATISFACTORILY. NO CAUSE COULD BE FOUND FOR THE FLOW FAILURE; THEREFORE, THE UNIT WILL BE CLOSELY MONITORED TO TRY & DETECT A DEVELOPING PROBLEM. DURING NORMAL PLANT OPERATION, PRIMARY CONTAINMENT AMBIENT TEMP EXCEEDED 135 DEG. F (135.176 DEG. F). TEMPS. OVER PREVIOUS SEVERAL DAYS HAD BEEN 133-134 DEG. F WITH ALL AVAILABLE DRYWELL COOLERS OPERATING. DRYWELL LEAKAGE HAD INCREASED TO APPROX. 2 GPM & AIRBORNE PARTICULATE ACTIVITY WAS HIGHER THAN NORMAL, INDICATING A SMALL STEAM LEAK. HEAT LOAD ON RBCCW SYSTEMS WAS HI DUE TO HI SERVICE WATER INJECTION TEMP. RWCU REJECTING TO HOTWELL, & SUPPLYING 20 GPM CONCENTRATOR IN RADWASTE. T/S 3.6.1.6, 6.9.1.9B. RWCU REJECT TO HOTWELL WAS DECREASED FROM 130 GPM TO 100 GPM & SERVICE WATER FLOW TO RBCCW HEAT EXCHANGERS WAS INCREASED. THIS LOWERED RBCCW OUTLET TEMP FROM 99 DEG. F TO 89 DEG. F & DRYWELL AMBIENT TEMP WAS LOWERED FROM 135.176 DEG. F TO 134 DEG. F. DURING RECENT OUTAGE, A LEAK IN KING PIN COVER ON FEEDWATER CHECK VALVE B21-F010B WAS REPAIRED.
BRUNSWICK-2 CONTAINMENT HEAT REMOV SYS + CONT VALVES CHECK COMPONENT FAILURE MECHANICAL ANCHOR/DARLING INDUSTRIES	05000324 79-080/03L-0 026850	083079 092579 30-DAY	WHILE REMOVING RWCV A "LEAK HI HI" ALARM WAS RECEIVED WHICH ISOLATES THE RWCV SYSTEM. THE OPERATOR NOTICED THAT THE SUCTION OUTBOARD VALVE SHUT AS REQUIRED BUT THE SUCTION INBOARD VALVE FOOT FAILED IN THE MID-POSITION. TECHNICAL SPECIFICATION 3.6.3, 6.9.1.9B. AN INVESTIGATION REVEALED THAT THE TORQUE LIMIT SWITCH HAD OPENED, CAUSING THE MOTOR TO STOP. THE VALVE WAS MANUALLY SHUT THEN CYCLED FOUR TIMES ELECTRICALLY AND THE PROBLEM COULD NOT BE MADE TO RECUR. THIS IS CONSIDERED AN ISOLATED EVENT AND NO FURTHER ACTION IS REQUIRED.
BRUNSWICK-2 REAC COOL CLEANUP SYS + CONT VALVE OPERATORS ELECTRIC MOTOR - AC COMPONENT FAILURE MECHANICAL LIMITORQUE CORP.	05000324 79-078/03L-0 026849	083179 092579 30-DAY	

1543 040

NOV 08, 1979

LER MONTHLY REPORT SORTED BY FACILITY
PROCESSED DURING OCTOBER, 1979 FOR POWER REACTORS

PAGE 19

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
BRUNSWICK-2 CONTINUIT COMBUS GAS CONTROL SYS AIR DRYERS SUBCOMPONENT NOT APPLICABLE COMPONENT FAILURE OTHER HANKISON CORP.	05000324 79-079/03L-0 026851	083179 092579 30-DAY	DURING NORMAL PLANT OPERATION, THE OPERATOR NOTICED THAT THE DRYWELL OXYGEN/HYDROGEN MONITOR, CPC-1263, HAD A LOW FLOW CONDITION AND WAS NOT INDICATING NORMALLY. DRYWELL OXYGEN CONCENTRATION WAS MAINTAINED LESS THAN 4% BY THE CAC-1259 INSTRUMENT. TECHNICAL SPECIFICATIONS 3.6.6.4, 6.9.1.9B. AN INVESTIGATION FOUND THAT AIR DRYER HAD FROZEN, BLOCKING SAMPLE AIR FLOW. DRYER WAS DEENERGIZED & ALLOWED TO THAW, & A DRY NITROGEN PURGE WAS USED TO BLOW OUT MOISTURE & DRY COILS. DRYER WAS INSPECTED BY A CONTRACT HEATING & AIR-CONDITIONING CO. & NO PROBLEM COULD BE FOUND WITH DRYER. SYSTEM WAS RETURNED TO SERVICE & MONITORED FOR SEVERAL DAYS.
BRUNSWICK-2 SAFETY RELATED DISPLAY INSTRUMENTATION + CONTROLS INDICATOR COMPONENT FAILURE ELECTRICAL GENERAL ELECTRIC CO.	05000324 79-076/03L-0 026945	090879 100179 30-DAY	DURING A NORMAL REACTOR STARTUP, THE OPERATOR NOTICED THAT ROD 26-07 HAD NO POSITION INDICATION AT NOTCH 48. ALL OTHER INDICATIONS WERE NORMAL. TECHNICAL SPECIFICATION 3.1.3.7, 6.9.1.9B. ROD 26-07 OPERATIONALLY TESTED & NO PROBLEM FOUND WITH POSITION INDICATING PROBE. ROD WAS NOTCHED IN TO NOTCH 46 & BACK TO NOTCH 48 & NORMAL INDICATION RETURNED. AN ENGINEERING WORK REQUEST HAD BEEN WRITTEN TO INVESTIGATE THE POSITION INDICATING SYSTEM DUE TO THE NUMBER OF POSITION INDICATING FAILURES WE HAVE BEEN EXPERIENCING.
BRUNSWICK-2 REACTIVITY CONTROL SYSTEMS INSTRUMENTATION + CONTROLS COMPUTATION MODULE COMPONENT FAILURE ELECTRONIC GENERAL ELECTRIC CO.	05000324 79-068/03L-0 026953	091079 100379 30-DAY	WHILE PERFORMING PT 1.2.4. APRM HIGH FLUX AND DOWNSCALE TEST, THE DOWNSCALE ALARM FOR APRM "F" ACTUATED AT 2% VICE THE REQUIRED 3%. APRM "B" WAS ALSO OUT OF SERVICE DUE TO A DETECTOR OPEN SIGNAL LEAD. TECHNICAL SPECIFICATION 3.3.1, 6.9.1.9A. APRM "F" WAS OUT OF CALIBRATION DUE TO INSTRUMENT DRIFT. THE INSTRUMENT WAS CALIBRATED AND RETURNED TO SERVICE SATISFACTORILY. APRM "D" WILL BE REPLACED DURING THE NEXT OUTAGE OF SUFFICIENT LENGTH. AS THIS IS THE FIRST APRM CALIBRATION PROBLEM, THIS IS CONSIDERED AN ISOLATED EVENT AND NO FURTHER ACTION IS REQUIRED.
CALVERT CLIFFS-1 SYSTEM CODE NOT APPLICABLE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000317 78-056/04T-0 023644	122178 010479 2-WEEK	OYSTER SAMPLES COLLECTED 12/5/78 FROM CAMP CANOY LOCATION AND ANALYZED PER ETS 3.2, APPENDIX B, SHOWED AG-110M AT 81 +/- 11% PCI/KG. BACKGROUND LOCATION SHOWED AG-110M AT < 7 PCI/KG. BASED ON OBSERVED LEVELS, AVERAGE INDIVIDUAL DOSES TO GI TRACT AND WHOLE BODY ARE VERY SMALL FRACTIONS OF ALLOWABLE DOSES TO MEMBERS OF GENERAL PUBLIC (40CFR PART 190) AND ARE OF NO CONSEQUENCE TO PUBLIC HEALTH AND SAFETY. INTRODUCTION OF MORE SENSITIVE TECHNIQUE HAS REDUCED THE MDL VALUE FOR A G110M AT < 7 PCI/KG, LOWER THAN PREVIOUS AVERAGE MDL VALUE OF < 40 PCI/KG. DECEMBER CAMP CANOY SAMPLES EXCEEDED NEW BACKGROUND VALUE BY > FACTOR OF 10 WHILE SHOWING CONTINUED TREND OF DECREASING AG-110M ACTIVITY IN OYSTERS. NO CORRECTIVE ACTION IS REQUIRED.

1543 041

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
CALVERT CLIFFS-1 DEMIN WATER MAKE-UP PIPES, FITTINGS LESS THAN 4 INCHES COMPONENT FAILURE CORROSION OTHER	05000317 79-007/04T-0 026799	022879 031479 2-WEEK	DURING NORMAL OPERATIONS A WATCHSTANDER OBSERVED WHAT APPEARED TO BE ACID ON GROUND NEAR THE SULFURIC ACID STORAGE TANK. ACID LINES IN THE AREA WERE ISOLATED AND THE FLOW OF LIQUID ARRESTED. CHEMICAL ANALYSES WERE PERFORMED ON SUSPECT MATERIAL WHICH WAS VERIFIED TO BE ACID. LESS THAN 5 GALLONS OF SULFURIC ACID WAS DISCHARGED TO THE BAY VIA THE STORM DRAIN S. NO ENVIRONMENTAL IMPACT IS EXPECTED DUE TO SMALL AMOUNT OF ACID RELEASED. CAUSE HAS BEEN DETERMINED TO BE FAILURE OF A PIPE WELD. IMMEDIATE CORRECTIVE ACTION CONSISTED OF ISOLATING AND CONTAINING THE SPILL. SUBSEQUENT CORRECTIVE ACTION CONSISTED OF LOCATING AND SEALING THE LEAK BY WELDING.
CALVERT CLIFFS-1 LIQ RADIOACT WASTE MANAGMNT SYS COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000317 79-012/04L-0 026800	032279 042079 30-DAY	SECTION 4.6.2.C OF THE ENVIRONMENTAL TECHNICAL SPECIFICATIONS REQUIRES A REPORT WHEN THE SITE'S RADIOACTIVE LIQUID WASTE RELEASE RATE EXCEEDS 1.25 CURIES PER QUARTER. THIS VALUE WAS EXCEEDED ON MARCH 22, 1979. LER'S 78-46, 78-50 DESCRIBE SIMILAR EVENTS.
CALVERT CLIFFS-1 CHEM. VOL CONT + LIQ FOISH SYS INSTRUMENTATION + CONTROLS SENSOR/DETECTOR/ELEMENT COMPONENT FAILURE NATURAL END OF LIFE ASHCROFT GAUGE	05000317 79-032/03L-0 026718	080679 083179 30-DAY	ENVIRONMENTAL TECH. SPEC. CHANGE WAS SUBMITTED TO MODIFY SECTION 5.6.2.C TO AGREE WITH SECTION 2.3.A.7. DURING THIS PERIOD, MISCELLANEOUS WASTE ION EXCHANGER WAS RENDERED USELESS DUE TO A SALT WATER LEAK. THE ION EXCHANGER WAS REPLACED AND WILL SIGNIFICANTLY HELP TO REDUCE RELEASE RATE OF RADIOACTIVE LIQUID EFFLUENTS. AT 0845, #12 CHARGING PUMP PLACED OUT OF SERVICE BECAUSE OF PUMP TRIPS DUE TO LOW SUCTION PRESSURE & UNSUCCESSFUL ATTEMPTS TO RESTART PUMPS & MAINTAIN IT IN OPERATION. PLACING PUMP OUT OF SERVICE REDUCED NUMBER OPERABLE CHARGING PUMPS TO 1 (#11 CHARGING PUMP WAS ISOLATED BECAUSE OF PACKING LEAK). #11 CHARGING PUMP WAS REPAIRED & PLACED BACK IN SERVICE AT 1530 ON 8/6/79, BRINGING NUMBER OF OPERABLE PUMPS TO 2 AS REQ BY TS 3.1.2.4. #13 CHARGING PUMP REMAINED OPERABLE DURING EVENT. NOT REPETITIVE OCCUR. #12 CHARGING PUMP LOW SUCTION PRESSURE TRIPS WERE CAUSED BY A FAULTY PRESSURE INDICATING SWITCH: 1-PC-224Y. THIS ASHCROFT MODEL 1379 TAKEF WAS REPAIRED BY REPLACEMENT OF GAUGE INTERNALS WHICH WERE WORN. THIS IS BEING CONSIDERED AS AN ISOLATED FAILURE AND NO FURTHER CORRECTIVE ACTION IS TO BE TAKEN.
CALVERT CLIFFS-1 AIRBORNE RADIOACT MONITOR SYS INSTRUMENTATION + CONTROLS SENSOR/DETECTOR/ELEMENT COMPONENT FAILURE ELECTRONIC WESTINGHOUSE ELECTRIC CORP.	05000317 79-035/03L-0 026783	081179 091079 30-DAY	AT 0130 THE CONTROL ROOM OPERATOR NOTICED THAT THE CONTAINMENT AIR PARTICULATE MONITOR HAD FAILED. THE MONITOR WAS DECLARED INOPERABLE PER T.S. 3.4.6.1. THE CONTAINMENT PARTICULATE MONITOR WAS RETURNED TO SERVICE AT 1345. THE CONTAINMENT GASEOUS MONITOR AND CONTAINMENT SUMP LEVEL ALARM REMAINED OPERABLE DURING THE EVENT. LER 78-28 (U-2) DESCRIBES A SIMILAR EVENT. CAUSE OF THE LOW INDICATION WAS DUE TO THE DETECTOR TUBE GIVING LOW RESPONSE (WESTINGHOUSE P/N 2372A80-H01). TUBE FAILURE WAS PROBABLY CAUSED BY DIRT ON ITS SOCKET ASSEMBLY, WHICH WAS CLEANED. THE DETECTOR WAS REPLACED. NO PREVENTIVE ACTION IS NECESSARY. HEAVY WORK IN CONTAINMENT DURING REFUELING CAUSED SAMPLER TO DRAW IN UNUSUAL AMOUNT OF DUST AND DIRT.

1543 042

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
CALVERT CLIFFS-1 REACTOR TRIP SYSTEMS OTHER COMPONENTS SUBCOMPONENT NOT APPLICABLE COMPONENT FAILURE ELECTRICAL ITEM NOT APPLICABLE	05000317 79-036/03L-0 026784	081279 091179 30-DAY	AT 0105 WHILE PERFORMING A SURVEILLANCE TEST IT WAS DISCOVERED THAT WIDE RANGE NUCLEAR INSTRUMENT (WRNI) CHANNEL D WOULD NOT INDICATE PROPERLY WHILE IN CALIBRATION MODE. WRNI CHANNEL D WAS DECLARED INOPERABLE PER T.S. 3.3.1.1 ACTION 2. WRNI CHANNEL D WAS RETURNED TO SERVICE AT 0220. THE THREE REDUNDANT WRNI CHANNELS REMAINED OPERABLE DURING THE EVENT. THIS IS NOT A REPETITIVE OCCURRENCE.
CALVERT CLIFFS-1 REACTIVITY CONTROL SYSTEMS INSTRUMENTATION + CONTROLS INDICATOR COMPONENT FAILURE INSTRUMENT METRA INSTRUMENTS	05000317 79-034/03L-0 026865	081379 091379 30-DAY	DISCONNECTED "TEST" AND "POWER" CABLES ON DRAWER. CHECKED CALIBRATION PULSES. SIGNALS WERE NORMAL. RECONNECTED CABLES AND DRAWER FUNCTIONED PROPERLY. APPARENT CAUSE WAS BAD CONNECTION. CABLE CONNECTORS WERE INSPECTED, FOUND TO BE IN GOOD CONDITION. NO PREVENTIVE ACTION IS NECESSARY.
CALVERT CLIFFS-1 EMERG CORE COOLING SYS + CONT VALVES GATE PERSONNEL ERROR LICENSED & SENIOR OPERATORS VELAN VALVE CORP.	05000317 79-037/01T-0 026785	082879 090679 2-WEEK	AT 0030 WHILE PERFORMING ROUTINE SURVEILLANCE TESTING, IT WAS DISCOVERED THAT CONTROL ELEMENT ASSEMBLY DEVIATION OF GREATER THAN 7.5 INCHES WAS REQUIRED TO INITIATE CEA MOTION INHIBIT. CEA DRIVE SYSTEM WAS PLACED IN "OFF" AND ALL CEAS WERE FULLY WITHDRAWN AS REQUIRED BY T.S. 3.1.3.1 UNIT 1 CORRECTIVE ACTION WAS COMPLETED. CMI WAS RESTORED ON 8-21-79. THIS IS NOT A REPETITIVE EVENT FOR UNIT 1. SEE UNIT 2 LERS 79-13, 79-25, 79-30. REPLACED FAULTY CEA #4 OPERATIONAL AMPLIFIER, CEA GRP. #4 OUT OF SEQUENCE CIRCUIT A-25, & DEVIATION OUTPUT CIRCUITS FOR GRPS. A, B, C, 3, 4, AND 5. EITHER OF THE FIRST TWO CIRCUITS, IN FAILING WITH HIGH CONDUCTION, IS BELIEVED TO HAVE AFFECTED THE FAILURE OF THE OTHER STAGES. THE DEVIATION OUTPUT STAGES FAILED TO CONDUCT SUFFICIENTLY TO INITIATE A CMI.
CALVERT CLIFFS-1 CNTNMENT COMBUS GAS CONTROL SYS INSTRUMENTATION + CONTROLS POWER SUPPLY COMPONENT FAILURE ELECTRICAL DELPHI INDUSTRIES	05000317 79-038/03L-0 026960	082979 092879 30-DAY	AT 0600 DURING PERFORMANCE OF SURVEILLANCE TEST, OPERATOR DISCOVERED THAT SI-4145-MOV (12 HEADER CONTAINMENT SUMP SUCTION VALVE) WAS OPEN & SI-4143-MOV (12 HEADER RWT SUCTION VALVE) WAS SHUT, CAUSING ONE ECCS & ONE CONTAINMENT SPRAY SYSTEM TO BECOME INOPERABLE (T.S. 3.5.2 & 3.6.2.1). UPON DISCOVERY, OPERATOR IMMEDIATELY REPOSITIONED VALVES TO THEIR PROPER POSITION. REDUNDANT CONTAINMENT SPRAY & ECCS SYSTEMS REMAINED OPERABLE DURING THE EVENT. THIS IS NOT A REPETITIVE OCCURRENCE. ON 8-27-79, CONTROL ROOM OPERATOR INADVERTENTLY SHUT SI-4143-MOV WHILE RETURNING ECCS SYSTEM TO NORMAL FOLLOWING SURVEILLANCE TESTING OF SI-4145-MOV & OPEN SI-4143-MOV. FURTHER CORRECTIVE ACTION WILL BE TO INITIATE A COLOR SIGNALING SYSTEM TO AID OPERATORS IN VERIFYING PROPER POSITION OF ECCS VALVES AND PLACE POSITION ANNUNCIATORS ON RWT SUCTION VALVES.
			WHILE PERFORMING A ROUTINE SURVEILLANCE TEST, IT WAS DISCOVERED THAT THE 115 VOLT POWER SUPPLY TO HYDROGEN ANALYZER O-AE-6527 WAS INOPERATIVE (T.S. 3.6.5.1). HYDROGEN ANALYZER O-AE-6527 WAS REPAIRED AND RETURNED TO SERVICE ON 8/31/79. THE REDUNDANT HYDROGEN ANALYZER REMAINED IN OPERATION THROUGHOUT THIS EVENT. THIS HAS NOT BEEN A REPETITIVE EVENT. TROUBLESHOOTING DISCLOSED THE DELPHI MODEL B1B POWER TRANSFORMER T-1 HAD A SHORTED SECONDARY WINDING. THERE WAS NO OTHER FAILED COMPONENT WHICH MAY HAVE BEEN A PRIMARY CAUSE FOR TRANSFORMER FAILURE. THE OCCURRENCE IS CONSIDERED TO BE AN END-OF-LIFE FAILURE; NO PREVENTIVE ACTION IS NECESSARY.

1543 043

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
CALVERT CLIFFS-1 COOL SYS FOR REAC AUX + CONT VALVE OPERATORS PNEUMATIC/DIAPHRAGM/CYLINDER COMPONENT FAILURE MECHANICAL MASONIEILAN INTERNATIONAL, INC.	05000317 79-045/03L-0 026965	083179 092879 30-DAY	AT 0830 THE OPERATOR NOTICED THAT 1-CC-3830-CV (12 SHUTDOWN COOLING HEAT EXCHANGER OUTLET VALVE) WAS INDICATING INTERMEDIATE. SUBSEQUENT INVESTIGATION REVEALED THAT THE VALVE OPERATOR HAD BECOME DISCONNECTED FROM THE VALVE STEM (T.S. 3.6.2.1). THE VALVE WAS REPAIRED AND RETURNED TO SERVICE AT 1445. THIS IS NOT A REPETITIVE OCCURRENCE.
			THE PIVOT LOCKING PLATE FAILED, DISCONNECTING THE ACTUATOR (MASONIEILAN MODEL 71-34312) FROM THE VALVE STEM. FCR 79-60 WAS INITIATED ALLOWING FABRICATION AND INSTALLATION OF NEW PLATE FROM STRONGER MATERIAL. THE ACTUATOR WAS REPAIRED AND RETURNED TO SERVICE.
CALVERT CLIFFS-2 PRCSS + EFF RADIOL MONITOR SYS CIRCUIT CLOSERS/INTERRUPTERS OTHER NOT APPLICABLE WESTINGHOUSE ELECTRIC CORP.	05000318 79-029/03L-0 026713	080379 083179 30-DAY	DURING A TURBINE ROLL WITH THE REACTOR AT 3% PWR CONTAINMENT PARTICULATE AND GASEOUS MONITOR WAS RENDERED INOPERABLE BY A BLOWN FUSE. THE PLANT START-UP WAS STOPPED AND POWER WAS REDUCED TO HOT STANDBY AT 0750 (MODE 3). THE PARTICULATE AND GASEOUS MONITOR SYSTEM WAS RETURNED TO SERVICE AT 0853 ON 8/3/79. THE CONTAINMENT SUMP LEVEL ALARM REMAINED IN SERVICE THROUGHOUT THIS EVENT (T.S. 3.4.6.1.). THIS IS NOT A REPETITIVE OCCURRENCE.
			THE INITIAL CAUSE OF EVENT WAS A BLOWN NEUTRAL PHASE FUSE FOR THE AFFECTED CABINET'S CONTROL POWER. DURING REPLACEMENT, A FUSE BROKE IN THE HOLDER. EFFORTS TO REMOVE A FUSE END CAP DAMAGED THE HOLDER SUCH THAT HOLDER WAS SHORTED TO GROUND. HOLDER WAS JUMPED AND CONTROL POWER RESTORED. A REPLACEMENT HOLDER IS ON ORDER.
CALVERT CLIFFS-2 REACTIVITY CONTROL SYSTEMS CONTROL ROD DRIVE MECHANISMS SUBCOMPONENT NOT APPLICABLE COMPONENT FAILURE ELECTRICAL POWER-MATE	05000318 79-028/03L-0 026862	090279 091379 30-DAY	AT 0043 WHILE PERFORMING A SURVEILLANCE TEST, CONTROL ELEMENT ASSEMBLY (CEA) 43 SLIPPED TO 100 INCHES. REACTOR POWER WAS REDUCED TO LESS THAN 70 PERCENT AT 0140 IN ACCORDANCE WITH T.S. 3.1.3.1. CEA 43 WAS WITHDRAWN AND LEVELED WITH ITS GROUP AT 0143. LER'S 78-48 (U-1) AND 79-24 (U-2) DESCRIBE SIMILAR EVENTS.
			THE SLIPPED CEA IS ASSUMED TO BE THE RESULT OF A VOLTAGE FLUCTUATION IN THE 15 VOLT POWER SUPPLY. A DESIGN MODIFICATION TO IMPROVE THE RELIABILITY OF THE SYSTEM BY INSTALLING DUAL POWER SUPPLIES (FCR 78-72) IS TO BE INSTALLED DURING THE NEXT REFUELING OUTAGE.
CALVERT CLIFFS-2 REACTOR TRIP SYSTEMS INSTRUMENTATION + CONTROLS SWITCH COMPONENT FAILURE INSTRUMENT COMBUSTION ENGINEERING, INC.	05000318 79-031/03L-0 026961	090379 100179 30-DAY	WHILE OPERATING AT STEADY STATE POWER, SPURIOUS TRIPS ON RPS CHANNEL "C" HI POWER TRIP UNITS OCCURRED ON THE FOLLOWING DATES 9-3-79, 9-21-79 AND 9-22-79. IN EACH CASE, CHANNEL "C" HIGH POWER, TM/LP AND AXIAL FLUX OF FSETS WERE BYPASSED PER T.S. 3.3.1.1, ACTION 2. ALL OTHER RPS TRIP UNITS REMAINED IN SERVICE THROUGHOUT THE EVENT. LER 79-27 U-2 DESCRIBES A SIMILAR EVENT.
			REPLACED TEMPERATURE ELEMENT 2-TE-122 HC UNDER MAINTENANCE REQUEST 0-78-374 ON 9/11/79. THIS PLANNED MAINTENANCE WAS REPORTED UNDER LER 79-27. THE CHANNEL AGAIN EXHIBITED SIMILAR SYMPTOMS OF A FAILING ELEMENT ON 9/21/79 AND 9/22/79. MR NO. 0-79-2911 IS BEING HELD FOR FURTHER WORK DURING THE NEXT COLD SHUTDOWN.

1543 044

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
CALVERT CLIFFS-2 EMERG GENERATOR SYS + CONTROLS HANGERS,SUPPORTS,SHOCK SUPPRS HANGERS DESIGN/FABRICATION ERROR DESIGN OTHER	05000318 79-034/01T-0 026964	091479 092879 2-WEEK	DURING INSPECTION OF 12 AND 21 DIESEL GENERATOR PIPE HANGERS PER IE BULL ETIN 79-14, DISCOVERED THAT THE AIR START SYSTEM HANGERS WERE NOT BUILT TO MEET SEISMIC REQUIREMENTS. IN ORDER TO MEET T.S. 3.8.1.1 D/G'S WERE STARTED WITHIN ONE HOUR AND RAN CONTINUOUSLY. THIS ACTION ELIMINATED THE RELIANCE ON THE AIR START SYSTEM FOR OPERABILITY. THIS IS NOT A REPETITIVE OCCURRENCE.
COOPER-1 ONSITE POWER SYSTEM + CONTROL CIRCUIT CLOSERS/INTERRUPTERS SWITCH (OTHER THAN SENSOR) DESIGN/FABRICATION ERROR MANUFACTURING GENERAL ELECTRIC CO.	05000298 78-015/03X-1 026291	052578 080179 OTHER	THE INSTALLATION OF SEISMIC PIPE SUPPORTS UPGRADED THE DIESEL STARTING AIR SYSTEM TO MEET SEISMIC REQUIREMENTS. THESE SUPPORTS HAD NOT BEEN PREVIOUSLY INSTALLED DUE TO AN ERROR THAT CLASSIFIED THESE LINES AS NON-SEISMIC. DIESELS WERE ELECTRICALLY LOADED FOR ONE HOUR OF EVERY EIGHT HOURS DURING THEIR CONTINUOUS RUN TO PRECLUDE EXCESSIVE CARBON BUILD-UP. AFTER REACTOR SCRAMMED ON APRM HI UPSCALE, BREAKER 1A5 FAILED TO CLOSE AUTOMATICALLY. THE BREAKER WAS THEN CLOSED BY ITS CONTROL SWITCH. BREAKER 1A5 TIES 4160V BUS 1A TO THE STARTUP TRANSFORMER WHEN THE GENERATOR TRIPS. BREAKER 1FA FAILED TO TRIP AUTOMATICALLY AND WHEN ITS CONTROL SWITCH WAS OPERATED TO TRIP. THIS BREAKER IS ONE OF TWO BREAKERS CONNECTED IN SERIES WHICH TIES 4160V BUS 1F TO BUS 1A. REDUNDANT SYSTEMS WERE AVAILABLE. BREAKER 1FA FAILURE TO TRIP IS REPETITIVE (79-8). BREAKER 1A5 APPARENTLY FAILED TO CLOSE BECAUSE OF IMPROPER OPERATION OF SWITCH 52 IN BREAKER 1AN. GE HAS BEEN REQUESTED TO EVALUATE. SWITCH CONTACTS WERE CLEANED AND TESTED SATISFACTORILY. BREAKER 1FA FAILED TO TRIP BECAUSE MISALIGNMENT OF THE TRIP COIL AND THE TRIP ARMATURE. BREAKERS ARE GE MAGNA BLAST TYPE AMH 4.76-250.
COOPER-1 ENGRD SAFETY FEATR INSTR SYS INSTRUMENTATION + CONTROLS SWITCH COMPONENT FAILURE INSTRUMENT YARWAY CORP.	05000298 79-005/03X-1 025608	021679 080279 OTHER	DURING NORMAL OPERATION, REACTOR RECIRCULATION MOTOR GENERATOR SET "A" TRIPPED DUE TO FAILURE OF LEVEL SWITCH NBI-LIS-58A. TECHNICAL SPECIFICATION 3.6.F.3 ALLOWS OPERATION OF UP TO 24 HOURS WITH ONE RECIRC. LOOP OUT OF SERVICE. THERE WAS NO SIGNIFICANT OCCURRENCE AS A RESULT OF THIS EVENT. THERE WAS NO ADVERSE AFFECTS TO PUBLIC HEALTH AND SAFETY. THIS EVENT IS REPETITIVE. (REFERENCE LER 76-48). (UPDATE OF LER DATED 3-12-79).
COOPER-1 MAIN STEAM ISOL SYS + CONTROLS INSTRUMENTATION + CONTROLS SWITCH OTHER NOT APPLICABLE YARWAY CORP.	05000298 79-018/03L-0 026693	070679 080379 30-DAY	TRIP OF "A" RMG SET WAS CAUSED BY LEVEL SWITCH NBI-LIS-58A. CORROSION BUILDUP IN SWITCH CAUSED IT TO ACTUATE. NBI-LIS-58A IS A YARWAY MODEL 3 318C LEVEL INDICATING SWITCH. ALL CORROSION WAS CLEANED FROM INSIDE SWITCH CASE & SWITCH REPLACED. OTHER YARWAY INDICATORS OF THIS TYPE WERE INSPECTED & ALL AREAS WHERE MOISTURE COULD ENTER CASE HAVE BEEN SEALED. DURING ROUTINE TESTING, REACTOR VESSEL LEVEL INDICATING SWITCH NBI-LIS-58A SWITCH NUMBER ONE WAS FOUND WITH A TRIP POINT LESS CONSERVATIVE THAN ALLOWED IN T.S. TABLE 3.2.A. THERE WAS NO SIGNIFICANT OCCURRENCE AS A RESULT OF THIS EVENT. THE REDUNDANT LEVEL SWITCH NBI-LIS-57A WAS OPERABLE. THERE WERE NO ADVERSE AFFECTS TO PUBLIC HEALTH & SAFETY. THIS EVENT IS REPETITIVE. REFERENCE LER 79-5, 77-12.
			A YARWAY MODEL 4418C LEVEL INDICATING SWITCH FAILED TO ACTUATE WITHIN TOLERANCE. INVESTIGATION DISCLOSED THAT SEDIMENT CONSISTING OF DUST & MOISTURE IN AUXILIARY SWITCH MECHANISM HAD CAUSED SWITCH TO HANG-UP. SWITCH WAS CLEANED & AFTER CLEANING TESTED SATISFACTORILY. A NEW MECHANICAL CAM ACTUATED SOLID STATE SWITCH MODULE IS UNDER EVALUATION.

1543 045

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
COOPER-1 OTHR INST SYS NOT REQD FR SFTY INSTRUMENTATION + CONTROLS SENSOR/DETECTOR/ELEMENT DESIGN/FABRICATION ERROR MANUFACTURING ITEM NOT APPLICABLE	05000298 79-020/03L-0 026895	080979 090579 30-DAY	WHILE PERFORMING SURVEILLANCE PROCEDURE (S.P. 6.2.2.2.5) ON THE RELIEF VALVE BELLOWS MONITORING SYSTEM AS REQUIRED BY TECH. SPEC. 4.6.D.4, PRESSURE SWITCH MS-PS-71G FAILED TO ACTUATE. THE PRESSURE SWITCHES ON ALL THE OTHER RELIEF VALVES WERE OPERABLE. THERE WERE NO SIGNIFICANT OCCURRENCES AS A RESULT OF THE EVENT. SIMILAR EVENT WAS UE 75-1. THERE WERE NO ADVERSE EFFECTS TO PUBLIC HEALTH AND SAFETY.
COOPER-1 MAIN STEAM ISOL SYS + CONTROLS INSTRUMENTATION + CONTROLS SWITCH COMPONENT FAILURE MECHANICAL BARTON INSTRU CO., DIV OF ITT	05000298 79-023/03L-0 026899	080979 090779 30-DAY	A PRESSURE SWITCH, MODEL A 17-1, MANUFACTURED BY PRESSURE CONTROLS, INC. FAILED TO ACTUATE. PRESSURE SWITCH WAS REPLACED & SURVEILLANCE TESTING PERFORMED SATISFACTORILY. REMOVED PRESSURE SWITCH WAS RETURNED TO MANUFACTURER WHOSE ANALYSIS SHOWED THAT IT HAD BEEN IMPROPERLY ASSEMBLED. MANUFACTURER STATED THIS WAS A UNIQUE OCCURRENCE & NO FURTHER ACTION REQUIRED. WHILE PERFORMING ROUTINE SURVEILLANCE PROCEDURE 6.2.1.4.2, MS-DPIS-119B WAS FOUND WITH A SETPOINT IN EXCESS OF THAT ALLOWED IN TECHNICAL SPECIFICATIONS TABLE 3.2.A. ALL REDUNDANT DIFFERENTIAL PRESSURE SWITCHES WERE FUNCTIONING PROPERLY AND WERE WITHIN SPECIFICATION. THERE WERE NO SIGNIFICANT OCCURRENCES AS A RESULT OF THIS EVENT AND THERE WERE NO ADVERSE EFFECTS TO PUBLIC HEALTH AND SAFETY. THIS EVENT IS NOT REPETITIVE.
COOPER-1 EMERG CORE COOLING SYS + CONT VALVE OPERATORS HYDRAULIC COMPONENT FAILURE NATURAL END OF LIFE MILLER FLUID POWER CO.	05000298 79-019/01T-0 026930	080979 082079 2-WEEK	MS-SPIS-119B IS A BARTON MODEL 288 DIFFERENTIAL PRESSURE INDICATING SWITCH. THE CAUSE OF THE SETPOINT DRIFT IS ATTRIBUTED TO A FAULTY MICROSWITCH. ASSEMBLY WAS REPLACED.
COOPER-1 FIRE PROTECTION SYS + CONT INSTRUMENTATION + CONTROLS SENSOR/DETECTOR/ELEMENT DESIGN/FABRICATION ERROR CONSTRUCTION/INSTALLATION AUTO SPRINKLER CORP	05000298 79-021/03L-0 026926	081179 091779 30-DAY	UPON RECEIPT OF AN AUTO START SIGNAL, THE HPCI (HIGH PRESSURE COOLANT INJECTION) PUMP DID NOT INITIALLY START. HOWEVER, A SHORT TIME LATER THE PUMP STARTED AND WAS USED TO INCREASE REACTOR LEVEL. THE RCIC SYSTEM WAS OPERABLE AND STARTED AS REQUIRED, AS WERE ALL LOW PRESSURE INJECTION SYSTEMS. THE EVENT IS NOT REPETITIVE.
			THE PISTON RINGS IN THE VALVE ACTUATOR FOR THE TURBINE STOP VALVE HAD DEGRADATED AND WERE ALLOWING OIL TO FLOW AROUND THE PISTON. THE RINGS WERE REPLACED AND A SIMULATED AUTO ACTUATION TEST (S.P. 6.3.3.3) WAS PERFORMED SATISFACTORILY. THE PREVENTIVE MAINTENANCE PROGRAM REVISED TO REPLACE RINGS AND CHECK FOR RING LEAKAGE.
			THE PLANT WAS AT STEADY STATE OPERATION WHEN THE CONTROL ROOM RECEIVED AN ACTUATION ALARM FOR THE DELUGE SYSTEM ON THE STANDBY GAS TREATMENT SYSTEM "B" CARBON ADSORBER. THE CARBON ADSORBER IN STANDBY GAS TREATMENT SYSTEM "B" WAS WETTED WITH WATER AND RENDERED INOPERABLE PER RTS 3.7.B.3. THERE WERE NO ADVERSE EFFECTS ON PUBLIC HEALTH AND SAFETY. REDUNDANT SYSTEM WAS AVAILABLE.
			CAUSE OF THIS EVENT IS ATTRIBUTED TO IMPROPER INSTALLATION OF BASEPLATE OF FIRE DETECTION UNIT (PYROTRONICS MODEL DGS-3). INTERMITTENT ACTUATION OF FIRE PROTECTION SYS WAS CAUSED BY LEAD WIRE BEING "PINCHED" BETWEEN BASEPLATE & A METAL FITTING ATTACHING A PIECE OF FLEXIBLE CONDUIT. CARBON ADSORBER WAS DRIED & NEW BASEPLATE INSTALLED ENSURING WIRE NOT PINCHED

NOV 08, 1979

LER MONTHLY REPORT SORTED BY FACILITY
PROCESSED DURING OCTOBER, 1979 FOR POWER REACTORS

PAGE 25

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
COOPER-1 FIRE PROTECTION SYS + CONT VALVES CHECK COMPONENT FAILURE MECHANICAL AUTO SPRINKLER CORP	05000298 79-022/03L-0 026898	081279 090779 30-DAY	DURING NORMAL OPERATIONS, WATER WAS OBSERVED COMING FROM THE CARBON ADSORBER HOUSING OF STANDBY GAS TREATMENT SYSTEM "A". THE DELUGE SYSTEM HAD NOT BEEN INITIATED AND THE VALVE WAS FOUND CLOSED. THE CARBON ADSORBER TRAYS WERE SPRAYED WITH WATER AND RENDERED INOPERABLE PER RTS 3.7.B.3. THERE WERE NO ADVERSE EFFECTS ON PUBLIC HEALTH AND SAFETY. REDUNDANT SYSTEM WAS AVAILABLE. THE EVENT IS REPETITIVE, SEE LER 79-21. THE CAUSE OF THIS EVENT IS ATTRIBUTED TO INADEQUATE SEATING AREA BETWEEN VALVE CLAPPER AND LATCH, SYSTEM 22 AUTOMATIC SPRINKLER CORP. OF AMERICA N DELUGE VALVE. THE CLAPPER WAS REPLACED AND ADJUSTED TO PROVIDE SUFFICIENT SEATING AREA. THE CARBON ADSORBER WAS DRIED OUT AND THE SYSTEM RETURNED TO NORMAL.
CRYSTAL RIVER-3 SYSTEM CODE NOT APPLICABLE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR OTHER ITEM NOT APPLICABLE	05000302 79-013/04L-0 026795	012379 022779 30-DAY	CONTRARY TO ETS 3.1.5 WATER SAMPLES WERE NOT OBTAINED FOR JANUARY FROM TEST WELLS 1, 3 & 4. THE DISCHARGE CANAL DIRECTLY NORTH OF THE PONDS, & THE CHEMICAL-INDUSTRIAL WASTE WATER PONDS WITHIN 1 MONTH (+25%) OF THE 12/13/79 SAMPLES. NEW LAB DIRECTOR WAS NOT PROPERLY INFORMED OF PROCEDURE. NEW DIRECTOR WAS INFORMED OF PROPER TIME RESTRAINT AND WILL BE FULLY RESPONSIBLE FOR THE PROCEDURE.
CRYSTAL RIVER-3 SYSTEM CODE NOT APPLICABLE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000302 79-021/04L-0 026794	031579 040379 30-DAY	A DIFFERENCE OF >2 STANDARD DEVIATIONS EXISTED BETWEEN PREOP. STUDY AND OPERATIONAL STUDY IN METABOLIC FUNCTIONS FOR 2 AQUATIC ECOSYSTEMS IN DISCHARGE SALT MARSHES: (1) SPARTINA, DEAD BIOMASS-SUMMER QTR. AND (2) JUNCUS, LIVE BIOMASS-WINTER, SPRING, SUMMER, FALL QTRS; DEAD BIOMASS SUMMER, FALL QTRS; GROSS PRODUCTIVITY-SUMMER QTR. ECOSYSTEMS ARE STILL REORGANIZING TO OPERATIONAL CONDITIONS. NATURAL OR SEASONAL CHANGES AND/OR INCREASED THERMAL OUTPUT FROM PLANT SITE COULD HAVE CAUSED CHANGE. OPERATIONAL STUDY WILL BE CONTINUED AND HOWEVEFULLY WILL CLARIFY CAUSE OF THIS EVENT.
CRYSTAL RIVER-3 SYSTEM CODE NOT APPLICABLE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE EXTERNAL CAUSE NOT APPLICABLE ITEM NOT APPLICABLE	05000302 79-027/04X-0 026872	033079 040679 OTHER	CONTRARY TO ETS 3.1.4.D, FIRST QUARTER 1979 SAMPLES OF NUMBERS OF ORGANISMS WITH A REEF QUADRATE WERE NOT COLLECTED ON THE MARCH 1979 FIELD TRIP UNUSUALLY HIGH TIDES AND SEVERE WEATHER CONDITIONS RESULTED IN THESE REEFS NOT BEING EXPOSED DURING FIELD OPERATION. BECAUSE ALL OYSTER REEF DATA ARE BASED ON SAMPLES TAKEN ON EXPOSED REEFS, DECIDED NOT TO CHANGE METHODOLOGY. LESSER NUMBER WILL BE USED AND SO INDICATED IN THE ANNUAL REPORT.

1543 047

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
CRYSTAL RIVER-3 SYSTEM CODE NOT APPLICABLE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000302 79-039/04L-0 026796	042679 050179 30-DAY	A DIFFERENCE OF MORE THAN 2 STANDARD DEVIATIONS EXISTED BETWEEN PREOPERATIONAL AND OPERATIONAL STUDIES IN THE METABOLIC FUNCTIONS OF THE AQUATIC SYSTEM IDENTIFIED AS DISCHARGE SALT MARSHES (JUNCUS) FOR BOTH LIVE BIOMASS AND DEAD BIOMASS DURING WINTER QTR. REPETITIVE. ECOSYSTEM STILL ADAPTING TO NEW OPERATIONAL CONDITIONS. CAUSE COULD BE NATURAL OR SEASONAL VARIATIONS IN CONJUNCTION WITH SITE THERMAL DISCHARGE. PERIOD OF ADJUSTMENT BY ECOSYSTEM WAS EXPECTED CONCURRENT WITH UNIT 3'S INITIAL OPERATION. PRESENT ENVIRONMENTAL MONITORING PROGRAM WILL CONTINUE. CHANGES IN UNIT OPERATION NOT REQUIRED AT THIS TIME.
CRYSTAL RIVER-3 SYSTEM CODE NOT APPLICABLE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000302 79-016/04L-0 026793	051179 051579 30-DAY	ENVIRONMENTAL SAMPLES WERE NOT ANALYZED USING PROCEDURES WHICH PROVIDED LLD'S EQUAL TO OR GREATER THAN ETS REQUIREMENTS. LLD'S WERE GREATER THAN REQUIRED FOR 1 SEAWATER SAMPLE IN JANUARY, 2 CRAB SAMPLES IN 1ST HALF, AND 1 HERBIVOROUS FISH SAMPLE IN 1ST HALF YEAR. ACTIVITY ASSOCIATED WITH ZN-65 WAS NON-DETECTABLE FOR THE 1ST HALF OF THE YEAR FOR THESE SAMPLES. INADEQUATE SAMPLE TIME. ANALYSES ARE PERFORMED TO ACHIEVE LLD'S UNDER ROUTINE CONDITIONS. BACKGROUND FLUX, UNAVOIDABLE SMALL SAMPLE SIZE, PRESENCE OF INTERFERING NUCLEIDES OR OTHER UNCONTROLLABLE FACTORS MAY RENDER LLD'S UNACHIEVABLE. NO CORRECTIVE ACTION PROPOSED.
D. C. COOK-1 ENGRD SAFETY FEATR INSTR SYS INSTRUMENTATION + CONTROLS SWITCH PERSONNEL ERROR OTHER WESTINGHOUSE ELECTRIC CORP.	05000315 79-043/03L-0 026820	020179 091379 30-DAY	ON FEBRUARY 1, IT WAS DISCOVERED THAT AFTER SWITCHING APDMS DETECTORS ON JANUARY 22, THE APDMS DETECTOR F(2) ALARM SETPOINT WAS SET AT THE T.S. VALUE. UPON DISCOVERY THE ALARM SETPOINT VALUE WAS RESET TO THE PROPER VALUE. THIS IS NON-CONSERVATIVE IN RESPECT TO A PREVIOUS COMMITMENT STATED IN RO-316/78-68 AND RO-315/78-58. THIS EVENT IS NON-CONSERVATIVE IN RESPECT TO T.S. 3.3.3.6.B. THIS CONDITION EXISTED FROM JANUARY 22, WHEN AN APDMS DETECTOR WAS SWITCHED AND THE T.S. VALUE WAS USED FOR THE POWER LEVEL F(2) ALARM SETPOINT. THE TRACES DURING THIS OCCURRENCE HAVE BEEN REVIEWED AND THERE WAS SUFFICIENT MARGIN SO THAT THERE WOULD HAVE BEEN NO F(2) VIOLATIONS. SETPOINTS NOW POSTED AT APDMS.
D. C. COOK-1 EMERG CORE COOLING SYS + CONT HEATERS, ELECTRIC SUBCOMPONENT NOT APPLICABLE COMPONENT FAILURE ELECTRICAL CHROMALOX	05000315 79-041/03L-0 026769	081479 091279 30-DAY	DURING NORMAL OPERATION, A GROUND WAS DISCOVERED ON THE BORON INJECTION TANK TRAIN B HEATERS. THE HEATER TRAIN WAS REMOVED FROM SERVICE AND THE REQUIRED ACTION ITEMS OF TECH. SPEC. 3.5.4.2 WERE FOLLOWED. NO PREVIOUS EVENTS OF THIS NATURE. PUBLIC HEALTH AND SAFETY WERE NOT JEOPARDIZED. ONE CHROMALOX TH-18 HEATER WAS REPLACED AND THE TRAIN B HEATER WAS VERIFIED TO BE OPERABLE. BOTH HEATER TRAINS ARE NOW CLEAR OF GROUNDS. THE CAUSE OF THE HEATER FAILURE HAS BEEN ATTRIBUTED TO NATURAL END OF LIFE.

1543 048

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
D. C. COOK-1 REACTOR TRIP SYSTEMS INSTRUMENTATION + CONTROLS TRANSMITTER PERSONNEL ERROR MAINTENANCE & REPAIR PERSONNEL BARTON INSTRU CO., DIV OF ITT	05000315 79-042/03L-0 026818	081479 091379 30-DAY	ON AUGUST 14, WHILE ISOLATING A PRESSURIZER LEVEL TRANSMITTER (NLP-152) THE ASSOCIATED PRESSURIZER PRESSURE TRANSMITTER (NPP-152) WAS ISOLATED. WHEN NPP-152 WAS VALVED BACK IN, INDICATION DIFFERED FROM THE OTHER PRESSURIZER PRESSURE CHANNELS. NPP-152 OUTPUT WAS ADJUSTED FOR PROPER OUTPUT. ON AUGUST 22, IT WAS DISCOVERED THAT THERE WAS A 30 PSI DIFFERENCE BETWEEN THE PRESSURIZER PRESSURE INDICATION AND A HEISE GAUGE. GAUGES WERE RE-CALIBRATED. THESE PRESSURIZER PRESSURE TRANSMITTERS WERE INSTALLED DURING THE LAST REFUELING OUTAGE BECAUSE THEY ARE ENVIRONMENTALLY QUALIFIED FOR USE UNDER POST ACCIDENT CONDITIONS. AS OF THIS TIME, IT IS NOT KNOWN WHAT CAUSED ALL OF THESE TRANSMITTERS TO DRIFT. HOWEVER, THE INVESTIGATION IS STILL OPEN. SURVEILLANCE IS PERIODIC.
D. C. COOK-1 REACTOR CONTAINMENT SYSTEMS HEAT EXCHANGERS CONDENSER EXTERNAL CAUSE NOT APPLICABLE WESTINGHOUSE ELECTRIC CORP.	05000315 79-045/03L-0 026967	083179 100179 30-DAY	DURING A ROUTINE TOUR ON 8-31-79, ONE ICE CONDENSER INTERMEDIATE DECK DOOR WAS FOUND TO BE FROZEN SHUT CONTRARY TO THE REQUIREMENTS OF T.S. 3.6.5.3. A SIMILAR SITUATION WAS DISCOVERED 9-17-79 WHEN SIX DOORS WERE FOUND FROZEN. IN BOTH CASES, THE ICE WAS CHIPPED AWAY AND THE DOORS WERE FREED. THIS EVENT DID NOT AFFECT PUBLIC HEALTH AND SAFETY. A SIMILAR OCCURRENCE WAS REPORTED AS #79-036/03L-0.
D. C. COOK-1 REACTIVITY CONTROL SYSTEMS CONTROL RODS SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000315 79-046/03L-0 026999	090579 100579 30-DAY	THE ICE BUILDUPS APPEAR TO HAVE BEEN CAUSED BY CONDENSATION. PRIOR TO EACH OCCURRENCE, THE ICE BED TEMPERATURE WAS DECREASING RESULTING IN INCREASED INFLUX OF HUMID AIR. THIS WITH THE HIGHER HUMIDITY IN THE SUMMER MONTHS RESULTED IN THE CONDENSATION WHICH FROZE STICKING THE DOORS SHUT. DAILY INSPECTIONS HAVE NOT INDICATED ANY FURTHER PROBLEMS. WHILE CONDUCTING A FULL LENGTH CONTROL ROD OPERABILITY TEST, AN URGENT FAILURE ALARM FROM POWER CABINET 2 AC WAS RECEIVED ON ROD CONTROL. ONLY SHUTDOWN BANK-A WOULD MOVE. THE OTHER CONTROL BANKS COULD NOT BE MOVED EVEN IN MANUAL CONTROL. THIS EVENT IS NON-CONSERVATIVE IN RESPECT TO T.S. 3.1.3.1. THE REQUIREMENTS OF ACTION ITEM B WERE MET AS THE CONTROL RODS WERE RETURNED TO OPERATION IN LESS THAN 6 HOURS.
D. C. COOK-2 ENGRD SAFETY FEATR INSTR SYS INSTRUMENTATION + CONTROLS SWITCH PERSONNEL ERROR MAINTENANCE & REPAIR PERSONNEL WESTINGHOUSE ELECTRIC CORP.	05000316 79-029/03L-0 026819	071579 091379 30-DAY	INVESTIGATION FAILED TO REVEAL ANY EQUIPMENT FAILURE OR MALFUNCTION. THE POWER SUPPLY WAS RESET AND THE FULL LENGTH CONTROL ROD OPERABILITY TEST WAS SATISFACTORILY COMPLETED. NO OTHER PROBLEMS HAVE BEEN ENCOUNTERED SINCE THIS EVENT. NO FURTHER ACTIONS ARE PLANNED AT THIS TIME.
			ON JULY 15, IT WAS DISCOVERED THAT AFTER COMPLETING REPAIRS TO THE APDMS ON JULY 13, AN APDMS DETECTOR F(Z) LIMIT SETPOINT WAS SET AT THE T.S. VALUE. THIS WAS RESET TO THE PROPER VALUE. THIS IS NON-CONSERVATIVE IN RESPECT TO A PREVIOUS COMMITMENT STATED IN RO-316/78-63. THIS EVENT IS NON-CONSERVATIVE IN RESPECT TO T.S. 3.3.3.7.B.
			THIS CONDITION EXISTED SINCE JULY 13, WHEN REPAIRS WERE COMPLETED TO THE APDMS. THE REPAIR TECHNICIAN WAS GIVEN THE CORRECT SETPOINT VALUES. HOWEVER, AS A SHIFT CHANGE OCCURRED, THE NEW INDIVIDUAL DID NOT RECEIVE THESE VALUES. THE TRACES DURING THIS EVENT HAVE BEEN REVIEWED AND THERE WERE NO VIOLATIONS. SETPOINTS NOW POSTED AT APDMS.

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
D. C. COOK-2 OTHER INST SYS REQD FOR SAFETY COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE DEFECTIVE PROCEDURES NOT APPLICABLE ITEM NOT APPLICABLE	05000316 79-028/03L-0 026714	081079 082979 30-DAY	WHILE PERFORMING THE DAILY SURVEILLANCE TESTS, IT WAS DISCOVERED THAT ONE OF THE THREE SPECIFIED LOWER CONTAINMENT TEMP READINGS HAD NOT BEEN RECORDED ON DATA SHEETS DUE TO FAILURE OF THAT TEMP MEASURING POINT. THE THREE POINTS ON THE DATA SHEET ARE CHOSEN FROM A TOTAL OF 8 POINTS WHICH MEET LOCATION REQUIREMENTS IN T.S. 4.6.1.5.1. THE REMAINING 7 POINTS WERE ALL OPERABLE & WERE RECORDING READINGS BELOW THE ALLOWABLE AVERAGE TEMPERATURE. THE REQUIREMENTS OF T.S. 4.6.1.5.3 WERE NOT MET. THE ERROR WAS CAUSED BY THE FACT THAT THE DATA SHEET DID NOT SPECIFICALLY INDICATE THAT THREE READINGS WERE REQUIRED, AND ALSO THAT IT DID NOT INDICATE THAT OTHER MEASURING POINTS COULD BE SUBSTITUTED FOR THESE POINTS. THE DATA SHEET HAS BEEN CORRECTED TO PREVENT A REOCCURRENCE.
DAVIS-BESSE-1 PROCESS + EFF RADIOLOGICAL MONITOR SYSTEMS INSTRUMENTATION + CONTROLS SENSOR/DETECTOR/ELEMENT COMPONENT FAILURE INSTRUMENT ITEM NOT APPLICABLE	05000346 79-001/04L-0 026807	010279 013079 30-DAY	REVIEW OF PREVIOUS RADIATION MONITOR FAILURES DETERMINED THAT STATION VENTILATION RADIATION MONITORS RE2024 AND RE2025 WERE BOTH INOPERABLE ON 8/29/77 & 12/14/77, VIOLATING ETS 2.4-3. GRAB SAMPLES WERE WITHIN LIMITS DURING EACH PERIOD. CONDENSER AIR EJECTOR MONITORS RE 1003A AND B WERE NOT OPERABLE DURING THIS TIME AS REQUIRED BY ETS.
DAVIS-BESSE-1 LIQUID RADIOACTIVE WASTE MANAGEMENT SYSTEMS COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE DESIGN/FABRICATION ERROR DESIGN ITEM NOT APPLICABLE	05000346 79-002/04L-0 026808	010479 020179 30-DAY	COMPONENT FAILURE. ALERT SETPOINT ON RE 2025 WAS RESET AND SETPOINTS ON BOTH MONITORS WERE RECALIBRATED. PERSONNEL REINSTRUCTED ON REPORTABILITY OF MONITOR FAILURES. ETS CURRENTLY UNDER REVISION. MODIFICATIONS TO SURVEILLANCE TESTS ST 5032.01 & ST 5032.02 MADE TO CLARIFY REPORTING REQUIREMENTS. MONTHLY FUNCTIONAL TEST OF RADIATION MONITORING SYSTEM DETERMINED THAT RE 2024, SERVICE WATER SYSTEM, HEADER OUTFLOW RADIATION MONITOR HAD LOW FLOW LIGHT AND WAS INOPERABLE (ETS 2.4-3). NO DANGER TO PUBLIC HEALTH & SAFETY. RE1412 AND RE1413 IN COMPONENT COOLING LINES 1 & 2, RESPECTIVELY, ARE UPSTREAM FROM RE2024 AND WOULD HAVE INDICATED ACTIVITY IF PRESENT. NEITHER RE1412, RE1413, NOR WEEKLY GRAB SAMPLES INDICATED ANY LEAKS.
DAVIS-BESSE-1 GAS RADIOACTIVE WASTE MANAGEMENT SYSTEMS PUMPS VANE TYPE COMPONENT FAILURE NATURAL END OF LIFE ITEM NOT APPLICABLE	05000346 79-004/04L-0 026809	012679 022179 30-DAY	COMPONENT DEFICIENCIES DUE TO DESIGN ERROR. NOT ENOUGH PRESSURE DIFFERENTIAL TO MAINTAIN CORRECT SAMPLE FLOW IN ALL OPERATION MODES OF SERVICE WATER SYSTEM. FLOW SWITCH STICKS WITHOUT ENOUGH FLOW. FLOW SWITCH WAS REPLACED WITHOUT SUCCESS. FACILITY CHANGE REQUEST INITIATED TO CORRECT FLOW PROBLEM. ON 01/22/79 STATION VENT MONITOR RE 2024 WAS DECLARED INOPERABLE. ON 2/26/79, THE PUMP FOR MONITOR RE 2025 SEIZED AND WAS DECLARED INOPERABLE, VIOLATING ETS 2.4.4 WHICH REQUIRES A MINIMUM OF 1 OPERABLE MONITOR FOR THE STATION VENT. NO GASEOUS RELEASES WERE MADE WHILE BOTH MONITORS WERE OUT. RE 2024 WAS RETURNED TO SERVICE LATER ON 2/26/79. NO DANGER TO PUBLIC HEALTH AND SAFETY.
			RE 2024 FAILED DUE TO NORMAL VANE WEAR. RE 2025 FAILURE PROBABLY DUE TO EXCESSIVELY LOW FLOW CONDITIONS DURING TESTING. PUMPS WERE REPLACED IN BOTH MONITORS AND OPERATIONALLY TESTED. PREVENTIVE MAINTENANCE PROGRAM MODIFIED.

1543 050

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
DUANE ARNOLD REACTOR TRIP SYSTEMS RELAYS CONTROL, GENERAL PURPOSE DESIGN/FABRICATION ERROR CONSTRUCTION/INSTALLATION GENERAL ELECTRIC CO.	05000331 78-031/01X-1 021862	061778 092079 OTHER	DURING WEEKLY CONTROL VALVE TESTING AN AUTOMATIC REACTOR SCRAM OCCURRED. PLANT TRIPPED WHEN 7 REACTOR PROTECTION SYSTEM RELAY AUXILIARY SWITCHES FAILED IN THE CLOSED POSITION LEADING TO ACTUATION OF THE BACK-UP SCRAM VALVE SOLENOIDS. THE PLANT REMAINED SHUTDOWN FOR REPAIRS. OPERATION OF THE REACTOR PROTECTION SYSTEM MAIN RELAYS WAS NOT AFFECTED BY THE AUXILIARY SWITCH MALFUNCTIONS.
DUANE ARNOLD COOLANT RECIRC SYS + CONTROLS PIPES, FITTINGS 6 TO 10 INCHES PERSONNEL ERROR CONTRACT. & CONSULT. PERSONNEL CHICAGO BRIDGE & IRON COMPANY	05000331 79-001/03X-1 025714	012879 092079 OTHER	THE CAUSE OF THE SWITCH PROBLEMS WAS TRACED TO THE SCREW WHICH RETAINS THE OPERATING ARM OF THE AUXILIARY SWITCH BECOMING LOOSE AND BACKING OUT. THIS CAUSED MISOPERATION AND IN ONE CASE ALLOWED THE ARM TO FALL OFF. THE RETAINING SCREWS AND OPERATING ARMS WERE REINSTALLED AND PROPERLY TIGHTENED. SWITCH VENDOR RECOMMENDED NO FURTHER COR. ACTION BE TAKEN. WHILE OPERATING RECIRCULATION SYSTEM IN PREPARATION FOR A HYDROSTATIC TEST, NO FLOW INDICATION WAS NOTED FOR NUMBER 3 & 4 JET PUMPS. FLOW INSTRUMENTATION WAS IMMEDIATELY TESTED & FOUND OPERABLE. ADDITIONAL TESTING WAS THEN PERFORMED WHICH CONFIRMED BLOCKAGE EXISTED IN EITHER N2B RISER OR IN ASSOCIATED JET PUMPS NUMBERS 3 & 4. PLANNING WAS BEGUN FOR INVESTIGATING NATURE AND POSITION OF BLOCKAGE AND FOR ITS REMOVAL. A REVIEW OF REPAIR PROCEDURES WAS BEGUN. (SEE LER 78-030). INVESTIGATION REVEALED CONSULTANT PERSONNEL MANAGING REPLACEMENT OF ALL RECIRC SYSTEM INLET NOZZLE SAFE-ENDS HAD NOT FOLLOWED PROCEDURES PROPERLY AND HAD APPARENTLY NOT ENSURED A LEAD SHIELD PLUG & CANNISTER WAS REMOVED FROM N2B NOZZLE. CONTRIBUTING CAUSE LACK OF QUALITY VERIFICATION THAT PIPE WAS CLEAR PRIOR TO CLOSURE. LEAD PLUG WAS REMOVED.
DUANE ARNOLD CONTAINMENT COMBUS GAS CONTROL SYS VALVES BUTTERFLY DESIGN/FABRICATION ERROR DESIGN FISHER CONTROLS CO.	05000331 79-002/01X-1 025713	030679 092079 OTHER	DURING A DESIGN REVIEW OF CONTAINMENT PURGING EQUIPMENT & CONTROLS IT WAS DETERMINED THAT CONTAINMENT PURGE VALVES CV4300, 4301, 4302, 4303, 4306, 4307 AND 4308 WERE NOT DESIGNED TO CLOSE FROM FULL OPEN POSITION AGAINST DIFFERENTIAL PRESSURE RESULTING FROM A DESIGN BASIS LOCA. VALVE VENDORS INDICATED VALVES WOULD CLOSE AGAINST LOCA FORCES IF LIMITED TO OPENING NO MORE THAN 30 DEGREES. VALVES WERE ALL PLACED IN CLOSED POSITION UNTIL MODIFICATIONS COULD BE COMPLETED. VALVE VENDOR DID NOT SUPPLY VALVES ACCORDING TO ARCHITECT ENGINEERS SPECIFICATIONS. SPECS REFLECTED PROPER DIFFERENTIAL PRESSURE UNDER WHICH VALVE WOULD HAVE TO OPERATE. THIS PRESSURE (46 PSID) IS BASED ON TIME DEPENDENT CONTAINMENT PRESSURE AFTER LOCA. ALL 7 VALVES HAVE BEEN MOD TO LIMIT OPENING TO 30 DEGREES. NO FURTHER ACTION PLANNED.
DUANE ARNOLD REACTOR COOL PRES BOUN LEAK DETEC INSTRUMENTATION + CONTROLS RECORDER COMPONENT FAILURE ELECTRONIC HONEYWELL CORPORATION	05000331 79-013/03L-0 026873	061479 071379 30-DAY	DURING DAILY SURVEILLANCE TESTING, RR 4379A & RR 4379B, DRYWELL GASEOUS RADIATION MONITORS, WERE FOUND TO BE INDICATING DOWNSCALE. PARTICULATE & IODINE MONITORING FUNCTIONS OF RECORDERS WERE OPERABLE. TECH SPEC SECTION 3.6.C REQUIRES BOTH SUMP & AIR SAMPLING SYSTEMS TO BE OPERABLE DURING REACTOR OPERATION. A SEVEN DAY LIMITING CONDITION FOR OPERATION WAS ENTERED. THERE HAD BEEN 2 PREVIOUS OCCURRENCES INVOLVING THESE RECORDERS (SEE LERS 77-3 AND 77-4). AN AMPLIFIER CARD IN RR 4379B WAS REPAIRED & RECORDER TESTED & FOUND OPERABLE. THIS ACTION WAS COMPLETED APPROXIMATELY 25 HRS AFTER RECORDERS WERE FOUND DOWNSCALE. THIS CANCELLED 7 DAY LO. RES102A WAS REPLACED & RR 4379A IS AWAITING OPERABILITY TESTING. BOTH RECORDERS ARE HONEYWELL MODEL 37303.

1543 051

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
DUANE ARNOLD SYSTEM CODE NOT APPLICABLE HANGERS, SUPPORTS, SHOCK SUPPRSS SUPPORTS DESIGN/FABRICATION ERROR CONSTRUCTION/INSTALLATION RED HEAD/PHILLIPS DRILL CO.	05000331 79-014/01T-0 026876	070379 071779 2-WEEK	AS A RESULT OF NRC BULLETIN 79-02, A SPECIAL TESTING PROGRAM WAS DEVELOPED & IMPLEMENTED TO TEST PIPE SUPPORT BASE PLATE DESIGNS USING CONCRETE EXPANSION ANCHOR BOLTS. RESULTS OF TESTING INDICATED A POTENTIAL GENERIC PROBLEM EXISTED WITH ANCHOR BOLTS NOT MEETING SEISMIC DESIGN CRITERIA. ANALYSIS BY ARCHITECT ENGINEER CONCLUDED FAILURE RATE SUFFICIENTLY LOW SO AS TO NOT COMPROMISE ECCS OPERABILITY IN EVENT OF A DESIGN BASIS EARTHQUAKE. ECCS DETERMINED THEREFORE TO BE OPERABLE. CAUSE DETERMINED TO BE PRIMARILY FAULTY INSTALLATION WITH A CONTRIBUTING CAUSE OF INADEQUATE DESIGN. MAJORITY OF INSTALLED ANCHOR BOLTS WERE MADE BY PHILLIPS DRILL CO. AT THE PRESENT TIME AN ANCHOR BOLT REPLACEMENT PROGRAM IS IN PROGRESS. REPLACEMENT ANCHOR BOLTS OF AN IMPROVED DESIGN MADE BY HILTI ARE BEING INSTALLED.
DUANE ARNOLD EMERG CORE COOLING SYS + CONT COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE DEFECTIVE PROCEDURES NOT APPLICABLE ITEM NOT APPLICABLE	05000331 79-015/03L-0 026874	070579 080379 30-DAY	DURING AN ANNUAL REVIEW OF SURVEILLANCE PROGRAM IT WAS DETERMINED THE REQUIREMENT ON TECH SPEC PAGE 3.2-15, NOTE 6, TO MEASURE RELAY DROPOUT VOLTAGE HAD NOT BEEN INCORPORATED INTO SURVEILLANCE TEST WHICH TESTS HPCI, RCIC, LPCI, ADS & CORE SPRAY TRIP SYSTEM BUS POWER MONITOR RELAYS. THE SURVEILLANCE TEST IN QUESTION DID PROVIDE FOR A FUNCTIONAL TEST OF THE RELAYS WHICH VERIFIED OPERABILITY. ECCS OPERABILITY NOT AFFECTED.
DUANE ARNOLD FEEDWATER SYSTEMS + CONTROLS VALVES SINGLE BLADE COMPONENT FAILURE MECHANICAL HEX INDUSTRIES, INC.	05000331 79-016/01T-0 026875	072579 080879 2-WEEK	DEFECTIVE PROCEDURE. A SURVEILLANCE TEST PROCEDURE (STP) MEASURING RELAY DROPOUT VOLTAGE WAS APPARENTLY DELETED FOLLOWING CHANGE 15 TO T.S. WITH OUT INCORPORATING THIS TEST REQUIREMENT INTO ANOTHER STP. A NEW STP IS CURRENTLY BEING DEVELOPED WHICH WILL SATISFY CURRENT T.S. TESTING REQUIREMENTS. THIS TEST WILL BE PERFORMED WHEN REVIEW & APPROVAL IS COMPLETED. DURING NORMAL OPERATION IT WAS DETERMINED THAT PLANT HEAT RATES & EFFICIENCIES WERE BETTER THAN NORMALLY EXPECTED. AN INVESTIGATION WAS BEGUN WHICH CENTERED ON FEEDWATER FLOW INSTRUMENTATION. FOLLOWING A PLANT OUTAGE ON 7/21/79, DURING WHICH F/W FLOW INSTRUMENT MANIFOLD VALVES WERE REPAIRED, HEAT RATES & EFFICIENCIES WERE CLOSE TO EXPECTED VALUES. IT HAS SINCE BEEN CALCULATED THAT LICENSED THERMAL POWER LIMIT WAS EXCEEDED. IT CAN ALSO BE CONCLUDED MAPLHGR, LHGR & MCPR LIMITS WERE EXCEEDED. EQUALIZING VALVES ON VALVE MANIFOLDS FOR FLOW TRANSMITTERS FOR BOTH FEED WATER TRAINS WERE SLIGHTLY STEAM CUT, WHICH ALLOWED BYPASS FLOW & GAVE LOW F/W FLOW INDICATION. THIS CAUSED CORE THERMAL POWER CALCULATION TO BE NON-CONSERVATIVE. VALVES LAPPED. MANIFOLD MADE BY HEX INDUSTRIES WILL BE REPLACED. REDUNDANT INDICATION WILL BE ADDED.
DUANE ARNOLD REACTOR CONTAINMENT SYSTEMS INSTRUMENTATION + CONTROLS SWITCH COMPONENT FAILURE ELECTRICAL BARTON INSTRU CO., DIV OF ITT	05000331 79-018/03L-0 026878	072679 082479 30-DAY	DURING SURVEILLANCE TESTING PRESSURE DIFFERENTIAL SWITCHES WHICH CONTROL SUPPRESSION CHAMBER TO REACTOR BLDG VACUUM BREAKERS TRIPPED AT OUT OF SPECIFICATION VALUES. PDS 4304 HAD NOT TRIPPED BY TIME UPPER LIMIT (3.5 PSID) OF TEST INSTRUMENT WAS REACHED & PDS 4305 TRIPPED AT .64 PSID. SETPOINT REQUIRED BY TECH SPEC 3.7.A.3 IS .5 PSID. SWITCHES WERE RECALIBRATED & FUNCTIONALLY TESTED. THERE WERE 3 PREVIOUS SIMILAR OCCURRENCES (SEELERS 75-33, 77-55 AND 78-32). PDS 4305 WAS OUT OF TOLERANCE DUE TO INSTRUMENT DRIFT. CAUSE OF PDS 4304 NOT TRIPPING IS UNKNOWN. BOTH SWITCHES ARE BARTON MODEL 288A PRESSURE DIFFERENTIAL SWITCHES. SWITCHES WERE CALIBRATED & FUNCTIONALLY TESTED WITH SATISFACTORY RESULTS. A DESIGN REVIEW IS CURRENTLY IN PROGRESS TO DETERMINE ADEQUACY OF THIS INSTRUMENT APPLICATION.

1543 052

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
DUANE ARNOLD REACTIVITY CONTROL SYSTEMS OTHER COMPONENTS SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000331 79-019/03L-0 026879	072879 082779 30-DAY	FOLLOWING A POWER INCREASE IN ACCORDANCE WITH APPROVED PROCEDURES, CPR W AS FOUND TO BE AT FLOW ADJUSTED 1.364 T.S. LIMIT. IN ORDER TO GAIN MARGI N CORE FLOW WAS DECREASED FROM 62% TO 48% IN PREPARATION FOR DRIVING CON TROL RODS. CPR WAS AGAIN CHECKED & FOUND TO BE 1.430, BELOW FLW ADJUSTE D 1.436 T.S. LIMIT. FOUR CONTROL RODS WERE INSERTED FROM POSITION 18 TO POSITION 12 WITHIN 6 MINUTES. CPR WAS AGAIN CHECKED & FOUND TO BE 1.588, WELL ABOVE THE 1.436 T.S. LIMIT. THIS OCCURRENCE WAS RESULT OF A XENON TRANSIENT CAUSING THERMAL POWER TO INCREASE. CORRECTIVE ACTIONS TO INCREASE CPR WERE PROPER AND WELL WITHI N TIME LIMITS SPECIFIED IN TECHNICAL SPECIFICATIONS PARAGRAPH 3.12.C. PL ANT HAS BEEN AND WILL CONTINUE TO BE OPERATED IN A MANNER WHICH WILL MTN IMIZE THIS TYPE OF OCCURRENCE.
DUANE ARNOLD SAFETY RELATED DISPLAY INSTR INSTRUMENTATION + CONTROLS TRANSMITTER COMPONENT FAILURE ELECTRONIC GENERAL ELECTRIC CO.	05000331 79-017/03L-0 026877	081079 090679 30-DAY	DURING NORMAL OPERATION OPERATIONS PERSONNEL NOTED SUPPRESSION CHAMBER W ATER LEVEL INDICATION ON LR 4385 WAS DRIFTING DOWNSCALE WHILE REDUNDANT INDICATION ON LR 4384 WAS STABLE. TECHNICAL SPECIFICATIONS TABLE 3.2-F R EQUIRES TWO SUPPORESSION CHAMBER WATER LEVEL INDICATORS BE OPERABLE. THE RE HAVE BEEN NO PREVIOUS SIMILAR OCCURRENCES.
DUANE ARNOLD CONT ROOM HABITBLTY SYS + CONT INSTRUMENTATION + CONTROLS TRANSMITTER COMPONENT FAILURE INSTRUMENT GENERAL ELECTRIC CO.	05000331 79-023/03L-0 027094	091779 101179 30-DAY	COMPONENT FAILURE. LEVEL TRANSMITTER, LT 2325, ASSOCIATED WITH LR4385 WA S FOUND TO HAVE A FAULTY AMPLIFIER CARD. LT 2325 IS A GE-MAC MODEL 555 L IQUID LEVEL TRANSMITTER. AMPLIFIER CARD WAS REPLACED WITH A LIKE-FOR-LIK E SPARE & TRANSMITTER CALIBRATED & FUNCTIONALLY TESTED WITH SATISFACTORY RESULTS. NO FURTHER CORRECTIVE ACTION PLANNED.
EDWIN I. HATCH-1 SYSTEM CODE NOT APPLICABLE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR CONSTRUCTION PERSONNEL ITEM NOT APPLICABLE	05000321 79-021/04L-0 026797	032079 032679 30-DAY	DURING SURVEILLANCE TESTING CONTROL BUILDING STANDBY FILTER UNIT (SBFU) 1V-SFU-30B DID NOT START WHEN INITIATED. REDUNDANT STANDBY FILTER UNIT IV-SFU-30A WAS OPERABLE. OPERABILIT. REQUIREMENTS ARE LISTED IN TECHNIC AL SPECIFICATIONS SECTION 3.10.1. A 7 DAY LCO WAS ENTERED AS PER TECH. SPEC. PARAGRAPH 3.10.A.3. THERE HAS BEEN ONE PREVIOUS SIMILAR OCCURRENC E (SEE RO REPORT 77-082).
			FT7320B WAS DRIFTED SUFFICIENTLY UPSCALE TO PREVENT THE PERMISSIVE START SIGNAL FOR THE "B" SBFU. FT7320B IS A GE MODEL 552 FLOW TRANSMITTER. FT7 320B WAS RECALIBRATED & SBFU SURVEILLANCE TEST COMPLETED WITH SAT. R ESULTS ENDING 7 DAY LCO. DESIGN REVIEW TO BE INITIATED. CALIBRATION OF FT7320B TO BE CHECKED WEEKLY PENDING DESIGN REVIEW RESULTS.
			DURING STEADY STATE POWER OPERATION AT 2384 MWt, 2 CHEMICAL RADIATION TE CHNICIANS OBSERVED WATER BUBBLING OUT OF GROUND WHILE OBTAINING A WATER SAMPLE FROM PIEZOMETER WELL P17B NEAR DIESEL GENERATOR BLDG. ANALYSIS O F WATER & SOIL REVEALED SMALL AMOUNTS OF RADIOACTIVITY AS FOUND IN REACT OR STEAM SAMPLES. NO SIGNIFICANT IMPACTS ON PUBLIC HEALTH & SAFETY BECAU SE EVENT OCCURRED IN PROTECTED AREA OF SITE, ACTIVITY RELEASED WAS SMALL , & ACTIVITY (EXCLUDING TRITIUM) WAS CONFINED TO IMMED POINT OF DISCHAR. DURING CONSTRUCTION A 1/2 INCH LINE WAS INSTALLED TO CARRY INERTING NITR OGEN TO FEEDWATER HEATERS FROM A TANK IN YARD. OPEN LINE NOT REMOVED A FTER UNIT STARTUP. VALVE DISCOVERED PARTIALLY OPEN ON THIS LINE NEAR FE EDWATER HEATER WAS IMMEDIATELY CLOSED. LINE WAS CAPPED INSIDE TURBINE B UILDING TO PREVENT RECURRENCE.

1543 053

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
EDWIN I. HATCH-1 MAIN STEAM ISOL SYS + CONTROLS VALVES GLOBE DESIGN/FABRICATION ERROR DESIGN NAMCO CONTROLS	05000321 79-037/01T-1 026153	061279 072379 2-WEEK	DURING THE 1979 REFUELING OUTAGE A GENERAL ELECTRIC REVIEW OF CLASS IE DRYWELL EQUIPMENT IN RESPONSE TO IEB 79-01, INDICATED THAT THE LIMIT SWITCHES ON MAIN STEAM ISOLATION VALVES B21-F022A, B, C, & D DID NOT HAVE A COMPLETE TEMPERATURE & RADIATION QUALIFICATION TEST REPORT DOCUMENT TO QUALIFY IT TO PERFORM UNDER AN ACCIDENT CONDITION. NO SIGNIFICANT EFFECT ON PLANT SAFETY FROM EVENT SINCE WORST CASE FAILURE OF THESE LIMIT SWITCHES WOULD ONLY RESULT IN A LOSS OF VALVE POSITION INDICATION. AT TIME OF INSTALLATION, NAMCO MODEL SL3-B2W LIMIT SWITCHES WERE NOT REQUIRED TO HAVE ENVIRONMENTALLY QUALIFIED TEST REPORT DOCUMENTS. LATER IMPLEMENTED IEB 79-01 REQUIRED ALL IE EQUIPMENT IN DRYWELL MEET TEST QUALIFICATIONS FOR ACCIDENT CONDITIONS. NEW NAMCO MODEL EA-740-8000 LIMIT SWITCH IS ORDERED & WILL BE INSTALLED AT FIRST SCHEDULED COLD SHUTDOWN. WITH THE REACTOR IN THE SHUTDOWN COOLING MODE, THE 1C RHR PUMP (E11-C002C) WAS FOUND TO HAVE AN EXCESSIVE LEAK AT THE MECHANICAL SEAL. WHEN THE 1C RHR PUMP WAS REMOVED FROM SERVICE TO REPAIR THE SEAL, THE REACTOR UNIT WAS NOT IN COMPLIANCE WITH TECHNICAL SPECIFICATION 3.5.B.1.A BECAUSE THE RHR PUMPS IN THE B LOOP WERE ALREADY OUT OF SERVICE FOR HANGER REPAIRS. PUBLIC HEALTH AND SAFETY WERE NOT AFFECTED BY THIS INCIDENT. THE EXCESSIVE LEAKAGE WAS CAUSED BY THE MECHANICAL SEAL BEING RUPTURED. THE SEAL WAS REPLACED AND THE 1C RHR PUMP RETURNED TO SERVICE ON JULY 27, 1979.
EDWIN I. HATCH-1 RESIDUAL HEAT REMOV SYS + CONT PUMPS CENTRIFUGAL COMPONENT FAILURE MECHANICAL BYRON JACKSON PUMPS, INC.	05000321 79-050/01X-1 026419	072579 090579 OTHER	WITH REACTOR IN COLD SHUTDOWN, WHILE PERFORMING RHR SERVICE WATER PUMP OPERABILITY TEST, RHR SERVICE WATER PUMPS WERE FOUND INCAPABLE OF DELIVERING A RATED FLOW FROM EACH PUMP OF 4000 GPM AT 384 PSI AS REQUIRED BY T.S. 4.5.C.1.B. THE PUMPS & FAILURE DATES ARE: E11-C001B & E11-C001D ON AUGUST 12, 1979, E11-C001A ON AUGUST 16, 1979, & E11-C001D ON AUGUST 20, 1979. PUBLIC HEALTH AND SAFETY WERE NOT AFFECTED BY THIS INCIDENT. PUMPS FAILED TO DELIVER RATED FLOW DUE TO NORMAL WEAR ON THE IMPELLER WEAR RINGS AND THE BUSHINGS. THESE PUMPS ARE DESIGNED TO DELIVER RATED FLOW UNDER FACTORY CONDITIONS WITH NO ALLOWANCES MADE FOR WEAR. THE PUMPS WERE REBUILT AND REINSTALLED. THE LAST PUMP TO BE TESTED, E11-C001C, WAS FOUND SATISFACTORY ON AUGUST 24, 1979. ON 8-16-79, AT 1000 CST IT WAS DISCOVERED THAT FUNCTIONAL TESTS FOR THE CABLE SPREADING ROOM CO2 SYSTEM & 130' EL. CONTROL BUILDING CORRIDOR SPRINKLER SYSTEM HAD NOT BEEN SUBMITTED FOR PLANT REVIEW BOARD APPROVAL OF TEMPORARY CHANGES MADE ON 7-30-79, & 7-31-79, BEFORE 14 DAY LIMIT SPECIFIED IN HMP-818 SECTION B.3. OPERABILITY OF FIRE PROTECTION SYSTEMS & PLANT SAFETY WERE NOT ADVERSELY AFFECTED. THIS IS A REPETITIVE OCCURRENCE - SEE LER 2-79-91. COORDINATING ENG FAILED TO SUBMIT TEMP CHANGES TO PRB WITHIN 14 DAY LIMIT. ADEQUATE TRACKING OF SUCH CHANGES WILL BE PROVIDED ADMINISTRATIVELY BY A REVISION TO PROCEDURE HNP-818 (TEMPORARY PROCEDURE CHANGE APPROVED 8-24-79, WHICH REQUIRES ALL TEMPORARY PROCEDURE CHANGE TO BE LOGGED & TRACKED BY APPRO DEPT HEAD. FULL COMPLIANCE WILL BE ACHIEVED BY 9-1-79.
EDWIN I. HATCH-1 RESIDUAL HEAT REMOV SYS + CONT PUMPS CENTRIFUGAL COMPONENT FAILURE MECHANICAL JOHNSTON PUMP CO.	05000321 79-063/03L-0 026732	081279 083179 30-DAY	
EDWIN I. HATCH-1 SYSTEM CODE NOT APPLICABLE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR MAINTENANCE & REPAIR PERSONNEL ITEM NOT APPLICABLE	05000321 79-067/03L-0 026729	081679 083179 30-DAY	

1543 054

NOV 08, 1979

LER MONTHLY REPORT SORTED BY FACILITY
 PROCESSED DURING OCTOBER, 1979 FOR POWER REACTORS

PAGE 33

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
EDWIN I. HATCH-1 FIRE PROTECTION SYS + CONT COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE DEFECTIVE PROCEDURES NOT APPLICABLE ITEM NOT APPLICABLE	05000321 79-069/03L-0 026777	082279 090579 30-DAY	WHILE PERFORMING PROCEDURE HNP-1-3357, (SPRAY/SPRINKLER VALVE CHECKS) IN SAFETY RELATED AREAS, A LINK IN THE ELECTRIC FIRE PUMP START CIRCUIT WAS OPENED PER PROCEDURE REQUIREMENTS MAKING THE ELECTRIC FIRE PUMP INOPERABLE. NUMBER 3 DIESEL FIRE PUMP HAD BEEN TAGGED INOPERABLE FOR MAINTENANCE THEREBY LEAVING ONLY ONE FIRE PUMP READY IN VIOLATION OF TECH. SPEC. 3.13.2. EVENT CAUSED BY INADEQUACY OF PROCEDURE HNP-1-3357 IN MAKING PLANT PERSONNEL AWARE THE ELECTRIC FIRE PUMP WOULD BE INOPERABLE WHILE PROCEDURE WAS BEING PERFORMED. PROCEDURE HNP-1-3357 HAD BEEN REVISED SO THAT IT WILL NOT MAKE ELECTRIC FIRE PUMP INOP & SO PLANT PERSONNEL WILL BE AWARE OF ELECTRIC FIRE PUMP STATUS WHILE THIS PROCEDURE IS BEING PERFORMED.
EDWIN I. HATCH-1 COMPRESSED AIR SYSTEMS + CONT HANGERS, SUPPORTS, SHOCK SUPPRESS HANGERS DESIGN/FABRICATION ERROR CONSTRUCTION/INSTALLATION BECHTEL CORP.	05000321 79-065/01T-0 026731	082379 083179 2-WEEK	WHILE SHUTDOWN FOR REFUELING & PERFORMING HANGER SURV IN RESPONSE TO IE BULLETIN 79-14, IT WAS DISCOVERED THAT A SECTION OF PIPING IN PLANT INSTRUMENT AIR SYSTEM (P52) WAS NOT SEISMICALLY SUPPORTED PER ORIGINAL DESIGN. FURTHER ANALYSIS BY ARCHITECT ENG HAS REVEALED THAT SINCE CONTROLLING LOAD FOR SUPPORT WAS FOR SEISMIC CONCERNS ONLY & SINCE NO SEISMIC EVENT HAS OCCURRED, PIPING WAS NOT DEGRADED. THIS IS A REPETITIVE OCCURRENCE. SEE LER 50-366/1978-02. DURING INITIAL INSTALLATION OF THE PIPING AND ITS ASSOCIATED HANGERS, THE AFOREMENTIONED HANGER WAS INADVERTENTLY LEFT OFF. THE PROBLEM WAS CORRECTED BY INSTALLING A PIPE HANGER AS CALLED FOR BY ORIGINAL DESIGN.
EDWIN I. HATCH-1 REAC CORE ISOL COOL SYS + CONT VALVES GATE COMPONENT FAILURE MECHANICAL TERRY STEAM TURBINE COMPANY	05000321 79-082/03L-0 026825	082579 091279 30-DAY	WITH REACTOR IN STARTUP & HOT STANDBY MODE, WHILE PERFORMING PROCEDURE HNP-1-3405, RCIC PUMP OPERABILITY, ON AUGUST 25, 1979, TURBINE WOULD NOT TRIP WITH TURBINE TRIP PUSHBUTTON & ON AUGUST 27, 1979 TURBINE TRIP & TH RATTLE VALVE WOULD NOT CLOSE WITH EITHER CONTROL SWITCH OR TURBINE TRIP PUSHBUTTON. RCIC SYSTEM WAS DECLARED INOPERABLE, AS A RESULT OF LATER INCIDENT, & REQUIREMENTS OF TECHNICAL SPECIFICATION 4.5.E.2 COMPILED WITH . THERE WERE NO EFFECTS TO PUBLIC HEALTH & SAFETY AS RESULT OF INCIDENT FAILURE OF TURBINE TO TRIP WITH PUSHBUTTON ON AUGUST 25, 1979 WAS DUE TO TURBINE TRIP ACTUATOR HAVING BURNED COILS. ACTUATOR PLUNGER & COIL HOUSING WERE CLEANED & BURNED COILS REPLACED. PROCEDURE HNP-1-3405 WAS THEN PERFORMED SATISFACTORILY. ON AUGUST 27, 1979, FAILURE WAS CAUSED BY SPRING CYLINDER ASSEMBLY OF VLV BINDING AFTER TURBINE TRIP COIL ACTUATED. DURING STEADY STATE OPERATION AT LOW POWER FOR STARTUP TESTING FOLLOWING REFUELING OUTAGE, ROUTINE SURV REVIEW REVEALED THAT HNP-1-9400 (JET PUMP INTEGRITY) HAD NOT BEEN PERFORMED SATISFACTORILY ON 8-26-79. PROCEDURE HAD BEEN PERFORMED, BUT WAS UNACCEPTABLE. TEST SHOP BEGAN CALIBRATION OF INSTRUMENTS SO THAT PROCEDURE COULD BE PERFORMED AGAIN TO ENSURE ACCURATE READINGS. T/S 3.6.I REQUIRES PLANT TO BE IN COLD SHUTDOWN MODE WITHIN 24 HRS. FAILURE TO COMPLY WITH SHUTDOWN REQ WAS NOT RECOGNIZED. PLANT PERSONNEL FAILED TO RECOGNIZE THAT LCO EXISTED. INSTRUMENT CALIBRATION WAS SUSPECTED & PROCEDURE WAS EXPECTED TO BE ACCEPTABLE WHEN INSTRUMENT CALIBRATION WAS COMPLETE. IMMEDIATELY UPON DISCOVERY PROCEDURE HNP-1-9400 WAS PERFORMED & WAS ACCEPTABLE. BALANCING OF RECIRC LOOP FLOW HAD PLACED PROCEDURE IN ACCEPTABLE STATUS. JET PUMP INTEGRITY DID EXIST.
EDWIN I. HATCH-1 REACTOR VESSEL INTERNALS COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR LICENSED & SENIOR OPERATORS ITEM NOT APPLICABLE	05000321 79-066/01T-0 026730	082779 090479 2-WEEK	

1543 055

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
EDWIN I. HATCH-1 GAS RADIOACT WSTE MANAGMNT SYS RECOMBINERS SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR LICENSED & SENIOR OPERATORS CATALYTIC INC.	05000321 79-070/03L-0 026826	082779 091479 30-DAY	DURING STARTUP OPERATIONS AT ABOUT 80 MWT, HYDROGEN GAS CONCENTRATION MEASURED DOWNSTREAM OF RECOMBINERS, EXCEEDED T.S. APPENDIX B SECTION 2.1. 3.H LIMIT OF 4%. HYDROGEN LEVEL WAS GREATER THAN 4% FOR APPROXIMATELY 30 MINUTES BEFORE RETURNING TO NORMAL. ANOTHER EVENT OF THIS TYPE OCCURRED ON 9-11-79 AT 1586 MWT (49% MWE). HYDROGEN LEVEL FOR THIS EVENT WAS GREATER THAN 4% FOR APPROXIMATELY 15 MINUTES BEFORE RETURNING TO NORMAL. THERE WERE NO EFFECTS ON PUBLIC HEALTH AND SAFETY DUE TO THESE EVENTS. PROBABLE CAUSE FOR EVENT ON 8-27-79 WAS THAT, WHILE TRYING TO PLACE 1 B SJAE IN SERVICE, WATER IN OFF GAS PIPING ENTERED RECOMBINERS, THUS REDUCING THEIR RECOMBINING CAPABILITY. PROBABLE CAUSE FOR EVENT ON 9-11-79 WAS THAT A SLUG OF WATER IN OFF GAS SYSTEM REDUCED THE TEMPERATURE IN PRE HEATER AND RECOMBINER, THUS REDUCING THE RECOMBINING CAPABILITY. ON 8-27-79, AT 1330 CST, WHILE PERFORMING MONTHLY SURV. PROCEDURE HNP-1-3353 FIRE EQUIPMENT INSPECTION, IT WAS DISCOVERED THAT PLANT SERVICE WATER SUPPLY ISOLATION VALVES FOR STANDBY GAS TREATMENT CHARCOAL FILTER FIRE PROTECTION DELUGE VALVES WERE IN CLOSED POSITION WHICH PREVENTED SATISFACTORY COMPLETION OF HNP-1-3353. FIRE PROTECTION FOR FILTER TRAINS T46-0001 A & B WAS AVAILABLE MANUALLY AND BY AREA SPRINKLER SYSTEM.
EDWIN I. HATCH-1 FIRE PROTECTION SYS + CONT VALVES GATE DESIGN/FABRICATION ERROR DESIGN OTHER	05000321 79-072/03L-0 026855	082779 092179 30-DAY	VALVES HAD BEEN CLOSED TO PREVENT SPURIOUS TRIPS OF SYSTEMS CAUSED BY LOW PSW PRESSURE & DELUGE VALVES OVERLY SENSITIVE TO PRESSURE. VALVES WILL BE MAINTAINED IN MANUAL MODE WITH BREAKAWAY LOCKS; REVISED ANNUNCIATOR RESPONSE & SURVEILLANCE PROCEDURES WILL ASSURE QUICK & PROPER ACTION IN EVENT OF A FIRE UNTIL A DESIGN REVIEW IS COMPLETED & IMPLEMENTED. ON 8-27-79, AT 1330 CST, WHILE PERFORMING MONTHLY FIRE PROTECTION EQUIPMENT INSPECTION PROCEDURE HNP-1-3353, IT WAS DISCOVERED THAT THE SUPPLY FOR CONTROL ROOM CHARCOAL FILTER FIRE PROTECTION DELUGE SYS DOES NOT MEET SEISMIC & REDUNDANCE REQUIREMENTS PER REG. GUIDE 1.52. A DESIGN CHANGE, DCR 76-209, WAS IMPLEMENTED WHICH CHANGED SUPPLY FROM PLANT SERVICE WATER TO FIRE PROTECTION WATER FOR RELIABLE DELUGE VALVE OPERATION WITH HIGHER FIRE PROTECTION H2O PRESS. SYS WOULD HAVE OPERATED IN EVENT OF FIRE. LOW PLANT SERVICE WATER PRESSURE HAD CAUSED PROBLEMS WITH SPURIOUS TRIPS & LEAKAGE SO SUPPLY PIPING WAS REROUTED TO FIRE PROTECTION WATER; AE'S RECOMMENDATION NOT TO DO SO WAS RECEIVED AFTER COMPLETION. A DESIGN STUDY IS UNDERWAY TO DETERMINE AN APPROPRIATE SOLUTION SUCH AS A DELUGE VALVE LESS SENSITIVE TO LOW SUPPLY PRESSURE.
EDWIN I. HATCH-1 FIRE PROTECTION SYS + CONT PIPES, FITTINGS LESS THAN 4 INCHES DESIGN/FABRICATION ERROR DESIGN OTHER	05000321 79-073/03L-0 026857	082779 092179 30-DAY	DURING INITIAL CYCLE 4 STARTUP, THE REACTOR WAS OPERATED AT > 1% POWER IN THE RUN MODE FOR MORE THAN 24 HOURS WITHOUT A MAXIMUM TOTAL PEAKING FACTOR BEING CALCULATED AS REQUIRED BY TECHNICAL SPECIFICATION 4.1.B. THERE WERE NO CONSEQUENCES TO THE HEALTH AND SAFETY OF THE PUBLIC. THIS IS A REPETITIVE OCCURRENCE - SEE LER 79-06.
EDWIN I HATCH-1 REACTOR CORE INSTRUMENTATION + CONTROLS OTHER OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000321 79-077/03L-0 026824	082979 091379 30-DAY	AT APPROX 28% OF RATED THERMAL PWR., MALFUNCTION OF TRAVERSING INCORE PROBABLE PREVENTED UPDATING PROCESS COMPUTER TO FACILITATE CALCULATION OF THE RMAL HYDRAULIC PARAMETERS. MAINTENANCE PERSONNEL WERE CALLED TO REPAIR MALFUNCTIONING TIP MACHINE; HOWEVER, REPAIRS NOT COMPLETED PRIOR TO EXPIRATION OF 24 HR LIMIT. FOLLOWING REPAIR OF TIP MACHINE, MPF CALCULATED

1543 056

NOV 08, 1979

LER MONTHLY REPORT SORTED BY FACILITY
PROCESSED DURING OCTOBER, 1979 FOR POWER REACTORS

PAGE 35

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
EDWIN I. HATCH-1 SYSTEM CODE NOT APPLICABLE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR LICENSED & SENIOR OPERATORS ITEM NOT APPLICABLE	05000321 79-071/03L-0 026779	083179 091079 30-DAY	WHILE IN STEADY STATE OPERATION AT LOW POWER FOR TESTS AFTER STARTUP, THE TORUS LEVEL WAS BEING LOWERED. PLANT PERSONNEL ALLOWED TORUS LEVEL TO DROP TO 12 FEET. MINIMUM LEVEL PER TECH SPECS. 3.7.A.1.A IS 12 FEET 2 INCHES. LEVEL WAS IMMEDIATELY RESTORED TO NORMAL LIMITS. THIS DID NOT CAUSE ANY SIGNIFICANT OCCURRENCE OR HAVE ANY EFFECT ON PUBLIC HEALTH OR SAFETY.
			TORUS LEVEL WAS BEING LOWERED BY NORMAL PROCEDURE. PLANT PERSONNEL PERFORMING PROCEDURE FAILED TO ADEQUATELY MONITOR LEVEL DECREASE. AFTER DISCOVERY, LEVEL WAS IMMEDIATELY RETURNED TO WITHIN NORMAL LIMITS. PLANT PERSONNEL HAVE BEEN REINSTRUCTED TO PREVENT REOCCURRENCE.
EDWIN I. HATCH-1 EMERG CORE COOLING SYS + CONT ELECTRICAL CONDUCTORS SUBCOMPONENT NOT APPLICABLE DESIGN/FABRICATION ERROR DESIGN ITEM NOT APPLICABLE	05000321 79-076/01T-0 026828	090279 091179 2-WEEK	THE NSSS SUPPLIER CONTACTED PLANT MANAGEMENT ABOUT POSSIBLE CABLE SEPARATION IRREGULARITIES WITHIN THE HPCI SYSTEM AFTER DISCOVERING A SIMILAR PROBLEM AT ANOTHER DWR PLANT. AT 1800 HOURS ON 9-2-79 WITH REACTOR OF UNIT 1 AT STEADY STATE POWER OF 1892 MWt, PLANT ENGINEERING PERSONNEL CONFIRMED NSSS SUPPLIER'S COMMENTS REGARDING HPCI. PLANT ENGINEERING PERSONNEL REVIEWED WIRING DIAGRAMS AND CONFIRMED A PROBLEM WITH HPCI CABLE SEPARATION DID EXIST. THIS IS A NON-REPETITIVE OCCURRENCE.
			IT WAS DISCOVERED CONTROL CIRCUITS FOR HATCH UNIT 1 DIV. 1 E41-F002 HPCI STEAM ISOLATION VLV WAS ROUTED W/ADS SYS CONTROL CABLES. SEPARATION CRITERIA PER DESIGN NOTES WAS NOT MET. DESIGN ERROR DETERMINED TO BE CAUSE OF OCCURRENCE. ARCHITECT-ENGINEER WAS NOTIFIED OF HPCI/ADS CABLE SEPARATION PROBLEM. CURRENTLY IN PROCESS OF FORMULATING PROPOSED DESIGN CHANGE RBM 'B' WAS OUT OF SERVICE FOR GREATER THAN 24 HOURS. RBM 'B' WAS REMOVED FROM SERVICE AT 0500 ON SEPTEMBER 3, 1979 AND RETURNED TO SERVICE AT 1505 ON SEPTEMBER 4, 1979. A SIMILAR OCCURRENCE WAS REPORTED ON LER 75-54. THERE WERE NO EFFECTS ON THE ENVIRONS.
EDWIN I. HATCH-1 OTHR INST SYS REQD FOR SAFETY INSTRUMENTATION + CONTROLS COMPUTATION MODULE COMPONENT FAILURE INSTRUMENT GENERAL ELECTRIC CO.	05000321 79-080/03L-0 026947	090479 092579 30-DAY	THE RBM WAS REMOVED FROM SERVICE TO REPAIR CIRCUITS WHICH WERE MALFUNCTIONING. THE RBM HAD FAILED IN A CONSERVATIVE MODE BY NOT ALLOWING SPECIFIC RODS TO BE WITHDRAWN AT CONDITIONS WHICH WOULD HAVE ALLOWED THEIR WITHDRAWAL. THE RBM WAS RETURNED TO SERVICE FOLLOWING REPAIRS.
EDWIN I. HATCH-1 SYSTEM CODE NOT APPLICABLE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR LICENSED & SENIOR OPERATORS ITEM NOT APPLICABLE	05000321 79-078/03L-0 026827	090579 091479 30-DAY	DURING NORMAL OPERATION PLANT PERSONNEL DISCOVERED ISOLATION VALVE TO REACTOR BUILDING HVAC ROOM SPRAY SYSTEM CLOSED. SYSTEM WAS REQUIRED TO BE OPERABLE PER TECHNICAL SPECIFICATIONS 3.13.3. SYSTEM WAS IMMEDIATELY RESTORED TO SERVICE. THERE WERE NO SIGNIFICANT OCCURRENCES THAT TOOK PLACE AS A RESULT OF THE EVENT. THIS IS NOT A REPETITIVE OCCURRENCE.
			REACTOR BLDG HVAC ROOM SPRAY SYSTEM ISOLATION VALVE WAS CLOSED DURING OUTAGE BECAUSE OF WELDING IN AREA. ISOLATION VLV WAS NOT OPENED AT CONCLUSION OF WELDING. AFTER DISCOVERY, VLV WAS OPENED & SYS WAS RETURNED TO SERVICE. PLANT PERSONNEL HAVE BEEN REINSTRUCTED & PROCEDURES WILL BE REVISED TO PREVENT RECURRENCE. PROCEDURE HNP-1-3588 REVISED BY 10-11-79.

1543 057

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
EDWIN I. HATCH-1 RESIDUAL HEAT REMOV SYS + CONT PUMPS ROTARY DEFECTIVE PROCEDURES NOT APPLICABLE JOHNSTON PUMP CO.	05000321 79-075/01T-0 026939	090779 091879 2-WEEK	WITH THE UNIT 1 AT 2304 MEGAWATTS, THE RHR SERVICE WATER PUMPS "A", "C" & "D" WOULD NOT PUMP RATED FLOW AT RATED DISCHARGE PRESSURE AS PER HNP-1-3167, "RHR SERVICE WATER PUMP OPERABILITY AND RATED FLOW" TEST. LATER, THE "B" PUMP WAS ALSO DIAGNOSED TO HAVE THE SAME PROBLEM. SINCE THE RHR SERVICE WATER SYSTEM WAS INOPERABLE, THE REACTOR WAS TAKEN TO COLD SHUTDOWN AS PER THE TECH SPECS SECTION 3.5.C. THE OTHER EMERGENCY CORE COOLING SYSTEMS WERE AVAILABLE AND OPERABLE. THIS IS REPETITIVE (79-63). RHR SERVICE H2O PUMP OPERABILITY TEST CONTAINED FORMULAS FOR CALCULATING INLET PRESS & DISCHARGE PRESS WHICH WERE DETERMINED TO BE INCORRECT. A ARCHITECT ENG CONSULTED ABOUT EQUATIONS, THEIR SUGGESTIONS THEN IMPLEMENTED IN REVISION TO HNP-1-3167 & DOCUMENT CHANGE TO T.S. LIMIT ON PUMP TOTALY. DYNAMIC HEAD SUBMITTED & APPROVED BY NRR. PUMP TESTED SUCCESSFULLY. WHILE IN SHUTDOWN, IT WAS DISCOVERED THAT THE REACTOR WATER LEVEL (ADS) SURVEILLANCE TEST (HNP-1-3251) GRACE PERIOD HAD BEEN EXCEEDED. THE TEST WAS COMPLETED TEN (10) HOURS LATER THAN THE GRACE PERIOD ALLOWS. WHEN THE SURVEILLANCE TEST WAS PERFORMED, THE LEVEL SWITCHES WERE FOUND TO BE OPERATING SATISFACTORY.
EDWIN I. HATCH-1 ENGNRD SAFETY FEATR INSTR SYS INSTRUMENTATION + CONTROLS SWITCH PERSONNEL ERROR MAINTENANCE & REPAIR PERSONNEL ITEM NOT APPLICABLE	05000321 79-079/03L-0 026948	090979 092479 30-DAY	THE CAUSE WAS PERSONNEL ERROR. THE LIMIT OF THE GRACE PERIOD WAS OVERLOOKED. THE SURVEILLANCE TEST WAS PERFORMED SATISFACTORILY. PERSONNEL WERE COUNSELED ON THE IMPORTANCE OF COMPLETING SURVEILLANCE TESTS WITHIN THEIR GRACE PERIODS.
EDWIN I. HATCH-1 CONTINMNT COMBUS GAS CONTROL SYS VALVES BUTTERFLY DESIGN/FABRICATION ERROR DESIGN FISHER CONTINENTAL	05000321 79-081/01T-0 026856	091079 092079 2-WEEK	WITH UNIT 1 IN RUN & UNIT 2 IN SHUTDOWN, A POTENTIAL FAILURE MODE FOR SEVERAL PRIMARY CONTAINMENT PURGE & INERTING VALVES WAS DISCOVERED BY ARCHITECT-ENGINEER AND VALVE VENDOR. IT WAS POSTULATED THAT, IF A LOCA OCCURRED WHILE VALVES WERE OPEN, STEAM PRESSURE COULD CAUSE THESE VALVES TO OVERTRAVEL AND LOSE SEATING CAPABILITY. THIS WOULD ALLOW LEAKAGE OF CONTAMINATION TO REACTOR BUILDING. THIS FAILURE MODE APPLIES TO BOTH UNITS 1 & 2: IT IS A NON-REPETITIVE OCCURRENCE. THIS SITUATION IS A RESULT OF DESIGN DEFICIENCIES. A DESIGN CHANGE TO PREVENT THE VALVES FROM OPENING MORE THAN 30 DEGREES IS BEING INVESTIGATED. NOTE THAT FACILITY STATUS APPLIES TO UNIT 1 ONLY. UNIT 2 WAS SHUTDOWN AT THE TIME.
EDWIN I. HATCH-2 RESIDUAL HEAT REMOV SYS + CONT INSTRUMENTATION + CONTROLS CONTROLLER COMPONENT FAILURE INSTRUMENT FISHER CONTROLS CO.	05000366 77-097/03L-0 026832	082777 091279 30-DAY	THE COOLING WATER TO RHR SERVICE WATER PUMPS 2B AND 2D WAS FOUND TO BE LESS THAN THE AMOUNT NEEDED TO COOL THE BEARINGS PROPERLY. THERE WAS NO EFFECT ON THE ENVIRONS. THERE HAVE BEEN NO SIMILAR OCCURRENCES OF THIS TYPE.
			THE PRESSURE CONTROLLER FOR VALVE 2E11-F126B, COOLING WATER FLOW CONTROL VALVE, WAS NOT CONTROLLING THE VALVE POSITION PROPERLY. THE CONTROLLER WAS TUNED TO ALLOW THE PROPER COOLING WATER FLOW. 2E11-F126A WAS CHECKED AND FOUND TO BE OPERATING PROPERLY.

1543 058

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
EDWIN I. HATCH-2 REAC CORE ISOL COOL SYS + CONT INSTRUMENTATION + CONTROLS SWITCH OTHER NOT APPLICABLE BARTON INSTRU CO., DIV OF ITT	05000366 79-059/01T-1 026321	062879 091479 2-WEEK	AT 1220 CDT, MSIV FAST CLOSURE STARTUP TEST FOR UNIT 2 INITIATED. REACTOR SCRAMMED AS A RESULT OF MSIV CLOSURE. DURING RESULTING TRANSIENT, RCIC & HPCI BOTH ISOLATED ON STEAM LINE HIGH DIFFERENTIAL PRESSURE. T.S. 3/4.7.3.B & 3/4.5.1 ACTION A WERE MET FOR BOTH RCIC & HPCI RESPECTIVELY. ADS SYSTEM WAS OPERABLE. BOTH RCIC & HPCI SYSTEMS WERE SUCCESSFULLY STARTED MANUALLY. AT TIME OF OCCURRENCE UNIT 1 WAS IN COLD SHUTDOWN CONDITION FOR MAINTENANCE, HANGER MODIFICATIONS, AND REFUELING. RCIC & HPCI SYSTEMS ISOLATED ON STEAM LINE HIGH DIFFERENTIAL PRESSURE. AS SYSTEMS ISOLATED, THEY WERE MANUALLY STARTED & LATER SECURED UPON COMPLETION OF MSIV FAST CLOSURE STARTUP TEST. TEST SHOP PERSONNEL WERE INSTRUCTED TO CHECK CALIBRATION OF SWITCHES 2E51-N017 & N018 (RCIC) & 2E41-N004 & N005 (HPCI). INSTRUMENT LINES REDESIGNED & TESTING WAS SUCCESSFUL WHILE PERFORMING ROUTINE SURVEILLANCE PROCEDURE HNP-2-3005, MAIN STEAM LINE RADIATION MONITOR FUNCTIONAL TEST AND CALIBRATION, INSTRUMENT 2D11-K 603B SETPOINT WAS FOUND TO BE 2700 MR/HR. THE TECH. SPEC. ACCEPTANCE CRITERIA REQUIRES A SETPOINT OF 2175 +/- 10% MR/HR. THERE WAS NO EFFECT ON THE ENVIRONS. A SIMILAR OCCURRENCE WAS REPORTED ON LER-2-79-053.
EDWIN I. HATCH-2 MAIN STEAM SYSTEMS + CONTROLS INSTRUMENTATION + CONTROLS SWITCH COMPONENT FAILURE INSTRUMENT GENERAL ELECTRIC CO.	05000366 79-092/03L-0 026728	081379 082979 30-DAY	INSTRUMENT DRIFT WAS ATTRIBUTED AS THE CAUSE FOR THE PROBLEM. THE INSTRUMENT WAS RECALIBRATED PER HNP-2-5100 AND RETURNED TO SERVICE.
EDWIN I. HATCH-2 MAIN STEAM SYSTEMS + CONTROLS INSTRUMENTATION + CONTROLS SWITCH COMPONENT FAILURE INSTRUMENT BARKSDALE COMPANY	05000366 79-093/03L-0 026727	081879 082979 30-DAY	WHILE PERFORMING NORMAL SURVEILLANCE PROCEDURE HNP-2-3105, FOR MAIN STEAM LINE PRESSURE INSTRUMENT FUNCTIONAL TEST AND CALIBRATION, 2B21-N015A WAS FOUND TO HAVE A SETPOINT OF 835 PSIG DECREASING. THE TECH. SPEC. ACCEPTANCE CRITERIA REQUIRES A SETPOINT OF GREATER THAN OR EQUAL TO 825 PSIG PLUS 15 PSIG HEAD CORRECTION. THERE WAS NO EFFECT ON THE ENVIRONS. NO PREVIOUS OCCURRENCES OF THIS TYPE HAVE BEEN REPORTED.
EDWIN I. HATCH-2 FIRE PROTECTION SYS + CONT COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE DEFECTIVE PROCEDURES NOT APPLICABLE ITEM NOT APPLICABLE	05000366 79-094/03L-0 026780	082279 090779 30-DAY	THE PROBLEM WAS ATTRIBUTED TO SETPOINT DRIFT. THE INSTRUMENT WAS RECALIBRATED PER HNP-2-5279 AND RETURNED TO SERVICE.
			WHILE PERFORMING PROCEDURE HNP-2-3357, (SPRAY/SPRINKLER VALVE CHECKS) IN SAFETY RELATED AREAS, A LINK IN THE ELECTRIC FIRE PUMP START CIRCUIT WAS OPENED PER PROCEDURE REQUIREMENTS MAKING THE ELECTRIC FIRE PUMP INOPERABLE. NUMBER 3 DIESEL FIRE PUMP HAD BEEN TAGGED INOPERABLE FOR MAINTENANCE THEREBY LEAVING ONLY ONE FIRE PUMP READY IN VIOLATION OF TECH. SPEC. 3.7.6.1.
			EVENT CAUSED BY INADEQUACY OF PROCEDURE HNP-2-3357 IN MAKING PLANT PERSONNEL AWARE THAT ELECTRIC FIRE PUMP WOULD BE INOP WHILE PROCEDURE WAS BEING PERFORMED. PROCEDURE HNP-2-3357 HAS BEEN REVISED SO IT WILL NOT MAKE THE ELECTRIC FIRE PUMP INOP & SO PLANT PERSONNEL WILL BE AWARE OF THE ELECTRIC FIRE PUMP STATUS WHILE THIS PROCEDURE IS BEING PERFORMED.

1543 059

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
EDWIN I. HATCH-2 EMERG CORE COOLING SYS + CONT INSTRUMENTATION + CONTROLS SWITCH COMPONENT FAILURE INSTRUMENT BARKSDALE COMPANY	05000366 79-099/03L-0 026775	082979 090779 30-DAY	WHILE PERFORMING ROUTINE SURVEILLANCE PROCEDURE HNP-2-3309, HPCI TURBINE EXHAUST DIAPHRAGM PRESSURE SWITCH FUNCTIONAL TEST AND CALIBRATION, INSTRUMENT 2E41-N012C FAILED TO HOLD PRESSURE. INSTRUMENTS 2E41-N012 A, B, AND D WERE OPERABLE. THERE WAS NO EFFECT ON THE ENVIRONS. THERE HAVE BEEN NO SIMILAR OCCURRENCES REPORTED PREVIOUSLY. A CRACK WAS DISCOVERED IN THE DIAPHRAGM OF THE SWITCH. THE INSTRUMENT WAS REPLACED AND THE NEW SWITCH CALIBRATED PER HNP-2-5279. THE OTHER TURBINE EXHAUST SWITCHES (2E41-N012A, B AND D) WERE CHECKED AND WERE ABLE TO HOLD PRESSURE.
EDWIN I. HATCH-2 EMERG CORE COOLING SYS + CONT ELECTRICAL CONDUCTORS SUBCOMPONENT NOT APPLICABLE DESIGN/FABRICATION ERROR DESIGN ITEM NOT APPLICABLE	05000366 79-098/01T-0 026829	090279 091179 2-WEEK	THE NSSS SUPPLIER CONTACTED PLANT MANAGEMENT ABOUT POSSIBLE CABLE SEPARATION IRREGULARITIES WITHIN THE HPCI SYSTEM AFTER DISCOVERING A SIMILAR PROBLEM AT ANOTHER BWR PLANT. AT 1800 HOURS ON 9-2-79, WITH UNIT 2 REACTOR AT STEADY STATE POWER OF 2350 MWt, PLANT ENGINEERING PERSONNEL REVIEWED WIRING DIAGRAMS AND CONFIRMED A PROBLEM WITH HPCI CABLE SEPARATION DID EXIST. THIS IS A NON-REPETITIVE OCCURRENCE. IT WAS DISCOVERED THAT CONTROL CIRCUITS FOR HATCH UNIT 2 DIV. 1 2E41-F00 2 HPCI STEAM ISOLATION VLV WAS ROUTED WITH ADS SYSTEM CONTROL CABLES. SEPARATION CRITERIA PER DESIGN NOTES WAS NOT MET. DESIGN ERROR WAS CAUSE OF OCCURRENCE. ARCHITECT-ENGINEER WAS NOTIFIED OF HPCI/ADS CABLE SEPARATION PROBLEM. A/E IN PROCESS OF FORMULATING PROPOSED DESIGN CHANGE.
EDWIN I. HATCH-2 EMERG CORE COOLING SYS + CONT INSTRUMENTATION + CONTROLS SWITCH COMPONENT FAILURE INSTRUMENT BARTON INSTRU CO., DIV OF IIT	05000366 79-101/03L-0 026830	090379 091779 30-DAY	WHILE PERFORMING ROUTINE CALIBRATION PROCEDURE HNP-2-5202, BARTON MODELS 288A AND 289A DIFFERENTIAL PRESSURE INDICATING SWITCH, THE HIGH LEVEL SWITCHES OF 2B21-N017B AND 2B21-N017D WERE FOUND TO EXCEED THE TECH SPEC LIMIT BY APPROXIMATELY 0.5 INCHES. THESE SWITCHES ISOLATE HPCI AT +58 INCHES OF REACTOR WATER LEVEL. THERE WAS NO EFFECT ON THE ENVIRONS. A SIMILAR OCCURRENCE WAS REPORTED FOR 2B21-N017C ON LER 2-78-67. SETPOINT DRIFT WAS DETERMINED TO BE THE CAUSE OF THE FAILURE. THE INSTRUMENTS WERE RECALIBRATED AND RETURNED TO SERVICE.
EDWIN I. HATCH-2 REACTOR CORE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR OTHER ITEM NOT APPLICABLE	05000366 79-100/03L-0 026831	090579 091779 30-DAY	WHILE AT APPROX. 89% POWER DURING A LOAD INCREASE, CMPF WAS FOUND TO BE 2.570. LIMIT IS 2.38. FLOW INCREASED & A COMPUTER UPDATE PERFORMED TO REDUCE CMPF. AFTER 2 HRS, POWER HAD NOT DROPPED SIGNIFICANTLY & APRMS HAD NOT BEEN ADJUSTED IN VIOLATION OF T/S 3.2.2. FOLLOWING 2 HRS, ROD PATTERN WAS ADJUSTED & ANOTHER COMPUTER UPDATE WAS PERFORMED. CMPF DROPPED TO W.105. THIS IS A REPETITIVE OCCURRENCE, SEE LER 2-79-58. THERE WERE NO CONSEQUENCES TO THE HEALTH AND SAFETY OF THE PUBLIC. FOLLOWING MOVEMENT OF CONTROL RODS, CMPF WAS FOUND TO EXCEED ITS LIMIT. INITIAL CORRECTIVE ACTION TAKEN DID NOT SIGNIFICANTLY REDUCE CMPF & 2 HR TIME LIMIT HAD ELAPSED BEFORE FURTHER ACTION WAS COMPLETED. ROD PATTERN WAS ADJUSTED & A COMPUTER UPDATE WAS PERFORMED WHICH CORRECTED PEAKING PROBLEM. PERSONNEL INVOLVED HAVE BEEN ADVISED THAT ACTION WAS INADEQUATE

1543 060

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
EDWIN I. HATCH-2 CNTNMNT HEAT REMOV SYS + CONT COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR MAINTENANCE & REPAIR PERSONNEL ITEM NOT APPLICABLE	05000366 79-103/03L-0 026854	090779 091979 30-DAY	DURING NORMAL POWER OPERATION DRYWELL AVERAGE AIR TEMPERATURE WAS INCREASING BECAUSE OF A SUSPECTED STEAM LEAK. WHILE MAINTENANCE PERSONNEL WERE ADJUSTING FLOW THE AVERAGE DRYWELL TEMPERATURE REACHED 145.8 DEG. F. SYSTEM FLOW WAS READJUSTED AND TEMPERATURE WAS RETURNED TO T.S. 3.6.1.7. LIMITS. THE SAME CONDITION OCCURRED ON 9-8-79 WHEN CHILLER UNITS WERE BEING SWAPPED. THIS IS A REPETITIVE OCCURRENCE AS NOTED IN LER 79-81.
EDWIN I. HATCH-2 CNTNMNT COMBUS GAS CONTROL SYS RECOMBINERS SUBCOMPONENT NOT APPLICABLE DESIGN/FABRICATION ERROR DESIGN CATALYTIC INC.	05000366 79-095/03L-0 026852	091279 091979 30-DAY	MAINTENANCE PERSONNEL WERE ADJUSTING CHILLED WATER FLOW THROUGH REACTOR BLDG CHILLER COOLER TO ACHIEVE LESS FLOW AT A LOWER TEMP TO LOWER DRYWELL TEMP. THIS CAUSED DRYWELL TEMP TO INCREASE TO 145.8 DEG. F. FLOW WAS READJUSTED TO REDUCE DRYWELL AVERAGE TEMP. ON 9-8-79 PLANT PERSONNEL WERE SWAPPING CHILLER UNITS & 2ND UNIT DID NOT START. DURING STARTUP OPERATIONS, HYDROGEN GAS CONCENTRATION INCREASED GREATER THAN T. S. APPENDIX B SECTION 2.1.3.H LIMIT OF 4%. HYDROGEN CONCENTRATION EXCEEDED 4% FOR APPROXIMATELY 18 MINUTES. ON 9-15-79 AT 1391 MWE PREHEATER PROBLEMS CAUSED HYDROGEN TO EXCEED 4% FOR APPROXIMATELY 30 MINUTE S. THIS IS A REPETITIVE OCCURRENCE AS REPORTED ON LER 79-78. THERE WERE NO EFFECTS UPON THE PUBLIC HEALTH AND SAFETY DUE TO THESE EVENTS.
EDWIN I. HATCH-2 EMERG CORE COOLING SYS + CONT INSTRUMENTATION + CONTROLS CONTROLLER COMPONENT FAILURE INSTRUMENT WOODWARD GOVERNOR CO.	05000366 79-096/03L-0 026853	091279 091979 30-DAY	PROBABLE CAUSE FOR EVENT ON 9-12-79 IS THAT WHILE PREHEATING OFFGAS LINE S MOISTURE ENTERED RECOMBINER THUS REDUCING ITS RECOMBINING CAPABILITY. PROBABLE CAUSE FOR EVENT ON 9-15-79 IS THAT PREHEATER TEMPERATURE WAS NOT SUFFICIENT TO PREVENT MOISTURE FROM ENTERING RECOMBINER & REDUCED ITS RECOMBINING CAPABILITY. SWAPPED PREHEATERS & RECOMBINERS TO CORRECT. PROBL THE HPCI FLOW CONTROL LOOP WAS FOUND TO BE INOPERATIVE. THIS DEFICIENCY WOULD NOT ALLOW THE SYSTEM TO PERFORM ITS DESIGNED FUNCTION IN MANUAL OR AUTO. THERE WAS NO AFFECT ON THE ENVIRONS. THERE HAVE BEEN NO PREVIOUS REPORTS OF SIMILAR OCCURRENCES.
EDWIN I. HATCH-2 CNTNMNT COMBUS GAS CONTROL SYS INSTRUMENTATION + CONTROLS OTHER OTHER NOT APPLICABLE DELPHI INDUSTRIES	05000366 79-104/03L-0 026951	091579 100379 30-DAY	INVESTIGATIONS REVEALED A BAD RAMP GENERATOR IN TURBINE CONTROL LOOP. RAMP GENERATOR WAS REPLACED AND CONTROL LOOP FUNCTIONALLY TESTED TO ENSURE PROPER OPERATION. MODE OF FAILURE OF RAMP GENERATOR WOULD HAVE BEEN DETECTED DURING ROUTINE OPERABILITY TESTING DUE TO INABILITY TO MOVE TURBINE CONTROL VALVE TO POSITIONS GREATER THAN 40% OPEN. THE OXYGEN BOTTLE PROVIDING THE SOURCE OF REAGENT GAS FOR THE HYDROGEN ANALYZERS (2P33-P001A AND 2P33-P001B) WAS FOUND TO BE EMPTY. THE EMPTY BOTTLE RESULTED IN THE ANALYZERS BEING INOPERATIVE. THERE WAS NO EFFECT ON THE ENVIRONS. THERE HAVE BEEN NO SIMILAR OCCURRENCES OF THIS TYPE.
			ANALYZERS WERE INOP BECAUSE THEY HAD NO REAGENT GAS FLOW TO HYDROGEN CELLS. NEW BOTTLE OF GAS INSTALLED & ANALYZERS RETURNED TO OPERABLE STATUS. STANDING ORDER HAS BEEN WRITTEN TO SURVEY USAGE OF REAGENT GASES TO DETERMINE FREQUENCY NEEDED FOR REPLACING GAS BOTTLES. PROCEDURE HNP-2-10 60, DAILY ROUNDS WILL BE REVISED TO INCLUDE FREQ. CHECKS OF GAS PRESSURE

1543 061

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
EDWIN I. HATCH-2 CONTNMT ISOLATION SYS + CONT INSTRUMENTATION + CONTROLS SWITCH COMPONENT FAILURE INSTRUMENT BARTON INSTRU CO., DIV OF ITT	05000366 79-102/03L-0 026946	091879 092579 30-DAY	WHILE PERFORMING ROUTINE SURVEILLANCE PROCEDURE HNP-2-3106, MAIN STEAM LINE FLOW INSTRUMENT FUNCTIONAL TEST AND CALIBRATION. INSTRUMENT SETPOINTS FOR 2B21-N006A, 2B21-N006B, 2B21-N006D AND 2B21-N007A WERE FOUND TO EXCEED THE TECH. SPEC. LIMIT. 2B21-N006A, 2B21-N007B-D, 2B21-N008A-D AND 2B21-N009A-D WERE OPERABLE WITH SETPOINTS WITHIN THE TECH. SPEC. LIMIT. THERE WAS NO EFFECT ON THE ENVIRONS. THERE HAVE BEEN NO PREVIOUS OCCURRENCES OF THIS TYPE. SETPOINT DRIFT DETERMINED TO BE CAUSE OF EVENT. INSTRUMENTS WERE RECALIBRATED & RETURNED TO SERVICE. PROCEDURES FOR SURVEILLANCE & CALIBRATION REVIEWED FOR FACTORS WHICH WOULD ATTRIBUTE TO MULTIPLE DRIFTS BUT NONE FOUND. SETPOINT WAS CONSIDERED TO NEED MOVING TO A MORE CONSERVATIVE POINT. SETPOINT WILL BE CHANGED ON NEXT REGULAR SURVEILLANCE TEST.
FITZPATRICK-1 DEMION WATER MAKE-UP COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE DEFECTIVE PROCEDURES NOT APPLICABLE ITEM NOT APPLICABLE	05000333 79-005/04L-0 026805	012479 021479 30-DAY	AN APPARENT EXCESSIVE SOLUTE RELEASE FROM THE MAKEUP WATER TREATMENT WAS TREATED DURING 01/79 24-HOUR COMPOSITE SAMPLE ANALYSIS. CONCENTRATION OF SULFATE WAS GREATER THAN 5% ABOVE LAKE ONTARIO AMBIENT (INTAKE) CONC.
FITZPATRICK-1 REACTOR CONTAINMENT SYSTEMS VALVES GLOBE COMPONENT FAILURE OTHER ATKOMATIC VALVE CO., INC.	05000333 79-011/03X-1 025348	021479 091179 OTHER	CALCULATIONS INDICATE THAT ETS COULD NOT HAVE BEEN EXCEEDED. COMPOSITE SAMPLING OF CIRC. WATER SYSTEM DISCHARGE TUNNEL AND METHOD OF DETERMINING SOLUTE CONC AND TOTAL DISSOLVED SOLIDS ARE UNSOUND. TECHNICAL SPECIFICATION AMENDMENT REQUEST INITIATED. DURING NORMAL OPERATION, DRYWELL ATMOSPHERE SAMPLE ISOLATION VALVE 27-50 V-123B DID NOT INDICATE OPEN. INSPECTION SHOWED A BLOWN FUSE DUE TO A SHORTED VALVE SOLENOID. SOLENOID WAS REPLACED BUT AGAIN SHORTED.
FITZPATRICK-1 OTHER INST SYS REQD FOR SAFETY INSTRUMENTATION + CONTROLS OTHER COMPONENT FAILURE ELECTRONIC GENERAL ELECTRIC CO.	05000333 79-015/03X-1 025542	031579 091179 OTHER	APPARENTLY A FLUX WASHER WAS MISSING IN PREVIOUS VALVE SOLENOID ASSEMBLIES. A NEW SOLENOID COIL AND FLUX WASHER WAS INSTALLED WHICH HAS SOLVED THE PROBLEM. DURING A LOAD REDUCTION TO A COLD SHUTDOWN CONDITION, THE ROD SEQUENCE CONTROL SYSTEM FAILED TO PASS TEST F-ST-23A. THERE WAS INSUFFICIENT TIME TO REPAIR THE SYSTEM (DUE TO TIME LIMITATIONS TO COLD SHUTDOWN IMPOSED IN A 3/13/79 HRC SHOW CAUSE ORDER) SO REACTOR WAS MANUALLY SCRAMMED FROM ABOUT 21% OF RATED POWER. RSCS WAS REPAIRED BY REPLACING CERTAIN PRINTED CIRCUIT BOARDS AND PROPER OPERATION WAS DEMONSTRATED BY SUCCESSFUL COMPLETION OF TEST F-ST-23A ON 8/24/79.

1543 062

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
FITZPATRICK-1 COOL SYS FOR REAC AUX + CONT COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000333 79-033/03X-1 026073	052479 091179 OTHER	DURING A REVIEW IN RESPONSE TO NRC BULLETIN 79-02, IT WAS FOUND THAT THE REACTOR BUILDING COOLING SYSTEM SUPPLY AND RETURN LINES TO DRYWELL EQUIPMENT DRAIN SUMP DID NOT HAVE A SEISMIC STRESS ANALYSIS PERFORMED. PLAN T IS IN COLD SHUTDOWN CONDITION.
			REANALYSIS IS COMPLETE AND REVEALED THAT THE EXISTING DESIGN CONFIGURATION IS ACCEPTABLE WITHOUT MODIFICATION TO EITHER THE LINES OR SUPPORTS. THEREFORE, THE EVENT DID NOT REPRESENT ANY HAZARD TO PUBLIC HEALTH OR SAFETY.
FITZPATRICK-1 FIRE PROTECTION SYS + CONT VALVES CHECK COMPONENT FAILURE MECHANICAL LONERGAN	05000333 79-047/03L-0 026758	081079 090679 30-DAY	DURING ANNUAL FIRE PUMP PERFORMANCE TESTING, THE OPERATION OF THE DIESEL DRIVEN FIRE PUMP RELIEF VALVE, WHILE SATISFACTORY, APPEARED TO BE SLUGGISH IN NATURE. THE REDUNDANT ELECTRIC MOTOR DRIVEN FIRE PUMP WAS OPERABLE.
			THE RELIEF VALVE SPRING AND STEM ASSEMBLY WAS REPLACED, VALVE REASSEMBLED AND TESTED SATISFACTORY.
FITZPATRICK-1 OTHER COOLANT SUBSYS + CONTROL INSTRUMENTATION + CONTROLS SENSOR/DETECTOR/ELEMENT OTHER NOT APPLICABLE YARWAY CORP.	05000333 79-048/03L-0 026757	081579 090779 30-DAY	IT WAS FOUND THAT THE TRIP POINTS FOR THE LOW-LOW-LOW WATER LEVEL INSTRUMENTS SHOULD BE READJUSTED TO A MORE CONSERVATIVE SET POINT IN ORDER TO PRECLUDE POSSIBLE INSTRUMENT ERRORS AS A RESULT OF CERTAIN HYPOTHETICAL CONDITIONS.
			INSTRUMENT SET POINTS WERE RECALCULATED. THE CALCULATIONS WERE REVIEWED AND VERIFIED FOR ACCURACY BY GENERAL ELECTRIC.
FITZPATRICK-1 REACTIVITY CONTROL SYSTEMS OTHER COMPONENTS SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE GENERAL ELECTRIC CO.	05000333 79-049/03L-0 026860	081979 091879 30-DAY	CONTROL ROD 22-07 COULD NOT BE POSITIVELY SHOWN TO BE COUPLED TO THE DRIVE DURING ROD DRIVE VENT & TIMING TEST. ATTEMPT TO RECOUPLE ACCORDING TO PLANT PROCEDURES DID NOT RESULT IN POSITIVE COUPLING INDICATION. REACTOR WAS IN REFUEL MODE AT TIME. NO OTHER RODS WITHDRAWN.
			CONTROL ROD DRIVE WAS REMOVED AND REPLACED. OLD DRIVE WILL BE INSPECTED TO DETERMINE POSSIBLE CAUSE. WHEN WORK IS COMPLETE, FOLLOW UP REPORT WILL BE SUBMITTED.

1543 063

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
FITZPATRICK-1 PRCSS + EFF RADIOL MONITOR SYS INSTRUMENTATION + CONTROLS RECORDER COMPONENT FAILURE ELECTRONIC GENERAL ELECTRIC CO.	05000333 79-050/03L-0 026861	082879 092079 30-DAY	WHILE CONDUCTING SURVEILLANCE TEST F-ST-11 THE OFF GAS PROCESS RADIATION MONITOR, THE RECORDER (17-RR-152) DID NOT CORRESPOND TO THE READING ON THE "A" CHANNEL MONITOR. REDUNDANT INSTRUMENT WAS OPERABLE. RECORDER WAS RECALIBRATED AND PROPER OPERATION WAS VERIFIED BY SUCCESSFUL COMPLETION OF TEST.
FITZPATRICK-1 SYSTEM CODE NOT APPLICABLE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000333 79-051/04T-0 026918	082979 091979 2-WEEK	THE ACTIVITY LEVEL OF MN-54 IN MOLLUSK SAMPLES ON-SITE WAS FOUND TO BE GREATER THAN 10 TIMES THE CONTROL LOCATIONS OFF-SITE FOR THE SAME SAMPLE PERIOD. A POSSIBLE EXPLANATION COULD BE THE VERY HIGH BIOACCUMULATION FACTOR OF MANGANESE IN FRESH WATER MOLLUSKS ONE INDIGENOUS TO THE OFF-SHORE AREA OF THE SITE. THE FRESH WATER MOLLUSKS ARE NOT CONSUMED BY HUMANS. EVEN IF THEY WERE, BASED ON AVERAGE HUMAN CONSUMPTION OF SEAFOOD, THE DOSE WOULD BE ONLY 0.0005 MREM/YR AND 0.0074 MREM/YR TO THE WHOLE BODY AND GASTROINTESTINAL TRACTS, RESPECTIVELY.
FITZPATRICK-1 EMERG CORE COOLING SYS + CONT ELECTRICAL CONDUCTORS SUBCOMPONENT NOT APPLICABLE DESIGN/FABRICATION ERROR CONSTRUCTION/INSTALLATION ITEM NOT APPLICABLE	05000333 79-046/03T-0 026846	083079 091279 2-WEEK	A/E NOTIFIED PLANT MANAGEMENT ABOUT POSSIBLE CABLE SEPARATION IRREGULARITIES WITHIN HPCI AFTER DISCOVERY AT OTHER BWR. CABLE FOR HPCI STEAM SUPPLY ISOLATION VALVE AND APS CABLES WERE ROUTED IN SAME CABLE TRAYS. THIS DOES NOT MEET DESIGN SPEC. FOR SEPARATION OF DIVISION J AND DIVISION I EQUIPMENT. DESIGN ERROR WAS CAUSE OF OCCURRENCE. PLANT MODIFICATION WAS IMPLEMENTED AND CABLES REROUTED ERROR TO PLANT STARTUP.
FITZPATRICK-1 CIRCULATING WATER SYS + CON INSTRUMENTATION + CONTROLS OTHER COMPONENT FAILURE ELECTRONIC GENERAL ELECTRIC CO.	05000333 79-052/04L-0 026847	083079 092579 30-DAY	DURING CONDUCT OF "CIRCULATING WATER SYSTEM WATER TEMP. RTD'S" THE CALCULATIONS FOR INLET TEMP AND DISCHARGE DIFFERENTIAL TEMP WERE OUT OF CALIBRATION. ACCURACY WAS NOT WITHIN 0.5 DEGREES F AS REQUIRED BY T.S. DRIFT WAS IN CONSERVATIVE DIRECTION. INSTRUMENTS WERE RECALIBRATED TO WITHIN T.S. LIMITS AND CALCULATIONS PERFORMED AND VERIFIED TO BE SATISFACTORY.

1543 064

NOV 08, 1979

LER MONTHLY REPORT SORTED BY FACILITY
PROCESSED DURING OCTOBER, 1979 FOR POWER REACTORS

PAGE 43

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
FITZPATRICK-1 FIRE PROTECTION SYS + CONT OTHER COMPONENTS SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000333 79-053/03L-0 026848	090179 092579 30-DAY	PENETRATION SLEEVE NOT SEALED. FIRE WATCH MAINTAINED DURING TIME SLEEVE WAS NOT SEALED. SLEEVE WAS REMOVED TO ALLOW PULLING OF NEW CABLES.
			SEAL MATERIAL RECEIVED AND PENETRATION SEALED ON 9-17-79.
FITZPATRICK-1 MAIN STEAM ISOL SYS + CONTROLS INSTRUMENTATION + CONTROLS OTHER COMPONENT FAILURE ELECTRONIC NUCLEAR MEASUREMENTS CORP.	05000333 79-055/03L-0 026919	090279 092679 30-DAY	DURING SURVEILLANCE TEST F-ST-12D (RADWASTE BUILDING EXHAUST MONITOR INSTRUMENT FUNCTIONAL TEST), THE "A" RADWASTE BUILDING EXHAUST MONITOR (17-RIS-458A) WAS FOUND OUT OF CALIBRATION. THE REDUNDANT INSTRUMENT (17-RIS-458B) WAS VERIFIED OPERABLE.
			THE INSTRUMENT WAS REPAIRED, RECALIBRATED AND SATISFACTORY OPERATION WAS DEMONSTRATED BY THE SUCCESSFUL COMPLETION OF F-ST-12D.
FITZPATRICK-1 MAIN STEAM ISOL SYS + CONTROLS INSTRUMENTATION + CONTROLS OTHER COMPONENT FAILURE ELECTRONIC NUCLEAR MEASUREMENTS CORP.	05000333 79-054/03L-0 026920	090279 092679 30-DAY	DURING SURVEILLANCE TEST F-ST-12B (REACTOR BUILDING EXHAUST MONITOR FUNCTIONAL TEST), THE "B" REACTOR BUILDING EXHAUST MONITOR (17-RIS-452B) WAS FOUND OUT OF CALIBRATION. THE REDUNDANT INSTRUMENT (17-RIS-452A) WAS VERIFIED OPERABLE.
			THE INSTRUMENT WAS RECALIBRATED AND SATISFACTORY OPERATION WAS DEMONSTRATED BY THE SUCCESSFUL COMPLETION OF F-ST-12B.
FITZPATRICK-1 EMERG CORE COOLING SYS + CONT PUMPS CENTRIFUGAL OTHER NOT APPLICABLE TERRY STEAM TURBINE COMPANY	05000333 79-058/03L-0 026921	090379 100179 30-DAY	THE HPCI SYSTEM TURBINE WAS INTENTIONALLY UNCOUPLED FROM THE PUMP TO ALLOW OVER SPEED TESTING OF THE TURBINE IN ACCORDANCE WITH F-ST-4K (HPCI TURBINE OVER SPEED TESTING). THIS ACTION WAS REQUIRED BY THE INSURANCE UNDERWRITERS. THE DISABLING WAS DONE AT A PRESSURE OF LESS THAN 150 PSIG, SO THERE WAS NO SAFETY HAZARD.
			THE TEST WAS SATISFACTORY. AFTER THE TEST, THE PUMP AND TURBINE WERE RECOUPLED AND THE SYSTEM DEMONSTRATED OPERABLE.

1543 065

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
FITZPATRICK-1 DC ONSITE POWER SYS + CONTROLS OTHER COMPONENTS SUBCOMPONENT NOT APPLICABLE COMPONENT FAILURE ELECTRICAL GOULD-NATIONAL BATT	05000333 79-059/03L-0 026922	090479 100279 30-DAY	A LEAKING CELL WAS NOTED IN STATION BATTERY "B". THE CELL WAS INTENTIONALLY JUMPERED UNTIL A REPLACEMENT COULD BE OBTAINED. JUMPERING OF THE CELL CAUSES THE BATTERY TO BE OPEN-CIRCUITED FOR A SHORT TIME PERIOD AND THEREFORE MAKES THE ENTIRE BATTERY INOPERABLE. THE OTHER BATTERY, AND ITS ASSOCIATED EQUIPMENT WERE VERIFIED OPERABLE. WHEN A REPLACEMENT CELL IS AVAILABLE AND PLANT CONDITIONS PERMIT, THE CELL WILL BE REPLACED.
FITZPATRICK-1 SYSTEM CODE NOT APPLICABLE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000333 79-060/03L-0 026923	090479 100379 30-DAY	DURING REVIEW OF UPDATED FUEL PARAMETERS, A CHANGE IN THE VALUE OF THE TEMPERATURE COEFFICIENT OF REACTIVITY WAS NOTED. REVIEW OF SHUT DOWN MARGIN DEMONSTRATION USING THE NEW VALUE SHOWED THE REACTIVITY INSERTION NEEDED TO DEMONSTRATE THE SHUTDOWN VALUE WAS ABOUT 0.05% DELTA K LARGER THAN VALUE ACTUALLY USED DURING DEMONSTRATION PERFORMED AT BEGINNING OF THE CURRENT FUEL CYCLE. RECALCULATION SHOWED THAT THE SHUT DOWN MARGIN CAPABILITY AT BEGINNING OF THE CYCLE WAS GREATER THAN 1% COMPARED TO VALUE OF R+ 0.38% REQUIRED BY T.S.; THEREFORE, THERE WAS NO SIGNIFICANT SAFETY HAZARD.
FITZPATRICK-1 EMERG CORE COOLING SYS + CONT INSTRUMENTATION + CONTROLS SWITCH DEFECTIVE PROCEDURES NOT APPLICABLE YARWAY CORP.	05000333 79-061/03L-0 026924	090579 100379 30-DAY	DURING HPCI SUB-SYSTEM LOGIC FUNCTIONAL TEST, IT WAS NOTED THAT SWITCH NO. 3 ASSOCIATED WITH LEVEL INSTRUMENT 02-3-LIS-72D DID NOT PROPERLY PICK UP ITS FOLLOWER RELAY WHEN THE STATE OF SWITCH NO. 3 WAS CHANGED AS PART OF THE TEST. THE OTHER 3 SWITCHES (INCLUDING THE REDUNDANT CHANNEL) ASSOCIATED WITH THE SAME PARAMETER WERE VERIFIED OPERABLE. CAUSE DUE TO A WIRING ERROR DURING INSTALLATION OF A NEW SWITCH IN JUNE, 1979. THE WIRING ERROR WAS CORRECTED AND PROPER OPERATION DEMONSTRATED. THE TEST HAS BEEN REVISED TO REQUIRE VERIFICATION OF PROPER OPERATION OF THE FOLLOWER RELAY.
FITZPATRICK-1 EMERG CORE COOLING SYS + CONT INSTRUMENTATION + CONTROLS SWITCH PERSONNEL ERROR NONLIC. OPERATIONS PERSONNEL YARWAY CORP.	05000333 79-062/03L-0 026925	090579 100379 30-DAY	DURING TEST F-ST-4E (HPCI SUB-SYSTEM LOGIC FUNCTIONAL TEST) IT WAS NOTED THAT A PLUG IN INSTRUMENT 02-3-LIS-72A WAS LEAKING. THE OTHER INSTRUMENTS MONITORING THE SAME PARAMETER WERE VERIFIED OPERABLE BEFORE ANY ATTEMPT TO REPAIR THE LEAKING PLUG WAS MADE. THE REPAIR OF THE INSTRUMENT WAS COMPLETED ON THE SAME DAY AS THE DISCOVERY.

1543 066

NOV 08, 1979

LER MONTHLY REPORT SORTED BY FACILITY
PROCESSED DURING OCTOBER, 1979 FOR POWER REACTORS

PAGE 45

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
FITZPATRICK-1 EMERG CORE COOLING SYS + CONT COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000333 79-064/03L-0 027006	090679 100379 30-DAY	DURING TEST (HPCI SUB-SYSTEM LOGIC FUNCTIONAL TEST), THE MOTOR ON THE SY STEMS CONDENSATE STORAGE TANK SUCTION VALVE FAILED. DURING REPAIRS, DUE TO A VALVE BEING IN A CLOSED POSITION, THE TORUS WAS NOT AUTOMATICALLY AVAILABLE TO THE HPCI SYSTEM FOR ABOUT 5 HOURS.
			INADEQUATE COMMUNICATION BETWEEN PLANT MANAGEMENT AND OPERATIONS PERSONN EL. VALVE PLACED IN OPEN POSITION, MOTOR REPLACED, AND PROPER OPERATION DEMONSTRATED.
FITZPATRICK-1 OTHR INST SYS REQD FOR SAFETY INSTRUMENTATION + CONTROLS COMPUTATION MODULE PERSONNEL ERROR LICENSED & SENIOR OPERATORS GENERAL ELECTRIC CO.	05000333 79-066/03L-0 027004	090779 100479 30-DAY	DURING TEST (FLOW BIAS FUNCTIONAL TEST), AVERAGE POWER RANGE MONITOR (AP RM) CHANNELS A, D, AND F TRIPPED AT A VALUE OF 120.5 COMPARED TO T.S. VA LUE 120% OF RATED POWER.
			INVESTIGATION COULD NOT REPRODUCE THE OUT OF TOLERANCE TRIP VALUES AND R E TEST OF THE INSTRUMENTS SHOWED THE TRIP POINTS TO BE WITHIN T.S. LIMITS . THEREFORE, THE APRM SYSTEM WAS RESTORED TO NORMAL.
FITZPATRICK-1 REACTIVITY CONTROL SYSTEMS INSTRUMENTATION + CONTROLS OTHER COMPONENT FAILURE INSTRUMENT GENERAL ELECTRIC CO.	05000333 79-065/03L-0 027005	090779 100479 30-DAY	THE ROD SEQUENCE CONTROL SYSTEM FAILED IN SUCH A MANNER AS TO NOT ALLOW NORMAL CONTROL ROD INSERTION OR WITHDRAWAL. THE SCRAM FUNCTION FOR CONT ROL RODS REMAINED UNAFFECTED. THE SYSTEM DID MAINTAIN CONTROL OF THE WI THDRAWAL SEQUENCE.
			FAILED RELAY ON ONE OF THE PRINTED CIRCUIT BOARDS ASSOCIATED WITH CONTRO L ROD GROUP 3. THE RELAY WAS REPLACED.
FITZPATRICK-1 OTHER ENGRD SAFETY FEATR SYS COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR LICENSED & SENIOR OPERATORS ITEM NOT APPLICABLE	05000333 79-068/03L-0 026968	090879 100479 30-DAY	WHILE ESTABLISHING DRYWELL TO TORUS DIFFERENTIAL PRESSURE REQUIRED BY T. S. THE TORUS WATER LEVEL EXCEEDED THE MAXIMUM VENT PIPE SUBMERGENCE LIMI TATIONS AS CONTAINED IN THE T.S. MAXIMUM LEVEL WAS 0.33" ABOVE ALLOWED FOR A PERIOD OF 9 MINUTES.
			THE TORUS WAS IMMEDIATELY PUMPED DOWN TO RETURN THE LEVEL TO NORMAL. AL SO, OPERATIONS PERSONNEL WERE COUNSELED IN IMPORTANCE OF CONFORMING TO T .S.

1543 067

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
FITZPATRICK-1 REACTIVITY CONTROL SYSTEMS INSTRUMENTATION + CONTROLS COMPUTATION MODULE COMPONENT FAILURE NATURAL END OF LIFE GENERAL ELECTRIC CO.	05000333 79-069/03L-0 027002	090879 100579 30-DAY	ON 9/10/79, 9/13/79, AND 9/14/79, ROD BLOCK MONITOR "B" FAILED IN AN INOPERABLE CONDITION. IN EACH CASE, ROD BLOCK MONITOR "A" WAS DEMONSTRATED OPERABLE.
			REPLACEMENT OF THE RELAY CARD ASSOCIATED WITH ROD BLOCK MONITOR B ELIMINATED THE REPEATED FAILURES, AND PROPER OPERATION WAS DEMONSTRATED.
FITZPATRICK-1 OTHER ENGRD SAFETY FEATR SYS COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR LICENSED & SENIOR OPERATORS ITEM NOT APPLICABLE	05000333 79-067/03L-0 027003	090879 100479 30-DAY	THE REQUIRED DIFFERENTIAL PRESSURE BETWEEN THE DRYWELL AND TORUS WAS NOT ESTABLISHED WITHIN THE SPECIFIED TIME REQUIREMENTS (24 HOURS) OF PLACING THE MODE SWITCH IN THE RUN POSITION. THE DIFFERENTIAL PRESSURE WAS COMPLETED WITHIN 24 HOURS AND 15 MINUTES.
			OPERATIONS PERSONNEL WERE COUNSELED IN THE PROPER PROCEDURES.
FITZPATRICK-1 REACTIVITY CONTROL SYSTEMS INSTRUMENTATION + CONTROLS COMPUTATION MODULE COMPONENT FAILURE ELECTRONIC GENERAL ELECTRIC CO.	05000333 79-070/03L-0 027001	090979 100579 30-DAY	IMPROPER INPUTS WERE NOTED AT THE "A" AND "C" LEVELS TO ROD BLOCK MONITOR "A". THE INSTRUMENT WAS DECLARED INOPERABLE AND THE REDUNDANT CHANNEL (ROD BLOCK MONITOR "B") WAS VERIFIED OPERABLE.
			FAILED INTEGRATED CIRCUIT. CIRCUIT WAS REPLACED AND THE INSTRUMENT RECALIBRATED AND RETURNED TO SERVICE.
FITZPATRICK-1 COOL SYS FOR REAC AUX + CONT HANGERS,SUPPORTS,SHOCK SUPPRS SUPPORTS DESIGN/FABRICATION ERROR CONSTRUCTION/INSTALLATION STONE & WEBSTER ENG. CORP.	05000333 79-074/01T-0 027000	092279 100579 2-WEEK	THE PLANT STAFF WAS NOTIFIED BY THE ARCHITECT ENGINEER THAT A PIPE SUPPORT ASSOCIATED WITH THE SERVICE WATER SYSTEM RETURN LINE FROM THE REACTOR BUILDING COOLING SYSTEM WAS CONSIDERED INOPERABLE IN ACCORDANCE WITH REQUIREMENTS OF THE 8/14/79 NRC LETTER LIFTING THE SHOW CAUSE ORDER OF 3/13/79.
			REPAIR AND MODIFICATIONS OF THE PIPE SUPPORT WERE COMPLETED WITHIN THE PRESCRIBED TIME FRAME AND THE PIPE SUPPORT IS NOW CONSIDERED FULLY OPERABLE.

1543 068

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
FT. ST. VRAIN-1 SYSTEM CODE NOT APPLICABLE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR CONTRACT. & CONSULT. PERSONNEL ITEM NOT APPLICABLE	05000267 79-022/03L-0 026892	072079 091779 30-DAY	DURING PERFORMANCE OF SURVEILLANCE REQUIREMENT SR NR 2.1, ECOLOGICAL MONITORING, AQUATIC MACROINVERTEBRATE SAMPLES WERE NOT COLLECTED FROM THE ST. VRAIN RIVER. REVIEW OF PAST SAMPLE ANALYSIS INDICATES NO SIGNIFICANT CHANGES WOULD HAVE BEEN EXPECTED. REPORTABLE PER TECHNICAL SPECIFICATION AC 7.5.2(B)3. NO ACCOMPANYING OCCURRENCE OR PROBABLE CONSEQUENCES. NO EFFECT ON PUBLIC HEALTH OR SAFETY.
			AN OVERSIGHT ON THE PART OF CONTRACT AGENT SAMPLING PERSONNEL RESULTED IN FAILURE TO COLLECT THE REQUIRED SAMPLES. SAMPLING WAS RESUMED AND WILL CONTINUE ON A BI-WEEKLY BASIS BEGINNING JULY, 1979.
FT. ST. VRAIN-1 COOLANT RECIRC SYS + CONTROLS COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000267 79-024/03L-0 026698	080479 083179 30-DAY	ON THREE OCCASIONS DURING PERIOD AUG 4, 1979, THROUGH AUG 16, 1979, TOTAL PRIMARY COOLANT OXIDANTS (SUM OF WATER, CARBON MONOXIDE, & CARBON DIOXIDE) EXCEEDED 10 PPM WITH CORE AVERAGE OUTLET TEMPERATURE GREATER THAN 1,200 DEG F. THIS CONSTITUTES OPERATION UNDER A DEGRADED MODE PERMITTED BY LCO 4.2.10 & IS REPORTABLE PER T.S. AC 7.5.2(B)2.
			LCO 4.2.10 PRIMARY COOLANT IMPURITY LIMITS WERE EXCEEDED DURING DRYING OUT OPERATIONS FOLLOWING FIRST REFUELING. A PREVIOUS DRYER BYPASS RESULTING IN WATER INGRESS TO CORE & BREAKTHROUGH OF PURIFICATION TRAIN CONTRIBUTED TO INCREASED OXIDANT LEVELS OBSERVED.
FT. ST. VRAIN-1 ONSITE POWER SYSTEM + CONTROL RELAYS OTHER COMPONENT FAILURE NATURAL END OF LIFE ITEM NOT APPLICABLE	05000267 79-025/03X-0 026697	080679 083179 OTHER	ON AUG 6, 1979, DURING STEADY STATE OPERATIONS AT 45% THERMAL POWER & 14.5 MW ELECTRICAL POWER, "A" EMERGENCY DIESEL GENERATOR WAS FOUND IN A DEGRADED MODE PER FT ST VRAIN T.S. LCO 4.6.1. THIS IS REPORTABLE PER FT ST VRAIN T.S. AC 7.5.2(B)2. WHEN "A" DIESEL ENGINE DECLUTCHED "B" DIESEL ENGINE ALSO DECLUTCHED. REDUNDANT EQUIPMENT WAS OPERABLE & AVAILABLE. THERE WAS NO EFFECT ON PUBLIC HEALTH OR SAFETY.
			A RELAY FAILED DUE TO NORMAL END OF LIFE. THE UNIT HAD BEEN TESTED SATISFACTORILY THE PREVIOUS MONTH. THE RELAY WAS REPLACED AND TESTED AND THE SURVEILLANCE SUCCESSFULLY COMPLETED.
FT. ST. VRAIN-1 COOLANT RECIRC SYS + CONTROLS PIPES, FITTINGS LESS THAN 4 INCHES COMPONENT FAILURE MECHANICAL OTHER	05000267 79-026/03L-0 026696	080779 083179 30-DAY	WITH REACTOR OPERATING AT APPROXIMATELY 65% POWER, BEARING WATER MAKEUP PUMP P-2105 WAS REMOVED FROM SERVICE TO PERFORM A LINE REPAIR. REPORTABLE PER T.S. AC 7.5.2(B)2 OPERATION UNDER DEGRADED MODE PERMITTED BY LCO 4.2.2. NO ACCOMPANYING OCCURRENCE OR PROBABLE CONSEQUENCES. NO AFFECT ON PUBLIC HEALTH OR SAFETY.
			A HOLE IN THE RECIRCULATION LINE TO THE PUMP REQUIRED THAT THE PUMP BE TAKEN OUT OF SERVICE FOR REPAIR. THE LINE WAS REPAIRED, INSPECTED, AND THE PUMP RETURNED TO SERVICE.

1543 069

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
FT. ST. VRAIN-1 ON-SITE POWER SYSTEM + CONTROL COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR MAINTENANCE & REPAIR PERSONNEL ITEM NOT APPLICABLE	05000267 79-028/01T-0 026691	081779 083179 2-WEEK	DURING NORMAL PLANT OPERATION WHILE CONNECTING A NEW INSTRUMENT, PLANT PERSONNEL GROUNDED AN INSTRUMENT PANEL, BLOWING THE PANEL'S FUSES AND CAUSING A VOLTAGE PERTURBATION ON INSTRUMENT BUS 2. THIS EVENT RESULTED IN A LOOP 1 SHUTDOWN, REACTOR SCRAM, AND A LOSS OF FORCED CIRCULATION FOR APPROXIMATELY 3 MINUTES. SIMILAR EVENTS WERE REPORTED IN RO 76-01, 77-14, AND 79-17. THERE WAS NO EFFECT ON PUBLIC HEALTH OR SAFETY. THE GROUND WAS CAUSED BY PERSONAL ERROR OF A NON-LICENSED MAINTENANCE PERSONNEL. THE GROUND WAS CORRECTED, POWER RESTORED TO THE INSTRUMENT PANEL AND ACTION TAKEN TO RETURN THE PLANT TO NORMAL CONDITIONS. THE EFFECTS OF THE UPSET ARE BEING ANALYZED.
FT. ST. VRAIN-1 COOLANT RECIRC SYS + CONTROLS HANGERS, SUPPORTS, SHOCK SUPPRESS HANGERS DESIGN/FABRICATION ERROR CONSTRUCTION/INSTALLATION GENERAL ATOMIC CO.	05000267 79-027/01T-0 026888	081779 083179 2-WEEK	ON AUGUST 17, 1979, WHILE OPERATING AT APPROXIMATELY 50% OF RATED POWER, IT WAS DETERMINED THAT A RECENT PIPE HANGER INSTALLATION ON PCRV COOLING WATER LINES WOULD HAVE PREVENTED PROPER INSTALLATION OF PIPE SPOOLS TO HIGH TEMPERATURE FILTER ADSORBER COOLERS. THESE ARE REQUIRED TO BE INSTALLED & OPERABLE WITHIN 1 1/2 HRS OF AN EXTENDED LOSS OF FORCED CIRCULATION. THIS DOES NOT MEET REQUIREMENTS OF FORT ST. VRAIN TECHNICAL SPECIFICATIONS LCO 4.2.18 AND IS REPORTABLE PER AC 7.5.2(A)5. HANGER ADDITIONS TO SYSTEM PIPING CAUSED PIPE ENDS TO CHANGE ALIGNMENT & MADE SPOOL PIECES INOPERABLE. SPOOL PIECES WERE MODIFIED TO FIT ON THE AVAILABLE PURIFICATION TRAIN AND WILL BE MODIFIED ON THE OTHER TRAIN AFTER IT IS REMOVED FROM SERVICE. THERE WAS NO EFFECT ON PUBLIC SAFETY OR HEALTH.
FT. ST. VRAIN-1 COMPRESSED AIR SYSTEMS + CONTROLS VALVES CHECK COMPONENT FAILURE NATURAL END OF LIFE GARDNER-DENVER	05000267 79-029/03L-0 026927	081979 091779 30-DAY	DURING PLANT STARTUP WHILE "C" INSTRUMENT AIR COMPRESSOR WAS REMOVED FROM SERVICE FOR SCHEDULED INSPECTION, "B" INSTRUMENT AIR COMPRESSOR BECAME INOPERABLE. OPERATION OF THE PLANT AT POWER WITH ONLY ONE INSTRUMENT AIR COMPRESSOR OPERABLE IS CONTRARY TO LCO 4.3.6. THERE WAS NO EFFECT UPON THE HEALTH OR SAFETY OF THE PUBLIC. BACKUP TO THE INSTRUMENT AIR SYSTEM WAS AVAILABLE FROM THE SERVICE AIR SYSTEM. THE CAUSE OF INOPERABILITY FOR "B" INSTRUMENT AIR COMPRESSOR WAS FAILURE OF THE DISCHARGE FEATHER VALVE. ALL DISCHARGE VALVES ON THE COMPRESSOR WERE REPLACED. RETURNING THE INSTRUMENT AIR SYSTEM TO OPERABILITY WAS ACCOMPLISHED BY RETURNING "C" INSTRUMENT AIR COMPRESSOR TO SERVICE.
FT. ST. VRAIN-1 COOLANT RECIRC SYS + CONTROLS COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000267 79-030/03L-0 026909	082179 092079 30-DAY	ON SIX OCCASIONS DURING THE PERIOD AUGUST 21, 1979, THROUGH SEPTEMBER 1, 1979, TOTAL PRIMARY COOLANT OXIDANTS (SUM OF WATER, CARBON MONOXIDE, AND CARBON DIOXIDE) EXCEEDED 10 PPM WITH AVERAGE CORE OUTLET TEMPERATURE GREATER THAN 1,200 DEG. F. THIS CONSTITUTES OPERATION UNDER A DEGRADED MODE PERMITTED BY LCO 4.2.10 AND IS REPORTABLE PER TECHNICAL SPECIFICATION AC 7.5.2(B)2. NO EFFECT ON PUBLIC HEALTH OR SAFETY. PRIMARY COOLANT IMPURITY LIMITS WERE EXCEEDED DURING THIS PERIOD AS A RESULT OF DRYING OUT OPERATIONS AND AN EXTENDED REGENERATION PERIOD ON THE OFF-LINE HELIUM DRYER. AT ANY TIME OXIDANTS DID NOT DECREASE IN TIME TO MAINTAIN LCO COMPLIANCE, CORE OUTLET TEMPERATURES WERE REDUCED.

1543 070

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
FT. ST. VRAIN-1 COOLANT RECIRC SYS + CONTROLS RELAYS TIME DELAY, PNEUMATIC COMPONENT FAILURE ELECTRICAL AGASTAT RELAY CO.	05000267 79-031/03L-0 026932	082179 092079 30-DAY	ON AUGUST 21, 1979, AND ON AUGUST 30, 1979, PLANT WAS OPERATED WITH REACTOR DEWPOINT OUTSIDE THE LIMITS OF LCO 4.2.11, FIGURE 4.2.11-1. NO ACCOMPANYING EVENTS OR PROBABLE CONSEQUENCES. NO EFFECT ON PUBLIC HEALTH OR SAFETY. REPORTABLE PER TECHNICAL SPECIFICATION AC 7.5.2(B)2. SIMILAR EVENTS HAVE BEEN REPORTED IN REPORTABLE OCCURRENCE REPORTS 76-06, 77-02, 77-13, 78-16, AND 78-39.
			NO CAUSE FOR AUGUST 21, 1979, EVENT TRACEABLE TO PLANT OPERATION. EVENT OF AUGUST 30, 1979, WAS RESULT OF HELIUM DRYER BYPASS DUE TO FAULTY TIME DELAY RELAY. RELAY WAS REPLACED AND TESTED, AND THE DRYER RETURNED TO SERVICE.
FT. ST. VRAIN-1 SYSTEM CODE NOT APPLICABLE VALVES CLOBE PERSONNEL ERROR NONLIC. OPERATIONS PERSONNEL ITEM NOT APPLICABLE	05000267 79-033/03L-0 026908	082879 092079 30-DAY	DURING NORMAL OPERATION WHILE ATTEMPTING TO MAKE AN AUTHORIZED RELEASE FROM THE 1B GAS WASTE SURGE TANK, AN UNAUTHORIZED RELEASE WAS MADE FROM THE 1A GAS WASTE SURGE TANK. ON DISCOVERY OF THIS OCC. RELEASE WAS TERMINATED & VALVE LINEUP CORRECTED. 1A GAS WASTE SURGE TANK WAS SAMPLED & ANALYZED & RELEASE FOUND TO BE BELOW LIMITS OF LCO 4.8.1. RELEASE OF RADIOACTIVE GAS WASTE WITHOUT PRIOR SAMPLE & ANALYSIS IS CONTRARY TO LCO 4.8.1. RO 78-22 SIMILAR. NO EFFECT ON HEALTH OR SAFETY OF THE PUBLIC. THE WRONG VALVE LINEUP WAS MADE. THE VALVES WERE POSITIONED FOR RELEASE FROM THE 1A GAS WASTE SURGE TANK WHEN RELEASE FROM 1B WAS AUTHORIZED. THE VALVE CHECKOFF SHEETS WERE REVISED TO REQUIRE OPERATOR INITIALS FOR EACH INDIVIDUAL VALVE. PERSONNEL INVOLVED WERE ADMONISHED.
FT. ST. VRAIN-1 SYSTEM CODE NOT APPLICABLE HANGERS, SUPPORTS, SHOCK SUPPRESS HANGERS DESIGN/FABRICATION ERROR DESIGN ITEM NOT APPLICABLE	05090267 79-035/01T-0 026902	083179 091379 2-WEEK	A FIELD AUDIT AND PRELIMINARY ENGINEERING ANALYSIS OF A RANDOM SAMPLE OF AS-BUILT SAFETY RELATED PIPING DRAWINGS SHOWED THAT SEVERAL HANGERS HAVE INCONSISTENCIES THAT MAY JEOPARDIZE THE OPERABILITY OF THE ASSOCIATED SYSTEMS IN THE EVENT OF A DESIGN BASIS EARTHQUAKE. BECAUSE OF THESE INCONSISTENCIES THE FORT ST. VRAIN UNIT WAS SHUTDOWN ON SEPTEMBER 1, 1979. THIS APPEARS TO BE REPORTABLE PER FORT ST. VRAIN TECHNICAL SPECIFICATION AC 7.5.2(A)9. THERE WAS NO EFFECT ON PUBLIC HEALTH OR SAFETY. THE CAUSE OF THIS PROBLEM IS DESIGN/INSTALLATION INCONSISTENCIES WHICH COULD JEOPARDIZE THE SYSTEMS INVOLVED. THE EXACT EXTENT OF THE PROBLEM IS NOT YET CERTAIN AND AN INVESTIGATION IS CONTINUING. WHEN THE EXACT CAUSE IS DETERMINED THE CORRECTIVE ACTION WILL BE DECIDED AND A REVISED LICENSEE EVENT REPORT SUBMITTED.
H. B. ROBINSON-2 FIRE PROTECTION SYS + CONT COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR CONTRACT. & CONSULT. PERSONNEL ITEM NOT APPLICABLE	05000261 79-024/03L-0 026701	072479 082379 30-DAY	ON JULY 24, 1979, BETWEEN 0000 & 0800, HOURLY FIRE PATROLS WERE NOT PERFORMED AS REQUIRED WHEN PORTIONS OF FIRE DETECTION SYSTEM WERE INOPERABLE. THESE PATROLS ARE REQUIRED BY "PROPOSED" T.S. 3.14.1.2.B, WHICH WE ARE CONSIDERED TO BE IN EFFECT. THEREFORE, THIS IS BEING REPORTED PER T.S. 6.9.2.B.
			MIDNIGHT SHIFT FIRE PATROL FAILED TO REPORT FOR WORK DUE TO CAR TROUBLE. EVENING SHIFT FIRE PATROL LEFT AT MIDNIGHT W/O INFORMING SHIFT FOREMAN THAT HE HAD NOT BEEN RELIEVED. FIRE PATROLS WERE RESUMED BY DAY SHIFT FIRE PATROL AT 0800. ALL FIRE PATROLS WERE INSTRUCTED TO INFORM SHIFT FOREMAN IF THEIR RELIEF IS NOT PRESENT & NOT TO LEAVE TIL THEY ARE RELIEVED.

1543 071

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
H. B. ROBINSON-2 FIRE PROTECTION SYS + CONT COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR CONTRACT. & CONSULT. PERSONNEL ITEM NOT APPLICABLE	05000261 79-025/03L-0 026700	073079 082379 30-DAY	ON JULY 30, 1979, BETWEEN 0800 & 1000, HOURLY FIRE PATROLS WERE NOT PERFORMED AS REQUIRED WHEN PORTIONS OF FIRE DETECTION SYSTEM WERE INOPERABLE. THESE PATROLS ARE REQUIRED BY "PROPOSED" T.S. 3.14.1.2.B. THIS CONSTITUTE A REPORTABLE OCCURRENCE PER T.S. 6.9.2.B.
H. B. ROBINSON-2 REAC COOL CLEANUP SYS + CONT HANGERS,SUPPORTS,SHOCK SUPPRSS SNUBBERS COMPONENT FAILURE OTHER TOMKINS-JOHNSON	05000261 79-026/03L-0 026692	080279 083179 30-DAY	DAY SHIFT FIRE PATROL FAILED TO REPORT FOR WORK. MIDNIGHT SHIFT FIRE PATROL LEFT PLANT AT 0800 W/O INFORMING SHIFT FOREMAN THAT HE HAD NOT BEEN RELIEVED. FIRE PATROL INSPECTIONS WERE RESUMED AT 1100 HRS THAT DAY BY AN AUX. OPERATOR. PERSON WHO FAILED TO REPORT TO WORK WILL BE REPLACED. CONTRACTOR THAT LEFT HAS BEEN STERNLY COUNSELLED ON RESPONSIBILITIES. WHILE PERFORMING REFUELING PERIODIC TEST ON 5/24/79, WHICH DEALS WITH HYDRAULIC SHOCK SUPPRESSORS (PT-31.0), ONE BLOW KNOX UNIT FAILED FUNCTIONAL TEST PORTION DUE TO BROKEN SHAFT WHICH OCCURRED DURING TEST. SNUBBER HAD BEEN INSTALLED ON CVC5 PIPING & IS REQUIRED BY T.S. 3.13.1. ON AUGUST 2, 1979, AS A RESULT OF METALLURGICAL ANALYSIS PERFORMED ON FAILED SHAFT, IT WAS DETERMINED THAT THIS TYPE OF FAILURE COULD HAVE OCCURRED WHILE SNUBBER WAS IN SERVICE, THUS RENDERING IT INOPERABLE. THE FAILED SNUBBER WAS REPLACED BY A SPARE OF SIMILAR SIZE AND RATING. THE FAILURE WAS CAUSED BY (1) INCORRECT SHAFT MATERIAL AS DETERMINED BY A METALLURGICAL ANALYSIS OF THE FAILED PART, AND (2) POSSIBLE SIDE LOADINGS IMPOSED ON THE SNUBBER DURING THE TEST SINCE FAILED SHAFT WAS SLIGHTLY BENT.
H. B. ROBINSON-2 CONTAINMENT ISOLATION SYS + CONT VALVES GLOBE COMPONENT FAILURE MECHANICAL BLAW-KNOX COMPANY	05000261 79-028/03L-0 026773	080979 091079 30-DAY	DURING NORMAL OPERATIONS ON 8/9/79, AT 1100 HRS VALVE SI-855 MECHANICALLY STUCK IN MID-TRAVEL AFTER ADDING NITROGEN TO ACCUMULATORS. VALVE IS A CONTAINMENT AUTO ISOLATION TRIP VALVE & ITS FAILURE IS REPORTABLE UNDER T.S. 6.9.2.B(2). PENETRATION WAS ISOLATED BY LOCKING CLOSED MANUAL VALVES WITHIN THE 4 HRS AS REQUIRED BY TECH. SPEC. 3.6.3.C. THIS IS A CLOSED SYSTEM WITHIN CONTAINMENT & THEREFORE WAS NOT A THREAT TO THE PUBLIC HEALTH OR SAFETY. THE BLOW KNOX, ONE INCH, GLOBE, AIR OPERATED, FAIL CLOSE, CARBON STEEL, 1500 POUND VALVE FAILED TO CLOSE DUE TO MECHANICAL BINDING. THE PARALLEL VALVES IN THE LINE DOWNSTREAM FROM CONTAINMENT WERE LOCKED CLOSED TO SATISFY CONTAINMENT ISOLATION CRITERIA. WHEN PLANT CONDITIONS PERMIT, THE BINDING IN VALVE 855 WILL BE CORRECTED.
H. B. ROBINSON-2 FIRE PROTECTION SYS + CONT COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR CONTRACT. & CONSULT. PERSONNEL ITEM NOT APPLICABLE	05000261 79-029/03L-0 026901	081479 091379 30-DAY	ON AUGUST 14, 1979, BETWEEN 0100 AND 0530, THE HOURLY FIRE PATROLS WERE NOT CONDUCTED AS REQUIRED WHEN PORTIONS OF THE FIRE DETECTION SYSTEM WERE INOPERABLE. THE PATROLS ARE REQUIRED BY "PROPOSED" TECHNICAL SPECIFICATION 3.14.1.2.B. THIS WOULD CONSTITUTE A REPORTABLE OCCURRENCE PER TECHNICAL SPECIFICATION 6.9.2.B.

THE MIDNIGHT SHIFT FIRE PATROLMAN FAILED TO CONDUCT HOURLY PATROLS BETWEEN 0100 & 0530. WHEN ASKED, HE INFORMED SHIFT FOREMAN THAT HE WAS ILL DURING THIS TIME PERIOD. HE WAS STRICTLY INSTRUCTED AGAIN ON IMPORTANCE OF HOURLY PATROLS & HIS RESPONSIBILITIES. FIRE PATROLS WERE RESUMED AT HIS TIME & WERE PERFORMED PROPERLY THROUGHOUT REMAINDER OF THE SHIFT.

1543 072

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
H. B. ROBINSON-2 STATION SERV WATER SYS + CONT PUMPS CENTRIFUGAL OTHER NOT APPLICABLE WORTHINGTON CORP.	05000261 79-030/01T-0 026931	082979 091279 2-WEEK	ON 8/29/79 AT 1119 HRS DURING NORMAL OPERATION AT 100% POWER, BOTH SWBP'S RENDERED OOS WHEN "B" SWBP WAS SECURED & "A" SWBP TRIPPED; NEITHER PUMP COULD BE RESTARTED IMMED. DURING THIS PERIOD, "D" SW PUMP WAS OOS FOR ROUTINE MAINTENANCE. THIS IS CONTRARY TO PARAGRAPH 3.3.4.2 OF T.S. & C ONSTITUTES A REPORTABLE OCCURRENCE UNDER PARAGRAPH 6.9.2.A.2. POWER REDUCTION WAS IMMEDIATELY COMMENCED. NO ADVERSE EFFECTS TO THE PLANT OR TO THE PUBLIC HEALTH OR SAFETY OCCURRED FROM THIS EVENT. THE STARTING & STOPPING OF "B" SWBP APPARENTLY CAUSED PRESSURE FLUCTUATIONS WHICH TRIPPED "A" SWBP ON LOW SUCTION PRESSURE. BOTH PUMPS FAILED TO RESTART APPARENTLY BECAUSE OF LOW SERVICE WATER SYSTEM PRESSURE. "D" SERVICE WATER PUMP WAS OUT OF SERVICE (OOS) FOR ROUTINE MAINTENANCE. A CHANGE IN DESIGN OF THE TRIPPING LOGIC FOR SWBP'S IS BEING CONSIDERED. ON 01/27/79 WHILE PLANT WAS IN PROCESS OF SHUTTING DOWN FOR ROUTINE REFUELING, THE PLANT COMPUTER ALARMED, INDICATING A DISCHARGE TEMPERATURE RATE OF CHANGE GREATER THAN THE ETS LIMIT OF 8 DEGREES F PER HOUR. NO ENVIRONMENTAL IMPACT EXPECTED.
HADDAM NECK-1 CIRCULATING WATER SYS + CON COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000213 79-002/04L-0 026870	012779 021279 30-DAY	NO CORRECTIVE ACTION TAKEN.
HADDAM NECK-1 CIRCULATING WATER SYS + CON COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000213 79-001/04L-0 026765	013179 020279 30-DAY	AN ESTIMATED 279 SPOTTAIL SHINERS (NOTORPIS HUDSONIUS) >6" WERE IMPINGED AS OF 01/31/79 EXCEEDING ETS LIMITS OF 25. SPOTTAIL SHINERS ARE 2ND MOST ABUNDANT FISH IN CONNECTICUT RIVER AND ARE UNIMPORTANT COMMERCIALY AND FOR SPORT.
HADDAM NECK-1 FIRE PROTECTION SYS + CONT ENGINES, INTERNAL COMBUSTION SUBCOMPONENT NOT APPLICABLE COMPONENT FAILURE ELECTRICAL DELCO CO.	05000213 79-003/03X-1 025479	021579 091179 OTHER	NO APPARENT CAUSE RELATED TO PLANT OPERATION. SEASONAL TEMPERATURE CHANGES APPARENTLY CONTRIBUTE TO INCREASED IMPINGEMENT DURING THE WINTER MONTHS.
HADDAM NECK-1 FIRE PROTECTION SYS + CONT ENGINES, INTERNAL COMBUSTION SUBCOMPONENT NOT APPLICABLE COMPONENT FAILURE ELECTRICAL DELCO CO.	05000213 79-003/03X-1 025479	021579 091179 OTHER	DIESEL FIRE PUMP WAS TO BE TESTED BEFORE REMOVING IT FROM SERVICE FOR INSPECTION. WHEN UNIT WAS GIVEN START SIGNAL IT FAILED TO START. INVESTIGATIONS SHOWED THAT ONE COIL OF STARTER MOTOR BURNED OPEN. THIS EVENT IS REPORTABLE UNDER T.S. 6.9.2.B(2). OPERATING IN DEGRADED MODE PERMITTED BY LIMITING CONDITIONS FOR OPERATION. T.S. 3.22 REQUIRES A 30-DAY REPORT IF INOPERABLE UNIT IS NOT RETURNED TO SERVICE WITHIN 7 DAYS. UNIT WAS RETURNED TO SERVICE AFTER 12 DAYS. REDUNDANT FIRE PUMP WAS OPERABLE. AS DESCRIBED IN ORIGINAL LER, PUMP SHAFT WAS FROZEN IN BLOCK OF ICE. TO PREVENT THIS FROM HAPPENING IN FUTURE, PLANT DESIGN CHANGE HAS BEEN APPROVED WHICH WILL ALLOW INSTALLATION OF 1/2" LINE COMING OFF SERVICE H2O HEADER TO BE RUN TO BOTH PUMP DISCHARGE COLUMNS TO PREVENT H2O IN COLUMNS FROM BECOMING STAGNANT. MODIFICATION INSTALLED PRIOR TO COLD WEATHER.

543 073

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
HADDAM NECK-1 RESIDUAL HEAT REMOV SYS + CONT HANGERS,SUPPORTS,SHOCK SUPPRSS SUPPORTS DESIGN/FABRICATION ERROR CONSTRUCTION/INSTALLATION STONE & WEBSTER ENG. CORP.	05000213 79-008/01T-0 026996	080379 081479 2-WEEK	WHILE PERFORMING A VISUAL INSPECTION OF CATEGORY I PIPING SYSTEM SUPPORT S, AS PART OF IE BULLETIN 79-02, REV. 01, A SEISMIC TYPE PIPE SUPPORT WA S FOUND TO BE MISSING (AC-ER-31), ON THE RESIDUAL HEAT REMOVAL PIPING (R WL-152-7) SYSTEM. INITIAL INVESTIGATION SHOWED THAT THE EXISTING SURROUN DING SUPPORTS MIGHT NOT PROVIDE THE LOAD SUPPORT CAPABILITY SPECIFIED ON THE PIPING DRAWING. NO EFFECT ON THE HEALTH AND SAFETY OF THE PUBLIC WA S EXPERIENCED. THE PIPING DRAWING WAS REVISED, DURING CONSTRUCTION OF PLANT, TO ADD A S EISMIC TYPE PIPING RESTRAINT. HOWEVER, THE SEISMIC SUPPORT WAS NOT ADDED IN THE FIELD. THE SUPPORT WAS INSTALLED AT THE LOCATION SHOWN ON THE PI PING DRAWING WITHIN 72 HOURS.
HADDAM NECK-1 EMERG GENERATOR SYS + CONTROLS ENGINES,INTERNAL COMBUSTION SUBCOMPONENT NOT APPLICABLE DESIGN/FABRICATION ERROR MANUFACTURING ELECTRO - MOTIVE DIV. OF G. M.	05000213 79-009/01T-0 026994	083179 091279 2-WEEK	MANUFACTURER OF PLANT EMERGENCY DIESEL GENERATORS HAS IDENTIFIED A POTEN TIAL PROBLEM WITH TURBOCHARGER THRUST BEARING LUBRICATION. IF THE ENGINE IS RESTARTED WITHIN 15 TO 180 MINUTES OF A PREVIOUS HOT RUN, SOME SMEAR ING OF BEARING METAL MAY OCCUR. CUMULATIVE DAMAGE FROM SEVERAL SIMILAR S TARTS COULD RESULT IN TURBOCHARGER FAILURE. CERTAIN CHECKS ON LUBE OIL S YSTEM AFTER MAINTENANCE, TO ENSURE PROPER LUBRICATION, ARE ALSO NECESSAR Y. NO EFFECT ON HEALTH & SAFETY OF PUBLIC WAS EXPERIENCED. DAMAGE TO TURBOCHARGER THRUST BEARING COULD OCCUR BECAUSE MAIN LUBE OIL SYSTEM PUMP "PRIME" MAY NOT BE MAINTAINED DURING THIS PERIOD. ADMINISTRA TIVE CONTROLS HAVE BEEN INSTITUTED TO AVOID THESE TYPE OF STARTS & ENSUR E THAT AT LEAST ONE DIESEL IS AVAILABLE AT ALL TIMES. MANUFACTURER IS DE VELOPING MODIFICATION TO LUBRICATION SYSTEM.
INDIAN POINT-2 OTHER SYSTEMS COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE EXTERNAL CAUSE NOT APPLICABLE ITEM NOT APPLICABLE	05000247 78-020/04T-0 023643	042878 060978 2-WEEK	TELEDYNE ISOTOPES, OUR CONTRACTING LAB, INFORMED CON EDISON THAT THE ACT IVITY OF A WATER SAMPLE TAKEN FROM CAMP FIELD RESEVOIR ON 03/27/78 EXCEE DED 10 TIMES THE HISTORICAL LEVEL AT THIS LOCATION. THIS EVENT DOES NOT HAVE ANY SIGNIFICANT ENVIRONMENTAL CONSEQUENCES, SINCE THE SAMPLE WAS N ON-REPRESENTATIVE, AND THE VALIDITY OF THE RESULTS IS THEREFORE QUESTION ABLE. THIS ANOMOLOUS SAMPLE ACTIVITY WAS CONSIDERED TO BE CAUSED BY NON-REPRES ENTATIVE SAMPLING TECHNIQUE IN CONJUNCTION WITH ADVERSE METEOROLOGICAL CO NDITIONS ON THE DAY THE SAMPLE WAS TAKEN. SAMPLING PROCEDURES ARE BEING REVIEWED AND UPGRADED WHERE NECESSARY TO PREVENT A RECURRENCE OF THIS E VENT.
INDIAN POINT-2 OTHER SYSTEMS COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000247 79-002/04X-0 026790	010879 041879 OTHER	TELEDYNE ISOTOPES, OUR CONTRACTING LABORATORY, PROVIDED CON EDISON WITH A REPORT ON JANUARY 8, 1979 THAT THE ACTIVITY OF OUR PRECIPITATION SAMPL E TAKEN FROM EASTVIEW ON NOVEMBER 30, 1978 EXCEEDED TEN TIMES THE CONTROL STATION LEVEL. THIS EVENT DID NOT HAVE ANY ENVIRONMENTAL CONSEQUENCES ATTRIBUTABLE TO PLANT OPERATIONS AT INDIAN POINT. THE ANOMALOUS SAMPLE ACTIVITY WAS DETERMINED TO BE CAUSED BY TRITIUM REL EASES FROM A SOURCE OTHER THAN INDIAN POINT. THE NEW YORK STATE DEPARTM ENT OF ENVIRONMENTAL CONSERVATION INVESTIGATED A MANUFACTURER IN THE VIC INITY OF EASTVIEW STATION, WHICH HAS SINCE MODIFIED THEIR INSTALLATION T O PREVENT A RECURRENCE OF THIS PROBLEM.

1543 074

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
INDIAN POINT-2 OTHER SYSTEMS COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000247 79-012/04T-0 026804	021379 031479 2-WEEK	TELEDYNE ISOTOPES, THE CONTRACTING LABORATORY, PROVIDED CON EDISON WITH A REPORT ON 2/13/79, THAT THE ACTIVITY OF THE PRECIPITATION SAMPLE TAKEN FROM EASTVIEW ON 1/2/79 EXCEEDED TEN TIMES THE CONTROL STATION LEVEL. THIS EVENT DID NOT HAVE ANY ENVIRONMENTAL CONSEQUENCES ATTRIBUTABLE TO PLANT OPERATIONS AT INDIAN POINT.
INDIAN POINT-2 MAIN STEAM SYSTEMS + CONTROLS HANGERS,SUPPORTS,SHOCK SUPPRSS SNUBBERS COMPONENT FAILURE MECHANICAL GRINNELL CORP.	05000247 79-021/03L-0 026834	081779 091479 30-DAY	THE ANOMALOUS SAMPLE ACTIVITY WAS CAUSED BY TRITIUM RELEASED FROM A SOURCE OTHER THAN INDIAN POINT. THE NEW YORK STATE DEPARTMENT OF ENVIRONMENTAL CONSERVATION INVESTIGATED A MANUFACTURER IN THE VICINITY OF EASTVIEW STATION, WHICH HAS SINCE MODIFIED THEIR INSTALLATION TO PREVENT A RECURRENCE OF THIS PROBLEM. WHILE SHUTDOWN FOR REFUELING, A REVIEW OF THE RESULTS OF SURVEILLANCE TEST PI-V1 (A) INDICATED THAT THE RESERVOIR ASSOCIATED WITH THE SNUBBER BANK LOCATED AT THE TOP OF THE SUPPORT STRUCTURE FOR NO. 24 STEAM GENERATOR HAD LESS THAN THE REQUIRED FLUID LEVEL - TECHNICAL SPECIFICATION 3.12.
INDIAN POINT-3 CONDENSATE STORAGE FACILITIES COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE EXTERNAL CAUSE NOT APPLICABLE ITEM NOT APPLICABLE	05000286 79-010/03L-0 026838	082379 092179 30-DAY	TUBING FITTING LEAKAGE RESULTED IN FLUID LOSS FROM THE GRINNEL 8" BORE, 5" STROKE, SNUBBER OIL RESERVOIR. FITTINGS WERE TIGHTENED AND RESERVOIR REFILLED TO THE REQUIRED LEVEL. TO PROVIDE FURTHER ASSURANCE THAT THE PROPER OIL LEVEL WILL BE MAINTAINED INCREASED SURVEILLANCE OF RESERVOIR FLUID LEVEL WILL BE PERFORMED. WHILE OPERATING AT 85 PERCENT POWER, THE CONDENSATE STORAGE TANK LEVEL DROPPED BELOW THE 360,000 GALLON LIMIT DESIGNATED BY TECHNICAL SPECIFICATION 3.4.A(3) TO A LEVEL OF 342,000 GALLONS. OUR USUAL DEMINERALIZED WATER SOURCE AT CONSOLIDATED EDISON (INDIAN POINT UNIT 1) WAS OUT OF SERVICE FOR REPAIRS AT THE TIME. SIMILAR EVENTS WERE REPORTED ON SEPTEMBER 2, 1978, SEPTEMBER 7, 1978, AND MARCH 27, 1979.
INDIAN POINT-3 CONDENSATE STORAGE FACILITIES COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000286 79-011/03L-0 026839	090279 092479 30-DAY	THE INCIDENT WAS CAUSED BY NORMAL USE OF THE STEAM GENERATOR BLOWDOWN SYSTEM, COMPOUNDED BY THE UNAVAILABILITY OF OUR STANDARD WATER SOURCE AT CONSOLIDATED EDISON. WATER WAS SUPPLIED FROM AN ALTERNATE SOURCE AT THE INDIAN POINT 2 HOT WELL, AND THE CONDENSATE STORAGE TANK LEVEL WAS RETURNED TO SPECIFICATION WITHIN THE DESIGNATED 48-HOUR LIMIT. WHILE IN HOT SHUTDOWN, THE CONDENSATE STORAGE TANK LEVEL DROPPED BELOW THE 360,000 GALLON LIMIT DESIGNATED BY TECHNICAL SPECIFICATION 3.4.A(3) TO A LEVEL OF 310,000 GALLONS. THE WATER SUPPLIED FROM OUR EXTERNAL SUPPORT FACILITY AT CONSOLIDATED EDISON (INDIAN POINT UNIT 1) WAS AT REDUCED CAPACITY DUE TO MAINTENANCE. SIMILAR EVENTS OCCURRED ON SEPTEMBER 2, 1978, SEPTEMBER 7, 1978, MARCH 27, 1979, AND AUGUST 23, 1979.
INDIAN POINT-3 CONDENSATE STORAGE FACILITIES COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000286 79-011/03L-0 026839	090279 092479 30-DAY	THE INCIDENT WAS CAUSED BY NORMAL LOSSES DUE TO THE STEAM GENERATOR BLOWDOWN SYSTEMS AND ATMOSPHERE STEAM DUMPS, COMPOUNDED BY THE INABILITY OF EXTERNAL SOURCE TO MAKE UP SUFFICIENT AMOUNT OF WATER. ENOUGH WATER WAS EVENTUALLY SUPPLIED TO RETURN THE CONDENSATE STORAGE TANK TO AN ACCEPTABLE LEVEL WITHIN THE DESIGNATED 48-HOUR LIMIT.

1543 075

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
INDIAN POINT-3 CONDENSATE STORAGE FACILITIES COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000286 79-012/03L-0 026981	091479 100979 30-DAY	WHILE AT 79 PERCENT POWER IN THE COURSE OF A ROUTINE SHUTDOWN FOR REFUELING, THE CONDENSATE STORAGE TANK LEVEL DROPPED BELOW THE 360,000 GALLON LIMIT DESIGNATED BY TECHNICAL SPECIFICATION 3.4.A(3). THE USUAL DEMINERALIZED WATER SOURCE WAS OPERATING AT REDUCED CAPACITY AT THE TIME. SIMILAR EVENTS OCCURRED ON SEPTEMBER 2, 1978, SEPTEMBER 7, 1978, MARCH 27, 1979, AUGUST 23, 1979 AND SEPTEMBER 2, 1979. THE INCIDENT WAS CAUSED BY NORMAL USE OF THE STEAM GENERATOR BLOWDOWN SYSTEM, COMBINED WITH LIMITED MAKEUP WATER FROM THE EXTERNAL WATER FACTORY. THEREFORE, THE PLANT CONTINUED ITS DESCENT TO SHUTDOWN BELOW 350 DEG. F.
JOSEPH M. FARLEY-1 AREA MONITORING SYSTEMS INSTRUMENTATION + CONTROLS OTHER NOT APPLICABLE VICTOREEN INSTRUMENT DIV.	05000348 79-028/03L-0 026716	062779 072679 30-DAY	AT 1335 FUEL STORAGE POOL AREA RADIATION MONITOR R-5 DECLARED INOPERABLE DUE TO A LOSS OF POWER TO R-5. T.S. SECTION 3.3.3.1 TABLE 3.3-6 REQUIRES R-5 OPERABLE WHEN FUEL IS IN THE STORAGE POOL. T.S. 3.3.3.1 ACTION STATEMENT REQUIREMENTS MET. R-5 RETURNED TO OPERATION AT 1425. THE FEED BREAKER TO R-5 WAS FOUND OPEN. AN INVESTIGATION FAILED TO DETERMINE THE CAUSE FOR THE BREAKER BEING OPEN. THE BREAKER WAS CLOSED AND R-5 DECLARED OPERABLE AT 1425 ON 6/27/79.
JOSEPH M. FARLEY-1 SYSTEM CODE NOT APPLICABLE HANGERS, SUPPORTS, SHOCK SUPPRESSORS SNUBBERS COMPONENT FAILURE OTHER ITT GRINNELL	05000348 79-026/03L-0 026715	071679 072679 30-DAY	135 SNUBBERS WERE FOUND NOT TO MEET SURVEILLANCE TEST REQUIREMENTS. T.S. 3.7.9.1 REQUIRES ALL HYDRAULIC SNUBBERS LISTED IN TABLE 3.7-4 TO BE OPERABLE IN MODES 1 THROUGH 4. THE PLANT HAS BEEN IN MODE 5 OR 6 SINCE PRIOR TO INITIATION OF SNUBBER FUNCTIONAL TESTING. T.S. ACTION STATEMENT REQUIREMENTS MET. ATTRIBUTED TO LOSS OF OIL DUE TO SEAL LEAKAGE AND FAILURE TO MEET LOCKUP AND BLEED ACCEPTANCE CRITERIA DURING FUNCTIONAL TEST. AS OF 7/16/79 ALL 135 SNUBBERS HAD BEEN REPAIRED AND RETESTED SATISFACTORILY, I.E., THE SNUBBERS PASSED THE FUNCTIONAL TEST.
JOSEPH M. FARLEY-1 EMERG GENERATOR SYS + CONTROLS CIRCUIT CLOSERS/INTERRUPTERS CIRCUIT BREAKER PERSONNEL ERROR NONLIC. OPERATIONS PERSONNEL ITEM NOT APPLICABLE	05000348 79-032/03L-0 026719	073079 082879 30-DAY	DIESEL GENERATORS 1C AND 2C (EMERGENCY POWER SOURCE FOR RIVER WATER PUMP S, 2850 KW D.G.) OUTPUT BREAKERS WERE RACKED OUT. AT LEAST ONE 4075 KW D.G. FOR BACKUP EMERGENCY POWER FOR REMAINING ESF EQUIPMENT WAS AVAILABLE. T.S. 3.8.1.2 REQUIRES ONE 4075 KW D.G. AND ONE 2850 KW D.G. OPERABLE. T.S. 3.8.1.2 ACTION STATEMENT REQUIREMENTS MET. RIVER WATER PUMPS NOT REQUIRED IN MODES 5 OR 6 AND STORAGE POND WAS AVAILABLE FOR BACKUP SUPPLY FOR SERVICE WATER. PERSONNEL ERROR. BREAKERS HAD BEEN RACKED OUT AND NOT PROPERLY RESTORED TO OPERATION DURING PERFORMANCE OF SURVEILLANCE TESTS FNP-1-STP-40.1 AND FNP-1-STP-40.2 (DIESEL GENERATOR SEQUENCER LOAD SHEDDING TESTS). IMMEDIATELY UPON DISCOVERY, BREAKERS WERE RACKED IN AND CONTROL POWER RESTORED.

1543 076

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
KEWAUNEE-1 OTHR INST SYS REQD FOR SAFETY COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR LICENSED & SENIOR OPERATORS ITEM NOT APPLICABLE	05000305 79-022/03L-0 026744	080879 090779 30-DAY	DURING POWER ASSUMPTION PHASE OF PLANT STARTUP, SP125 DATA, SHIFT INSTRUMENT CHANNEL CHECKS, WERE NOT RECORDED AS REQUIRED BY TS 4.1.A DURING 1 SHIFT. SP125 DATA TAKEN BEFORE & AFTER THIS EVENT INDICATE NORMAL INSTRUMENT CHANNEL OPERATIONS, THEREFORE, THIS EVENT HAD NO SAFETY SIGNIFICANCE. NO EFFECT ON PLANT OPERATION OR PUBLIC SAFETY. SP 125 IS PERFORMED EACH SHIFT WHILE OPERATING TO ASSURE ACCEPTABLE OPERABILITY OF EACH INSTRUMENT CHANNEL BY COMPARISON OF CHANNEL WITH OTHER INDEP. INST. CHANNELS. BECAUSE OF INVOLVEMENT IN PLANT STARTUP ACTIVITIES OPER OVERLOOKED REQ. TO PERFORM SP125. AS MUCH DATA AS POSSIBLE WAS OBTAINED FROM COMPUTER LOGS. INVOLVED OPER WERE INSTRUCTED ON IMPORTANCE OF ASSURING THAT ALL SP REQUIREMENTS ARE SATISFIED. DURING ROUTINE SHIFT TURNOVER, OPER REVIEW PLANT INDICATIONS & INFORMALLY VERIFY INDICATIONS AGREE WITH PLANT STATUS WHILE AT FULL POWER OPERATION A SAFETY VALVE DISCHARGE LINE HIGH TEMP ALARM WAS ACTUATED. CALCULATED RCS LEAKRATE WAS GREATER THAN THE TS 3.1.D .1 LIMIT. PLANT WAS TAKEN TO HOT SHUTDOWN CONDITION FOR INVESTIGATION OF LEAKAGE. SOURCE OF THE LEAKAGE WAS IDENTIFIED AND CORRECTED. THE SAFETY VALVE WAS NOT LEAKING. THE PLANT WAS RETURNED TO OPERATION WITHIN 8 HOURS. NO EFFECT ON PUBLIC HEALTH OR SAFETY. THIS REPORT SUBMITTED UNDER TS 6.9.2.6.2 REQUIREMENT FOR REPORTING OPERATION WITHIN AN LCO. 2 VALVES IN SAFETY VALVE LOOP SEAL DRAIN LINE & 2 RCS DRAIN VALVES (WHICH WERE NOT OPERATED DURING REFUELING SHUTDOWN) FOUND LEAKING. AFTER TIGHTENING THESE VALVES SHUT; CALCULATED LEAKRATE WAS BELOW THE T.S. LIMIT. THERMAL CYCLING DURING PLANT STARTUPS AND SHUTDOWNS IS BELIEVED TO BE THE CAUSE OF THIS VALVE LEAKAGE.
KEWAUNEE-1 COOLANT RECIRC SYS + CONTROLS VALVES GLOBE OTHER NOT APPLICABLE EDWARDS CO	05000305 79-023/03L-0 026817	081979 091879 30-DAY	DURING REACTOR OPERATION, A ROUTINE SURVEILLANCE TEST REVEALED 1A DIESEL ENGINE DRIVEN PUMP FAILED TO START UPON MANUAL ACTUATION OF CONTROL ROOM CONTROL SWITCH.
LA CROSSE BWR EMERG CORE COOLING SYS + CONT ENGINES, INTERNAL COMBUSTION SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000409 79-012/03L-0 026884	070279 072779 30-DAY	ELECTRICAL SHORT IN STARTING FUEL SOLENOID VALVE CIRCUIT CAUSED TWO ELECTRICAL DIODES TO BURNOUT AND FUEL VALVE TO REMAIN CLOSED DURING START CYCLE OF DIESEL ENGINE. REPLACED DIODES AND REINSULATED SHORTED WIRE. SATISFACTORY ENGINE OPERATION WAS ACHIEVED.
LA CROSSE BWR TURBINE BYPASS SYS + CONT VALVE OPERATORS HYDRAULIC COMPONENT FAILURE MECHANICAL VICKERS, INC	05000409 79-013/03L-0 026883	070479 072579 30-DAY	DURING REACTOR POWER ESCALATION, A FAILURE OF A PISTON ROD SEAL OCCURRED ON THE TURBINE MAIN STEAM BYPASS VALVE OPERATING CYLINDER RESULTING IN A LOSS OF HYDRAULIC OIL AND THE VALVE POTENTIALLY NOT BEING ABLE TO PERFORM ITS INTENDED FUNCTION IN ACCORDANCE WITH T.S. 4.2.5.7. NOTIFICATION IS MADE IN ACCORDANCE WITH T.S. 3.9.2.B.(2).
			REACTOR PLANT SHUTDOWN WAS PROMPTLY INITIATED. FOLLOWING SHUTDOWN, REPAIRS WERE EFFECTED INCLUDING REPLACEMENT OF THE FAULTY SEAL AND OTHER SEALS AND O-RINGS PRESENT & REPLENISHMENT OF HYDRAULIC OIL. SEAL FAILURE IS ATTRIBUTED TO NORMAL WEAR. A REPLACEMENT SEAL OF A DIFFERENT MATERIAL IS BEING INVESTIGATED TO PROBLING SERVICE LIFE.

1543 077

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
LA CROSSE BWR REACTIVITY CONTROL SYSTEMS CONTROL RODS SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR LICENSED & SENIOR OPERATORS NUCLEAR COMPONENTS, INC.	05000409 79-014/03L-0 026882	070879 072779 30-DAY	DURING POWER ESCALATION ON JULY 8, 1979, CONTROL ROD 10 WAS INADVERTANTLY PARTIALLY WITHDRAWN INSTEAD OF CONTROL ROD 12 WHICH PLACED THE CONTROL RODS IN AN OUT SEQUENCE CONDITION WITH REGARD TO THE REQUIREMENTS FOR MINIMUM CRITICAL POWER RATIO (MCPR) AS ADDRESSED IN T.S. 4.2.4.2.3.
MAINE YANKEE REACTOR TRIP SYSTEMS INSTRUMENTATION + CONTROLS POWER SUPPLY COMPONENT FAILURE ELECTRICAL LAMBDA ELECTRONICS	05000309 79-004/03L-0 026840	022379 031379 30-DAY	ACTION REQUIREMENTS T.S. 4.2.4.23 WERE COMPLETED SUCH THAT THE CONTROL RODS WERE RETURNED TO THE REQUIRED PATTERN WITHIN 30 MINUTES. SUBSEQUENTLY, THERMAL-HYDRAULIC CALCULATIONS SHOWED THAT THE LIMITING MCPR WAS NOT VIOLATED. IMPORTANCE OF COMPLIANCE WITH THE CONTROL ROD PROGRAM WILL BE EMPHASIZED TO ALL OPERATIONS PERSONNEL. DURING ROUTINE OPERATIONS, CONTROL ROOM OPERATORS NOTICED THAT THE CH. C MCB INDICATION FOR INCORE TILT AND THE POSITIVE AND NEGATIVE SOTC TRIP LIMITS WERE READING MORE NEGATIVE THAN THE OTHER THREE CHANNELS. INVESTIGATION BY THE I & C DEPT. DETERMINED THE CAUSE TO BE A FAILED +/- 18 VDC POWER SUPPLY AND REPLACED SAME. BECAUSE ONLY ONE OUT OF FOUR CHANNELS WERE AFFECTED, THE MINIMUM DEGREE OF REDUNDANCY WAS MAINTAINED AND THERE WAS NO EFFECT ON THE PUBLIC HEALTH OR SAFETY. THE INVESTIGATION REVEALED THE POWER SUPPLY'S + 18 VDC OUTPUT HAD DECREASED TO A VALUE OF APPROX. + 12 VDC CAUSING ALL INDICATIONS TO BECOME MORE NEGATIVE. THE UNIT WAS REPLACED IN KIND AND THE FAILED UNIT RETURNED TO THE VENDOR FOR FAILURE ANALYSIS.
MAINE YANKEE LIQ RADIOACT WASTE MANAGMNT SYS INSTRUMENTATION + CONTROLS SENSOR/DETECTOR/ELEMENT COMPONENT FAILURE ELECTRICAL HARSHAW CHEMICAL CO.	05000309 79-020/03L-0 027009	091079 100979 30-DAY	A ROUTINE REVIEW OF RADIOLOGICAL LIQUID WASTE DISCHARGE PERMITS, FOR DISCHARGES MADE DURING THE PERIOD SEPT. 10, 1979 THROUGH SEPT 16, 1979 INDICATED THAT THE WASTE LIQUID RADIATION MONITOR HAD NOT RESPONDED AS EXPECTED DURING THE RELEASES. SUBSEQUENT INVESTIGATION HAS SHOWN THAT THE WASTE LIQUID RADIATION MONITOR WAS OUT OF CALIBRATION. DOWNSTREAM SERVICE WATER RADIATION MONITOR REMAINED IN SERVICE.
MAINE YANKEE RESIDUAL HEAT REMOV SYS + CONT COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR LICENSED & SENIOR OPERATORS ITEM NOT APPLICABLE	05000309 79-018/01T-0 026976	092579 100379 2-WEEK	THE INSTALLED CHECK SOURCE WAS TOO SMALL TO PROVIDE A DEFINITIVE MEASURE OF CHANNEL CALIBRATION. THE PLANT IS CURRENTLY INVESTIGATING THE AVAILABILITY OF LARGER CHECK SOURCES. IN THE INTERIM, THE OPERATORS HAVE BEEN INSTRUCTED TO BE ESPECIALLY CONGNIZANT OF EXPECTED CHANNEL RESPONSE DURING RADIOLOGICAL RELEASES. DURING ROUTINE PREPARATION FOR PLANT HEATUP FOLLOWING A SCHEDULED MAINTENANCE OUTAGE, THE RHR SYSTEM WAS SECURED WITHOUT A STEAM GENERATOR BEING OPERABLE AS DEFINED BY TECH. SPEC. #3.8. STEAM GENERATOR WATER LEVEL WAS AT 300" INSTEAD OF 346" WHICH IS THE TOP OF THE TUBE BUNDLE. BECAUSE A HEAT SINK FOR CORE DECAY HEAT REMOVAL WAS AVAILABLE BUT NOT EXACTLY AS SPECIFIED BY THE TECH. SPECS., THERE WAS NO EFFECT ON THE PUBLIC HEALTH OR SAFETY. THE OPERATOR FAILED TO REALIZE THAT THE 300" LEVEL IN ALL 3 S/G'S WAS NOT ABOVE THE TOP OF THE BUNDLES AS SPECIFIED IN THE TECH. SPECS. UPON RECOGNIZING THE ERROR, LEVEL WAS RAISED IN ALL S/G'S TO THE NORMAL OPERATING LEVEL. THE INCIDENT HAS BEEN DISCUSSED WITH THE OPERATORS INVOLVED.

1543 078

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
MAINE YANKEE SYSTEM CODE NOT APPLICABLE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR OTHER ITEM NOT APPLICABLE	05000309 79-019/03L-0 026977	092579 100379 30-DAY	DURING A REVIEW OF OUTSTANDING PROCEDURE CHANGE REPORTS (PCR), IT WAS DE TERMINED THAT ONE PCR HAD NOT BEEN REVIEWED BY THE PORC WITHIN 14 DAYS O F BEING GENERATED AS REQUIRED BY T.S. #5.8.3.C. A MEETING OF THE PORC W AS HELD AND THE PCR WAS REVIEWED AND APPROVED. BECAUSE THE PCR REVIEW W AS ONLY SIX DAYS LATE FOR REVIEW AND WAS ULTIMATELY APPROVED, THERE WAS NO EFFECT ON THE PUBLIC HEALTH OR SAFETY.
MILLSTONE-1 CNTNMNT AIR PURI + CLEANUP SYS INSTRUMENTATION + CONTROLS POWER SUPPLY COMPONENT FAILURE ELECTRONIC GENERAL ELECTRIC CO.	05000245 79-024/03L-0 026726	073179 083079 30-DAY	FAILURE TO REVIEW THE PCR WITHIN 14 DAYS BY THE PORC WAS DUE TO THE PCR BEING MISPLACED IN ITS ROUTING FOR REVIEW AND APPROVAL. A MEMO TO ALL PL ANT PERSONNEL DESCRIBING THE PCR PROCEDURE AND REVIEW PROCESS HAS BEEN P REPARED TO REMIND ALL INDIVIDUALS ABOUT THE CORRECT METHOD OF UTILIZING PCR'S. ON JULY 31, 1979, AT 1300 HOURS, WHILE PERFORMING ROUTINE SURVEILLANCE, IT WAS DISCOVERED THAT CHANNEL 1 OF THE REFUEL FLOOR HIGH RADIATION MONI TOR WAS TRIPPING OUTSIDE THE TECH. SPEC. ALLOWABLE BAND. THE OTHER CHAN NEL WAS WITHIN SPECIFICATION AND WOULD HAVE PROVIDED THE ISOLATION INITI ATION SIGNAL BY ITSELF.
MILLSTONE-1 FIRE PROTECTION SYS + CONT INSTRUMENTATION + CONTROLS SENSOR/DETECTOR/ELEMENT PERSONNEL ERROR MAINTENANCE & REPAIR PERSONNEL ITEM NOT APPLICABLE	05000245 79-027/03L-0 026859	082779 092479 30-DAY	ON AUGUST 27, 1979, AT 0900 HOURS, IT WAS DISCOVERED THAT THE SEMIANNUAL FUNCTIONAL TEST OF THE CABLE VAULT SMOKE DETECTION SYSTEM HAD BEEN INAD VERTENTLY OVERLOOKED. NO CONSEQUENCES.
MILLSTONE-1 CNTNMNT ISOLATION SYS + CONT VALVES PLUG OTHER NOT APPLICABLE DEZURIK	05000245 79-028/03L-0 026933	082879 092579 30-DAY	ON AUGUST 28, 1979, AT 1045 HOURS, AFTER VENTING THE PRESSURE SUPPRESSIO N CHAMBER, THE VENT BYPASS VALVE (1-AC-12) FAILED TO CLOSE. THE REQUIRE D SURVEILLANCE FOR AN INOPERABLE CONTAINMENT ISOLATION VALVE WAS PERFORM ED. NO CONSEQUENCES, THE DOWNSTREAM VALVE WAS CLOSED.
DISASSEMBLY OF THE MAIN VALVE REVEALED RUST SCALE CONTAMINATION IN THE A REA OF THE PIVOT MECHANISM, APPARENTLY SUFFICIENT TO PREVENT THE VALVE P LUG FROM ROTATING COMPLETELY CLOSED. THE VALVE WAS CLEANED, REASSEMBLED AND TESTED. THIS OCCURRENCE IS SIMILAR IN NATURE TO LER-79-22/3L AND 7 9-23/3L.			

1543 079

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
MILLSTONE-1 RESIDUAL HEAT REMOV SYS + CONT INSTRUMENTATION + CONTROLS SWITCH COMPONENT FAILURE ELECTRICAL MICRO SWITCH	05000245 79-029/03L-0 026952	090479 100479 30-DAY	ON SEPTEMBER 4, 1979, AT 1000 HOURS, WHILE PERFORMING SURVEILLANCE ON CONTAINMENT ISOLATION VALVES, THE ISOLATION CONDENSER INBOARD STEAM SUPPLY VALVE, 1-IC-1 FAILED TO GO CLOSED UPON RECEIPT OF THE ISOLATION SIGNAL. NO CONSEQUENCES, THE DOWNSTREAM VALVE WAS DEMONSTRATED TO BE OPERABLE.
			A FAULTY MICRO-SWITCH ON THE CLOSING TORQUE SWITCH WAS IDENTIFIED AS THE CAUSE OF OCCURRENCE. THE MICRO-SWITCHES ON THE CLOSING AND OPENING TORQUE SWITCHES WERE REPLACED, ADJUSTED AND TESTED. THIS OCCURRENCE IS SIMILAR TO LER 76-42/3L.
MILLSTONE-1 REACTOR CORE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR OTHER ITEM NOT APPLICABLE	05000245 79-025/01T-0 026935	091379 092579 2-WEEK	ON SEPTEMBER 13, 1979, AT 1600 HOURS, IT BECAME APPARENT THAT THE TOTAL PEAKING FACTOR LIMIT FOR THE CURRENT RELOAD FUEL (8X8R) WAS MORE CONSERVATIVE THAN THE TECHNICAL SPECIFICATION LIMIT FOR THE STANDARD 8X8 FUEL TYPE. NO PROBABLE CONSEQUENCES. REVIEW OF TPF SURVEILLANCES ILLUSTRATED ADEQUATE MARGIN BETWEEN OPERATING VALUE AND THIS LIMIT.
			THE INADVERTENT OMISSION OF THIS NEW TOTAL PEAKING FACTOR LIMIT WAS AN APPARENT OVERSIGHT. THE OPERATING PROCEDURE WAS MODIFIED TO INCLUDE THE NEW LIMIT FOR 8X8R TYPE FUEL AND A TECHNICAL SPECIFICATION CHANGE WAS INITIATED TO INCLUDE THIS VALUE.
MILLSTONE-1 EMERG CORE COOLING SYS + CONT COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE DESIGN/FABRICATION ERROR DESIGN ITEM NOT APPLICABLE	05000245 79-026/01T-0 026934	091479 092779 2-WEEK	ON SEPTEMBER 14, 1979, AT 1430 HOURS, IT WAS DISCOVERED THAT UNDER A CERTAIN ELECTRICAL DISTRIBUTION ARRANGEMENT, A LOSS OF POWER COULD OCCUR TO THE SUPPLY FOR THE E.C.C.S. ELECTRICAL BUSES WITHOUT THE LOSS OF NORMAL POWER (LNP) INITIATION LOGIC BEING ABLE TO SENSE THIS LOSS.
			THE CAUSE OF THIS OCCURRENCE IS ATTRIBUTABLE TO A DESIGN OVERSIGHT. THE LOGIC WAS CHANGED TO ELIMINATE THIS POSSIBILITY.
MILLSTONE-2 OTHR INST SYS NOT REQD FR SFTY INSTRUMENTATION + CONTROLS OTHER COMPONENT FAILURE OTHER ROCHESTER INSTRU. SYSTEMS INC.	05000336 79-002/04L-0 026871	011679 020879 30-DAY	SURVEILLANCE TESTING DURING REACTOR STARTUP REVEALED CEA MOTION INHIBIT (CMI) INTERLOCK DID NOT FUNCTION PROPERLY. FOLLOWING A RETURN TO SUB-CRITICAL CONDITIONS INVESTIGATIONS SHOWED FAULTY POSITION INDICATION FOR CEA 64, INDICATING ABOUT 6 STEPS HIGH, EXCEEDING THE LIMITS OF TECHNICAL SPECIFICATIONS SECTION 3.1.3.3. WITH THE POSITION INDICATION FOR CEA 63 CORRECTED AND THE CMI FUNCTIONING PROPERLY, THE REACTOR STARTUP WAS RESUMED.
			THE CEA 63 POSITION INDICATION UNIT HAD DRIFTED GIVING INCORRECT POSITION INDICATION. THE UNIT, AN RIS, MODEL SC1370, RESISTANCE-TO-VOLTAGE CONVERTER WAS RECALIBRATED AND CORRECT INDICATION RESTORED.

1543 080

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
MILLSTONE-2 LIQ RADIOACT WSTE MANAGMNT SYS HEAT EXCHANGERS EVAPORATOR COMPONENT FAILURE MECHANICAL RILEY-BEARD, INC.	05000336 79-006/04T-0 026815	032379 032979 2-WEEK	FIRST QUARTER 1979 WASTE DISCHARGES WERE 1.31 CI AS OF 3/23/79. ENVIRON- MENTAL TECHNICAL SPECIFICATION (ETS) 2.4.1.2.B REQUIRES OPERATION OF LIQ UID RADWASTE PROCESSING EQUIPMENT IF PROJECTED QUARTERLY RELEASES COULD EXCEED 1.25 CI/REACTOR/CALANDAR QUARTER. DUE TO CORROSION, THE AERATED RADWASTE EVAPORATOR IS INOPERABLE, AND THE AERATED CONCENTRATES TANK IS UNAVAILABLE AS REPORTED IN LER 77-5673L, SUBMITTED 12/15/77, AND LER 77- 5673X, SUBMITTED 5/31/78. LIQUID WASTE PROCESSING HAS BEEN PERFORMED BY FILTRATION, DEMINERALIZATI ON & A FINAL FILTRATION WITH AERATED RADWASTE EVAPORATOR OUT OF SERVICE. GREATER THAN NORMAL RELEASE REQ DUE TO PROCESSING REACTOR COOLANT RELAT ED TO REFUELING OUTAGE RESULTED IN RELEASES GREATER THAN 1.25 CI. PROJEC TED ORTLY RELEASE OF 1.65 CI IS WELL BELOW ETS 2.4.1.2.E LIMIT OF 10 CI. DURING ROUTINE PLANT OPERATION, CEA 64 POSITION INDICATION WAS DECLARED INOPERABLE DUE TO ERRATIC INDICATION. CEA 64 WAS VERIFIED TO BE FULLY W ITHDRAWN BY ITS TOP LIMIT INDICATION AND OPERATION CONTINUED IN ACCORDAN CE WITH TECHNICAL SPECIFICATIONS, SECTION 3.1.3.3, ACTION STATEMENT C.
MILLSTONE-2 OTHR INST SYS NOT RECD FR SFTY INSTRUMENTATION + CONTROLS INDICATOR OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000336 79-022/03L-0 026842	072779 082479 30-DAY	THE CAUSE OF THE ERRATIC INDICATION WAS A LOOSE SIGNAL CABLE CONNECTOR (BENDIX MODEL 02MA-20-27R) AT THE CEA. AT THE NEXT PLANT SHUTDOWN, THE S IGNAL CABLE CONNECTOR WAS TIGHTENED AND THE POSITION INDICATION WAS REST ORED TO NORMAL OPERATION. TOTAL TIME INOPERABLE WAS 13 DAYS.
MILLSTONE-2 DC ONSITE POWER SYS + CONTROLS BATTERIES + CHARGERS SUBCOMPONENT NOT APPLICABLE DESIGN/FABRICATION ERROR DESIGN C&D BATTERIES, DIV OF ELTRA CO	05000336 79-023/03L-0 026979	080379 083079 30-DAY	DURING STEADY-STATE POWER OPERATION, THE SEISMIC BRACING FOR CELLS 18 AN D 31 IN THE 201B BATTERY WAS REMOVED TO ALLOW FOR REPLACEMENT OF THESE C ELLS. THIS RESULTED IN THE BATTERY BEING DECLARED INOPERABLE IN ACCORDA NCE WITH SECTION 3.8.2.3.B OF THE TECHNICAL SPECIFICATIONS. THE CELLS W ERE REPLACED, THE SEISMIC BRACING REINSTALLED AND THE BATTERY DECLARED O PERABLE WITHIN APPROXIMATELY 3 HOURS. THE CELLS HAD TO BE REPLACED AS A RESULT OF A REDUCTION IN INDIVIDUAL CE LL VOLTAGES ALTHOUGH THE CELLS WERE STILL OPERABLE. THIS CONDITION WAS THE SUBJECT OF AN INFORMATIONAL LETTER TO THE OFFICE OF INSPECTION AND E NFORCEMENT ON 8/20/79. BOTH THE 201A & 201B BATTERIES WILL BE REPLACED AS SOON AS NEW CELLS ARE AVAILABLE. DURING ROUTINE POWER OPERATION, A HYDRAULIC SNUBBER LOCATED ON THE B MAI N STEAM ATMOSPHERIC DUMP VALVE WAS FOUND TO BE INOPERABLE. THE FLUID RE SERVOIR HAD BEEN BROKEN OFF THE SNUBBER. THE FAULTY SNUBBER WAS REMOVED AND A REPLACEMENT UNIT INSTALLED. FACILITY OPERATION WAS IN ACCORDANCE WITH TECHNICAL SPECIFICATION 3.7.8.1. SNUBBER-HANGER 405388, ITT GRINN ELL, FIG. 201, 2 1/2 INCH BORE X 5 INCH STROKE. THE SNUBBER RESERVOIR WAS INADVERTENTLY BROKEN OFF BY CONTRACT INSULATOR S DURING REINSULATION OF A STEAM LINE IN THE VICINITY. SNUBBER REPLACED . THE PERIODIC SNUBBER VISUAL INSPECTION FREQUENCY WILL BE INCREASED TO A 12 MONTH FREQUENCY PER TECHNICAL SPECIFICATION TABLE 4.7-3.
MILLSTONE-2 MAIN STEAM SUPPLY SYS + CONT HANGERS, SUPPORTS, SHOCK SUPPRSS SNUBBERS PERSONNEL ERROR CONTRACT & CONSULT. PERSONNEL ITT GRINNELL	05000336 79-028/03L-0 026974	090479 100179 30-DAY	

1543 081

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
MILLSTONE-2 EMERG CORE COOLING SYS + CONT INSTRUMENTATION + CONTROLS TRANSMITTER COMPONENT FAILURE INSTRUMENT GENERAL ELECTRIC CO.	05000336 79-026/03L-0 026973	090679 092179 30-DAY	DURING STEADY STATE POWER OPERATION, A FLUCTUATION IN INDICATED LEVEL IN NUMBER 3 SAFETY INJECTION TANK WAS NOTED WITH NO CONCURRENT PLANT EVOLUTION OR CHANGE IN TANK PRESSURE. THIS RESULTED IN AN INDICATED LEVEL READING OF 58.4%, WHICH EXCEEDS THE LIMIT OF 5% AS STATED IN SECTION 3.5.1. B OF THE TECHNICAL SPECIFICATIONS. LEVEL IN SAFETY INJECTION TANK WAS DECREASED AND THE LEVEL TRANSMITTER SUBSEQUENTLY REPLACED. SIMILAR EVENT LER 77-48 SUBMITTED ON 11/2/77. CAUSE OF ERRATIC TRANSMITTER OPERATION WAS NOT DETERMINED. FOLLOWING INITIAL HIGH LEVEL INDICATION, LEVEL IN NUMBER 3 SAFETY INJECTION TANK WAS LOWERED AND A CONTAINMENT ENTRY MADE TO CHECK THE TRANSMITTER CALIBRATION. AS A RESULT OF THIS CHECK THE TANK LEVEL HAD TO BE LOWERED FURTHER. TRANSMITTER WAS THEN REPLACED THE FOLLOWING DAY. DURING A ROUTINE OPERATOR INSPECTION, A STEAM LEAK WAS OBSERVED ON THE 1 5A FEEDWATER EXTRACTION STEAM LINE DRAIN. THE LEAK APPEARED TO BE DUE TO STEAM EROSION THROUGH THE WALL OF THE STEAM TRAP ON THIS LINE. THIS CONSTITUTES AN ABNORMAL DEGRADATION OF A SYSTEM DESIGNED TO CONTAIN RADIOACTIVE MATERIAL AS REQUIRED BY TECHNICAL SPECIFICATION 6.7.B.2.D. THERE WERE NO PREVIOUS SIMILAR OCCURRENCES.
MONTICELLO-1 FEEDWATER SYSTEMS + CONTROLS OTHER COMPONENTS SUBCOMPONENT NOT APPLICABLE COMPONENT FAILURE OTHER YARWAY CORP.	05000263 79-017/03L-0 026710	080679 083179 30-DAY	THROUGH WALL EROSION DUE TO INSUFFICIENT AMOUNT OF MAINTENANCE FOR TRAP REPAIRS. EROSION MAY BE CONSIDERED NORMAL END OF LIFE FOR COMPONENT UNDER THESE CONDITIONS. STEAM TRAP WAS YARWAY 3/4" 600# CARBON STEEL BODY BUCKET TYPE TRAP. TRAP WAS ISOLATED PENDING REPAIR OR REPLACEMENT AT NEXT APPROPRIATE OUTAGE. STEAM TRAP MAINTENANCE PROGRAM WILL BE EXPANDED. DURING REFUELING OUTAGE, IT WAS NOTED THAT THE SITE OPERATIONS REVIEW COMMITTEE FAILED TO REVIEW TEMPORARY CHANGES TO 3 INSTRUMENT SURVEILLANCE PROCEDURES WITHIN THE 7 DAYS AS REQUIRED BY T.S. SINCE NO VIOLATIONS OF APPROVED OPERATING PROCEDURES WERE INVOLVED AND KNOWLEDGABLE PERSONNEL WERE CONSULTED IN EACH CASE, THERE WERE MINIMAL SAFETY IMPLICATIONS.
NINE MILE POINT-1 SYSTEM CODE NOT APPLICABLE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR NONLIC. OPERATIONS PERSONNEL ITEM NOT APPLICABLE	05000220 79-013/03X-1 026043	052579 092779 OTHER	SUBSEQUENT APPROVALS OF THE PROCEDURES HAVE BEEN MADE. REGULAR PROCEDURE CHANGES HAVE BEEN REVIEWED BY THE SITE OPERATIONS REVIEW COMMITTEE AND APPROVED BY THE GENERAL SUPERINTENDENT NUCLEAR GENERATION.
NINE MILE POINT-1 SYSTEM CODE NOT APPLICABLE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR LICENSED & SENIOR OPERATORS ITEM NOT APPLICABLE	05000220 79-019/03L-0 026768	081679 091079 30-DAY	A ROUTINE MANAGEMENT REVIEW DISCLOSED THAT 5 MONTHLY SURVEILLANCE TESTS HAD NOT BEEN COMPLETED ON SCHEDULE. THERE WERE MINIMAL SAFETY IMPLICATIONS SINCE ALL TESTS WERE SUCCESSFULLY COMPLETED AND THEREFORE, THE SYSTEMS INVOLVED WOULD HAVE OPERATED PROPERLY IF REQUIRED.
			MANAGEMENT REVIEW REVEALED A FAILURE TO PERFORM FIVE SURVEILLANCE TESTS ON SCHEDULE. THESE TESTS WERE IMMEDIATELY PERFORMED AND COMPLETED. APPROPRIATE PERSONNEL HAVE BEEN REINSTRUCTED TO FOLLOW THE PUBLISHED SURVEILLANCE TEST SCHEDULE.

1543 082

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
NINE MILE POINT-1 CONTNMT HEAT REMOV SYS + CONT HEAT EXCHANGERS COOLER COMPONENT FAILURE OTHER BUFFALO FORGE	05000220 79-020/03L-0 026767	090179 091079 30-DAY	DURING STEADY STATE OPERATION, #14 DRYWELL COOLER TRIPPED & DRYWELL LEAKAGE INCREASED TO ABOVE 5 GPM. SINCE DRYWELL COOLERS ARE SUPPLIED BY REACTOR BLDG CLOSED LOOP COOLING, IT WAS APPARENT THAT THE UNIDENTIFIED LEAKAGE WAS PROBABLY NOT REACTOR COOLANT, HOWEVER, UNIT SHUTDOWN WAS COMMENCED PER TECH. SPEC. PARAGRAPH 3.2.5. THE COOLER WAS THEN ISOLATED AND UNIDENTIFIED LEAKAGE RETURNED TO BELOW FIVE GPM. THUS THIS EVENT RESULTED IN MINIMAL SAFETY IMPLICATIONS. IT IS ASSUMED THAT UNIDENTIFIED LEAKAGE INCREASED DUE TO A TUBE LEAK IN NO. 14 DRYWELL COOLER. THIS IS BASED ON THE FACT THAT ONCE THE COOLER WAS ISOLATED, UNIDENTIFIED LEAKAGE DROPPED TO 1.2 GPM. AFTER THIS CORRECTIVE ACTION RETURNED LEAKAGE TO AN ACCEPTABLE LEVEL, THE SHUTDOWN WAS TERMINATED.
NINE MILE POINT-1 SYSTEM CODE NOT APPLICABLE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000220 79-021/04T-0 026772	090579 090779 2-WEEK	DURING REFUELING OUTAGE, AN ONSITE SAMPLE INDICATED THAT THE CONCENTRATION OF THREE (3) NUCLIDES WAS GREATER THAN TEN TIMES THE CONTROL VALUE AND ALSO THERE WAS A FAILURE TO COMPLETE THE CONFIRMATORY ANALYSIS WITHIN THIRTY DAYS. THIS RESULTED IN MINIMAL SAFETY IMPLICATIONS. INITIAL DATA WAS REPORTED LATE BY CONTRACTOR AND SUBSEQUENT RECOUNT WAS LATE DUE TO HIGH INFLUX OF SAMPLES. CONTRACTOR HAS INCREASED ITS STAFF AND IS ADDING ADDITIONAL PERSONNEL TO TAKE CARE OF SAMPLE BACKLOG.
NINE MILE POINT-1 REACTOR CONTAINMENT SYSTEMS OTHER COMPONENTS SUBCOMPONENT NOT APPLICABLE DESIGN/FABRICATION ERROR CONSTRUCTION/INSTALLATION ITEM NOT APPLICABLE	05000220 79-022/01T-0 026997	091879 100179 2-WEEK	FOUND ONE SEISMIC CONSTRAINT ON CONTAINMENT SPRAY SYSTEM OUTSIDE THE PRIMARY CONTAINMENT WAS NOT INSTALLED AS REQUIRED BY CONSTRUCTION DRAWINGS. NOT INSTALLED AT CONSTRUCTION. INITIATED DESIGN AND ORDER TO INSTALL CONSTRAINT. DECLARED APPLICABLE CONTAINMENT SPRAY LOOP INOPERABLE. PERFORMING REDUNDANT LOOP OPERABILITY TEST AS REQUIRED BY TECHNICAL SPECIFICATIONS.
NORTH ANNA-1 OTHER ENGRD SAFETY FEATR SYS HEAT EXCHANGERS COOLER COMPONENT FAILURE MECHANICAL DUNHAM BUSH	05000338 79-061/03X-1 025861	043079 100879 OTHER	DURING STARTUP OPERATIONS, AT 2% POWER, TEMPERATURE INDICATOR TI-RS-100A ON CASING COOLING TANK (1-RS-TK-1) WAS READING OUT OF SPECIFICATIONS AT GREATER THAN 50 DEG. F. THIS IS REPORTABLE PURSUANT TO T.S. 6.9.1.9.B. THIS EVENT DID NOT AFFECT THE HEALTH AND SAFETY OF THE GENERAL PUBLIC. THE TEMPERATURE ROSE ABOVE ITS LIMIT DUE TO A SLIPPING BELT ON THE MECHANICAL REFRIGERATION UNIT. THE BELT DRIVE WAS TIGHTENED, MAKING THE SYSTEM OPERABLE.

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
OCONEE-1 EMERG CORE COOLING SYS + CONT HEAT EXCHANGERS COOLER PERSONNEL ERROR OTHER BABCOCK & WILCOX COMPANY	05000269 79-021/01X-1 026472	070479 092479 OTHER	ON JUL 4, 1979, A SLIGHT LEAK IN LPI COOLER A ALLOWED APPROXIMATELY 456 MICROCURIES OF CORROSION & FISSION PRODUCTS TO BE RELEASED TO LAKE KEOWE E. SINCE THE RELEASE WAS VERY SMALL & SINCE THE OTHER LPI COOLER WAS AVAILABLE TO REMOVE DECAY HEAT IF REQUIRED, THE LEAKAGE IS CONSIDERED TO BE OF NO SIGNIFICANCE WITH RESPECT TO SAFE OPERATION & THE HEALTH & SAFETY OF THE PUBLIC WERE NOT AFFECTED.
OCONEE-1 EMERG GENERATOR SYS + CONTROLS CIRCUIT CLOSERS/INTERRUPTERS CIRCUIT BREAKER DEFECTIVE PROCEDURES NOT APPLICABLE WESTINGHOUSE ELECTRIC CORP.	05000269 79-026/03L-0 026712	080279 083179 30-DAY	THE LPI COOLER LEAK IS THE RESULT OF OVERPRESSURIZATION OF THE COOLER DUE TO LEAKAGE PAST THE COOLER INLET VALVES & AN IMPORTANT RELIEF VALVE SETPOINT. FIVE TUBES WHICH SHOWED THROUGH-WALL DEGRADATION GREATER THAN 40% WERE PLUGGED. ADMINISTRATIVE ACTIONS WILL BE TAKEN TO PRECLUDE OVERPRESSURIZATION IN THE FUTURE. WHILE UNITS 1 & 3 WERE AT COLD SHUTDOWN & UNIT 2 WAS AT 100% FULL POWER, POWER CIRCUIT BREAKER (PCB) 9 WAS OPENED, MAKING KEOWEE HYDRO UNIT 1 UNAVAILABLE TO PROVIDE EMERGENCY POWER BY WAY OF THE OVERHEAD FEEDER. THE BREAKER WAS OPENED ONLY MOMENTARILY. IN ADDITION, THE UNDERGROUND FEEDER WAS AVAILABLE TO SUPPLY EMERGENCY POWER IF REQUIRED. THEREFORE, THIS INCIDENT IS CONSIDERED NOT TO BE SIGNIFICANT WITH RESPECT TO SAFE OPERATION, AND THE HEALTH & SAFETY OF THE PUBLIC WERE NOT AFFECTED. PCB 9 WAS OPENED BY CIRCUIT PROTECTIVE EQUIPMENT AS A RESULT OF A DECREASE IN AIR PRESSURE DUE TO CYCLING AIR CIRCUIT BREAKER (ACB) 4 SEVERAL TIMES RAPIDLY. PCB 9 WAS RECLOSED ALMOST IMMEDIATELY. OPERATOR TRAINING AND PROCEDURES WILL BE REVISED TO INCLUDE CAUTIONS AGAINST REPEATEDLY CYCLING THE ACB'S TOO QUICKLY.
OCONEE-1 AC ONSITE POWER SYS + CONTROLS CIRCUIT CLOSERS/INTERRUPTERS CIRCUIT BREAKER OTHER NOT APPLICABLE WESTINGHOUSE ELECTRIC CORP.	05000269 79-027/03L-0 026786	080579 090479 30-DAY	AT 0455 ON AUGUST 5, 1979, UNIT 1 WAS AT HOT SHUTDOWN WHEN ONE OF THE TWO 4160 VOLT MAIN FEEDER BUSES FROM THE STARTUP TRANSFORMER WAS ISOLATED AS A RESULT OF A BREAKER TRIPPING FOR NO APPARENT REASON. ONE FEEDER BUS IS PERMITTED TO BE INOPERABLE FOR UP TO 24 HOURS, AND THE SECOND BUS REMAINED ENERGIZED. THEREFORE, THIS INCIDENT IS CONSIDERED TO BE OF NO SIGNIFICANCE WITH RESPECT TO SAFE OPERATION, AND THE HEALTH AND SAFETY OF THE PUBLIC WERE NOT AFFECTED. ALTHOUGH THE EXACT CAUSE OF THE OCCURRENCE COULD NOT BE DETERMINED, AT THE TIME THE BREAKER TRIPPED PROBLEMS WERE BEING EXPERIENCED WITH A DC POWER BUS GROUND WHICH MAY HAVE AFFECTED THE BREAKER'S DC OPERATED TRIP COIL. THE BREAKER WAS TESTED, DETERMINED TO BE OPERATING PROPERLY, AND RESET.
OYSTER CREEK-1 SYSTEM CODE NOT APPLICABLE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE EXTERNAL CAUSE NOT APPLICABLE ITEM NOT APPLICABLE	05000219 79-005/04T-0 026869	080379 091079 2-WEEK	FIFTY TO ONE HUNDRED DEAD FISH WERE OBSERVED IN BARNEGOT BAY, SOUTH OF THE MOUTH OF OYSTER CREEK, FLOATING ALONG THE SHORE. THIS REPORT CONFORMS WITH CONDITION 4.5 OF THE ENVIRONMENTAL TECHNICAL SPECIFICATIONS. LOSS OF THESE FISH SHOULD NOT ADVERSELY AFFECT THE POPULATION OF THE FOUR SPECIES IDENTIFIED IN APPENDIX I. EXACT CAUSE UNCERTAIN. TWO POSSIBILITIES ARE HIGH WATER TEMPERATURE AND LOW DISSOLVED OXYGEN. LOAD REDUCTION OF THE PLANT HAD BEEN MADE DURING AUGUST 2. SIX SPECIMENS WERE SENT TO RADIATION MANAGEMENT CORPORATION FOR IDENTIFICATION, LENGTH AND WEIGHT MEASUREMENTS.

1543 084

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
OYSTER CREEK-1 EMERG CORE COOLING SYS + CONT HANGERS,SUPPORTS,SHOCK SUPPRS SUPPORTS DESIGN/FABRICATION ERROR CONSTRUCTION/INSTALLATION ITEM NOT APPLICABLE	05000219 79-027/01T-0 026708	080779 082179 2-WEEK	ON AUGUST 7, 1979, DURING AN INSPECTION OF SEISMIC RESTRAINTS ASSOCIATED WITH CORE SPRAY SYSTEM II, FOUR SEISMIC RESTRAINTS, NZ-2-R5, NZ-2-R7, NZ-2-R8, AND NZ-2-R9, WERE DISCOVERED IN POSITIONS OTHER THAN REQUIRED BY ORIGINAL DESIGN OR HAD FAILED. ON AUGUST 8, 1979 TWO MORE RESTRAINTS, NZ-2-R6, AND NZ-2-R6A, WERE FOUND TO BE IN CONDITION NOT REPRESENTATIVE OF THE ORIGINAL DESIGN CRITERIA. CORE SPRAY SYSTEM II WAS CONSIDERED IN OPERABLE FOR A TIME UNTIL ANALYSES WERE MADE AND CONDITIONS CORRECTED. FOUR OF THE RESTRAINTS WERE FOUND TO BE INSTALLED CONTRARY TO ORIGINAL DESIGN CRITERIA AND BECAUSE OF THIS TWO OTHERS WERE DAMAGED DUE TO UNRESTRAINED PIPE MOVEMENT IN OTHER SECTIONS OF THE PIPING. FOUR OF THE RESTRAINTS WERE RESTORED TO THEIR DESIGNED CONDITION. NZ-2-R7 DESIGN WAS MODIFIED. NZ-2-R6 WILL BE RESTORED TO ORIGINAL DESIGN OR RELOCATED.
OYSTER CREEK-1 EMERG CORE COOLING SYS + CONT VALVE OPERATORS ELECTRIC MOTOR - AC OTHER NOT APPLICABLE GENERAL ELECTRIC CO.	05000219 79-028/03L-0 026709	080779 090679 30-DAY	ON AUGUST 7, 1979, DURING ROUTINE SURVEILLANCE OF CORE SPRAY SYSTEM I, PARALLEL ISOLATION VALVE V-20-15 BECAME INOPERABLE IN THE OPEN POSITION. THE CIRCUIT BREAKER FOR THE MOTOR OPERATOR TRIPPED WHEN THE ACTUATION PRESSURE SENSOR WAS RESET. A PARALLEL VALVE V-20-40, WHICH IS ACTUATED BY THE SAME PRESSURE SENSOR, OPERATED NORMALLY. VALVE STROKING CURRENTS WERE READ WITH THE BREAKER RESET AND FOUND TO BE NORMAL. THE VALVE WAS STROKED TO DETERMINE OPERABILITY AND RESURVEILLED WITHOUT INCIDENT. THE APPARENT CAUSE OF THE OCCURRENCE WAS THE HIGH MOTOR CURRENT DRAWN WHEN A VALVE CLOSE SIGNAL WAS INADVERTENTLY INITIATED DURING THE PERIOD WHEN THE VALVE WAS STILL STROKING OPEN. ALL ASSOCIATED ELECTRICAL COMPONENTS WERE FUNCTIONALLY TESTED AND FOUND SATISFACTORY. THE SURVEILLANCE PROCEDURE WAS REVISED. MOTOR CURRENT TESTS WERE PERFORMED.
OYSTER CREEK-1 LIQ RADIOACT WSTE MANAGMNT SYS PIPES,FITTINGS LESS THAN 4 INCHES COMPONENT FAILURE CORROSION ITEM NOT APPLICABLE	05000219 79-026/03L-0 026762	080779 090679 30-DAY	DURING NORMAL OPERATION, WHILE EXCAVATING TO EFFECT REPAIRS ON THE EQUIPMENT DRAIN TANK LINE, A LEAK WAS DISCOVERED IN THE LAUNDRY TANK DISCHARGE PIPE. FLOW RATE OF THE LEAK WAS APPROXIMATED TO BE 1/2 GPM WHILE WATER WAS BEING PUMPED TO RADWASTE. SAMPLES WERE ANALYZED AND REVEALED LEVELS OF CO(60) AND MN(54). THE EXTENT OF CONTAMINATION DUE TO THIS LEAK CANNOT BE DISTINGUISHED FROM THE LEAK IN THE EQUIPMENT DRAIN TANK LINE (R050-219/79-10). ISOTOPIC ANALYSIS PERFORMED ON THE SOIL AND RESIDUAL WATER REVEALED LEVELS OF MN(54) & CO(60). IMMEDIATE ACTION WAS TO ISOLATE THE LINE & TAG THE LAUNDRY TANK PUMP "OUT OF SERVICE". THE LINE HAS BEEN TEMPORARILY ROUTED UNTIL REPAIRS CAN BE MADE & AN ENCLOSURE CAN BE BUILT AROUND THE SE PIPE RUNS. SUPPLEMENTAL INFO WILL BE SENT UPON FURTHER ANALYSIS.
OYSTER CREEK-1 REACTIVITY CONTROL SYSTEMS PIPES,FITTINGS LESS THAN 4 INCHES PERSONNEL ERROR OTHER ITEM NOT APPLICABLE	05000219 79-030/03L-0 026782	081279 091279 30-DAY	DURING NORMAL OPERATION, "A" CRD PUMP WAS REMOVED FROM SERVICE DUE TO EXCESSIVE LEAKAGE FROM THE PUMP VENT PIPING. THE PIPING WAS FOUND TO BE CRACKED AT THE BUSHING WHERE IT ENTERS THE PUMP CASING. THE SAFETY SIGNIFICANCE OF THIS EVENT IS CONSIDERED MINIMAL BECAUSE OF THE AVAILABILITY OF REDUNDANT PUMP.
			THE CRACKING APPEARS TO BE CAUSED BY AN OPERATOR USING THE VENT LINE AS A FOOT SUPPORT. THE AFFECTED BUSHING AND A SHORT PIPE NIPPLE IN THE LINE WERE REPLACED AND THE PUMP RETURNED TO SERVICE.

FACILITY/SYSTEM/COMPONENT/
COMPONENT SUBCODE/CAUSE CODE/
CAUSE SUBCODE/MANUFACTURER

DOCKET NO./
LER NO./
CONTROL NO.

EVENT DATE/
REPORT DATE/
REPORT TYPE

EVENT DESCRIPTION/
CAUSE DESCRIPTION

OYSTER CREEK-1
REACTIVITY CONTROL SYSTEMS
PIPES/FITTINGS
LESS THAN 4 INCHES
PERSONNEL ERROR
OTHER
ITEM NOT APPLICABLE

05000219
79-031/03L-0
026962

082979
092879
30-DAY

DURING NORMAL OPERATION, "B" CRD PUMP WAS REMOVED FROM SERVICE DUE TO EXCESSIVE LEAKAGE FROM A SEAL WATER PIPING CONNECTION. THE PIPING WAS FOUND TO BE CRACKED ON A SHORT PIPE NIPPLE SECTION WHERE IT IS THREADED INTO THE SEAL CARTRIDGE. THE SAFETY SIGNIFICANCE OF THIS EVENT IS CONSIDERED MINIMAL BECAUSE OF THE AVAILABILITY OF A REDUNDANT PUMP. "A" CRD PUMP EXPERIENCED SIMILAR PROBLEM 8/12/79 AS REPORTED IN LER 79-30.

THE CRACKING APPEARS TO BE CAUSED BY AN OPERATOR USING THE 1/2" PIPING AS A FOOT SUPPORT. THE AFFECTED SHORT PIPE NIPPLE IN THE LINE WAS REPLACED AND THE PUMP RETURNED TO SERVICE.

PALISADES-1
REACTOR TRIP SYSTEMS
INSTRUMENTATION + CONTROLS
OTHER
PERSONNEL ERROR
MAINTENANCE & REPAIR PERSONNEL
COMBUSTION ENGINEERING, INC.

05000255
79-034/03L-0
026717

080479
083179
30-DAY

DURING NORMAL POWER OPERATION, IT WAS FOUND THAT THE OUTPUT LIMITER SETPOINT FOR THE CHANNEL B THERMAL MARGIN/LOW PRESSURE (TM/LP) TRIP WAS LOW. THE OTHER THREE CHANNELS WERE OPERABLE. THE SETPOINT WAS 1706 PSIA; IT 2.3 REQUIRES A MINIMUM SETTING OF 1750 PSIA. THE CHANNEL WAS RECALIBRATED AND RETURNED TO SPECIFICATION ON 8/7/79. NO THREAT TO PUBLIC HEALTH OR SAFETY EXISTED.

ON 8/3/79, DURING MONTHLY TESTING OF THE RPS, THE TM/LP OUTPUT LIMITER WAS INADVERTENTLY CHANGED TO THE OUT-OF-SPECIFICATION VALUE. THIS OCCURRENCE WILL BE REVIEWED WITH TECHNICIANS WHO PERFORM THESE TESTS.

PALISADES-1
CONDENSATE + FEEDWTR SYS + CONT
HEAT EXCHANGERS
STEAM GENERATOR
COMPONENT FAILURE
MECHANICAL
COMBUSTION ENGINEERING, INC.

05000255
79-039/03L-0
026903

082979
092879
30-DAY

FOLLOWING A CHANGE IN CONDENSATE DEMINERALIZERS, THE PH OF THE 'A' STEAM GENERATOR DROPPED TO 8.08. MORPHOLINE ADDITIONS TO BOTH S/G'S RESTORED PH TO TS LIMITS WITHIN THE TIME ALLOWED BY TS 3.18.3. OCCURRENCE SIMILAR TO LER 79-032. NO THREAT TO PUBLIC HEALTH OR SAFETY EXISTED.

HIGH CONDENSER TUBE INLEAKAGE RESULTED IN THE DECISION TO INCREASE THE DEMIN RESIN LOADING IN ORDER TO ENHANCE SODIUM REMOVAL. BECAUSE THE RESINS SELECTIVELY REMOVE AMMONIA AND MORPHOLINE BEFORE SODIUM, A DROP IN PH RESULTED. CORRECTIVE ACTION TO PREVENT RECURRENCE IS BEING EVALUATED.

PALISADES-1
STATION SERV WATER SYS + CONT
VALVES
CHECK
COMPONENT FAILURE
MECHANICAL
CRANE COMPANY

05000255
79-038/03L-0
026966

082979
092879
30-DAY

WHEN ATTEMPTING TO PLACE P-7C SERVICE WATER PUMP IN OPERATION, THE PUMP DISCHARGE CHECK VALVE FAILED TO OPEN. THE VALVE WAS OPENED BY DROPPING SYSTEM PRESSURE AND RESTARTING P-7C. OCCURRENCE IS A DEGRADED MODE OF OPERATION PERMITTED BY THE LCO OF TS 3.4.2. BOTH P-7A AND P-7B WERE OPERABLE. NO THREAT TO PUBLIC HEALTH OR SAFETY EXISTED. FOR SIMILAR OCCURRENCE, SEE LER 78-15.

THE SUSPECTED CAUSE OF THE VALVE FAILURE IS THAT CORROSION OF THE VALVE HINGE PINS CAUSED ENOUGH RESISTANCE TO KEEP THE VALVE FROM OPENING. THE VALVE WILL BE INSPECTED DURING THE CURRENT REFUELING OUTAGE TO VERIFY THE CAUSE. REPAIRS WILL BE MADE AS NEEDED.

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
PALISADES-1 GAS RADIOACT WSTE MANAGMNT SYS COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR RADIATION PROTECTION PERSONNEL ITEM NOT APPLICABLE	05000255 79-035/01T-0 026864	090579 091479 2-WEEK	DURING A RELEASE OF CONTENTS OF WASTE GAS DECAY TANK T-68B, WASTE GAS MONITOR ALARMED & TERMINATED RELEASE. INVESTIGATION REVEALED THAT T-68B HAD BEEN INCORRECTLY ASSIGNED AS TANK TO BE RELEASED. AS A RESULT, PARTIAL RELEASE OF T-68B OCCURRED WITHOUT HAVING FIRST MET SAMPLING & HOLDUP REQUIREMENTS OF TS 3.9.3 AND 3.9.17. NO RELEASE LIMITS WERE EXCEEDED; RELEASE RATE WAS 0.464 PERCENT OF ANNUAL AVERAGE LIMIT. NO THREAT TO PUBLIC HEALTH RESULTED. A PERSONNEL ERROR IN TRANSCRIBING THE ID NUMBER OF THE TANK TO BE RELEASED FROM THE SAMPLE/CALCULATION SHEET TO THE BATCH RELEASE FORM RESULTED IN THE WRONG TANK BEING RELEASED. TO PREVENT RECURRENCE, A REVIEW STEP WILL BE ADDED TO THE RELEASE FORM.
PEACH BOTTOM-2 POTABLE + SAN WATER SYS + CONT COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000277 79-017/04T-0 026764	041879 042779 2-WEEK	ROUTINE PH ANALYSIS OF SEWAGE PLANT EFFLUENT IDENTIFIED A PH OF 5.3 WHICH EXCEEDED THE TECH SPEC RANGE OF 6.0 TO 9.0. PH OF THE EFFLUENT WAS BELOW 6.0 FOR LESS THAN 4 HOURS AFTER DISCOVERY. PH OF THE WATER ENTERING CONOWINGO POND FROM THE DISCHARGE CANAL WAS NOT AFFECTED DUE TO LARGE DILUTION FACTOR. ENVIRONMENTAL IMPACT WAS INSIGNIFICANT. SOURCE OF LOW PH WATER COULD NOT BE DETERMINED. AERATION TANK WAS NEUTRALIZED TO BRING EFFLUENT PH WITHIN LIMITS. MODIFICATION TO THE SEWAGE TREATMENT PLANT TO PROVIDE AUTOMATIC PH CONTROL IS PRESENTLY UNDER INVESTIGATION.
PEACH BOTTOM-2 POTABLE + SAN WATER SYS + CONT BLOWERS SUBCOMPONENT NOT APPLICABLE COMPONENT FAILURE MECHANICAL HOFFMAN AIR-FILT., DIV. CLARKS	05000277 79-023/04T-0 026845	051579 052579 2-WEEK	ROUTINE PH ANALYSIS OF SEWAGE PLANT EFFLUENT IDENTIFIED A PH OF 5.8 WHICH EXCEEDED THE TECH SPEC RANGE OF 6.0 TO 9.0. THE PH OF THE EFFLUENT WAS BELOW 6.0 FOR LESS THAN 4 HOURS AFTER DISCOVERY. THE PH OF THE WATER ENTERING CONOWINGO POND FROM THE DISCHARGE CANAL WAS NOT AFFECTED DUE TO THE LARGE DILUTION FACTOR. THE ENVIRONMENTAL IMPACT WAS INSIGNIFICANT. FAILURE OF AIR BLOWERS ALLOWED THE DISSOLVED OXYGEN LEVEL TO DROP TO ZERO. THIS CAUSED THE AERATION TANK TO GO TO AN AEROBIC CONDITION WHICH DROPS PH. AERATION TANK WAS NEUTRALIZED AND AIR TEMPORARILY SUPPLIED TO BRING PH WITHIN LIMITS. BLOWERS WERE REPAIRED. MODIFICATION TO PROVIDE AUTOMATIC PH CONTROL IS PRESENTLY UNDER INVESTIGATION.
PEACH BOTTOM-2 REACTOR CONTAINMENT SYSTEMS VALVE OPERATORS PNEUMATIC/DIAPHRAGM/CYLINDER COMPONENT FAILURE MECHANICAL FISHER GOVERNOR	05000277 79-038/03L-0 026724	081279 090779 30-DAY	WHILE AT POWER, TORUS HIGH VACUUM ALARM WAS RECEIVED IN THE CONTROL ROOM. OPERATORS REDUCED VACUUM IN TORUS WITH THE CONTAINMENT ATMOSPHERIC DILUTION SYSTEM. SUBSEQUENTLY OPERATORS TESTED THE VACUUM BREAKER AIR OPERATED VALVES. VALVE A0-2502A FAILED TO OPEN AND WAS DECLARED INOPERABLE. THE REDUNDANT VALVE A0-2502B WAS PROVEN OPERABLE. SINCE THE REDUNDANT VALVE WOULD HAVE OPERATED PROPERLY AND OPERATORS WERE ALERTED TO THE INCREASE IN TORUS VACUUM THE SAFETY SIGNIFICANCE IS MINIMAL. THE NEEDLE VALVE WHICH BLEEDS AIR TO CLOSE VALVE A0-2502A WAS FOUND CLOGGED. MANUAL OPERATION OF THE NEEDLE VALVE RELIEVED THE CLOGGING AND BLEED RATE ADJUSTED. VALVE A0-2502A WAS TESTED FOR PROPER OPERABILITY AND RETURNED TO SERVICE ON 8/13/79.

1543 087

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
PEACH BOTTOM-2 AIRBORNE RADIOACT MONITOR SYS INSTRUMENTATION + CONTROLS SENSOR/DETECTOR/ELEMENT COMPONENT FAILURE ELECTRONIC LFE CORP.	05000277 79-037/03L-0 026725	081279 091179 30-DAY	AT POWER DURING A ROUTINE SURVEILLANCE TEST THE A AND B CONTROL ROOM INTAKE AIR RADIATION MONITORS FAILED DOWNSCALE. THE SYSTEM OPERATED CORRECTLY TO ISOLATE CONTROL ROOM VENTILATION. THE EMERGENCY VENTILATION SYSTEM WAS PLACED IN OPERATION. BOTH MONITORS WERE RESTORED TO SERVICE WITHIN 24 HOURS. THERE WAS MINIMAL SAFETY SIGNIFICANCE SINCE ALL APPROPRIATE SYSTEMS FUNCTIONED CORRECTLY AND NO RADIATION HAZARD EXISTED. FAILURE OF TRANSISTOR CIRCUITS WITHIN THE A AND B RADIATION MONITORS OCCURRED. THE A MONITOR WAS REPLACED. THE B MONITOR WAS REPAIRED. BOTH MONITORS WERE SATISFACTORILY TESTED AND RETURNED TO SERVICE.
PEACH BOTTOM-2 FIRE PROTECTION SYS + CONT COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR CONSTRUCTION PERSONNEL ITEM NOT APPLICABLE	05000277 79-040/01T-0 026722	082179 090579 2-WEEK	CONTRACT PERSONNEL WORKING IN THE E2 DIESEL ROOM DISARMED THE CO2 SYSTEM AND ESTABLISHED A FIRE WATCH IN ACCORDANCE WITH PROCEDURE. UPON COMPLETION OF WORK, THE CO2 SYSTEM WAS NOT RESTORED TO NORMAL AND THE AREA WAS WITHOUT A FIRE WATCH FOR ABOUT 10 MINUTES. CONSEQUENCES ARE MINIMAL DUE TO THE SHORT TIME INTERVAL INVOLVED AND ALSO THE FACT THAT NO WORK WAS BEING PERFORMED IN THE DIESEL GENERATOR BAY WHEN THE FIRE WATCH WAS ABSENT. PERSONNEL THOUGHT SECOND GROUP WORKING IN THE CARDOX ROOM OF THE DIESEL BUILDING REQUIRED THE CO2 SYSTEM TO BE DISARMED. CO2 SYSTEM WAS RESTORED TO NORMAL WITHIN 10 MINUTES. ALL PERSONNEL INVOLVED RECEIVED INSTRUCTION ON WORK REQUIREMENTS WHERE A FIRE WATCH IS POSTED.
PEACH BOTTOM-2 MAIN STEAM ISOL SYS + CONTROLS COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR CONTRACT. & CONSULT. PERSONNEL ITEM NOT APPLICABLE	05000277 79-039/03L-0 026936	082879 092779 30-DAY	INADVERTENTLY OPENED DRAIN VALVE CAUSED INOPERABILITY OF -B- CHANNEL OF THE -D- MAIN STEAM LINE HIGH FLOW ISOLATION SIGNAL. REDUNDANT CHANNELS REMAINED OPERABLE; SAFETY SIGNIFICANCE IS MINIMAL. DRAIN VALVE LOCATED ON INSTRUMENT RACK OPENED PARTIALLY WHEN STRUCK BY SCAFFOLDING BEING TRANSPORTED THROUGH THE AREA. VALVE WAS RECLOSED WITHIN 10 MINUTES AND THE INSTRUMENT RETURNED TO SERVICE. TEMPORARY BARRIER INSTALLED TO PRECLUDE SIMILAR EVENT. INSTRUCTIONS GIVEN TO CONTRACTOR PERSONNEL TO EXERCISE MORE CARE.
PEACH BOTTOM-2 EMERG CORE COOLING SYS + CONT COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR CONTRACT. & CONSULT. PERSONNEL ITEM NOT APPLICABLE	05000277 79-041/03L-0 026944	090579 100579 30-DAY	WHILE AT POWER AN INADVERTENTLY OPENED 440 VOLT BREAKER SWITCH MADE THE 'A' RHR LOOP INJECTION VALVE (MO-25A) INOPERABLE FOR APPROXIMATELY 10 MINUTES. DURING THIS INTERVAL, ALL OTHER ECCS SYSTEMS INCLUDING THE 'B' RHR LOOP WERE OPERABLE. SAFETY SIGNIFICANCE IS MINIMAL DUE TO SHORT DURATION OF THE EVENT AND AVAILABILITY OF REDUNDANT SYSTEMS. THE BREAKER SWITCH WAS HIT BY SCAFFOLDING BEING TRANSPORTED THROUGH THE AREA. FOLLOWING INVESTIGATION, THE BREAKER SWITCH WAS RECLOSED. INSTRUCTIONS WERE GIVEN TO CONTRACTOR PERSONNEL TO EXERCISE MORE CARE.

1543 088

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
PEACH BOTTOM-2 OTHER ENGNRD SAFETY FEATR SYS HANGERS,SUPPORTS,SHOCK SUPPRSS HANGERS DESIGN/FABRICATION ERROR CONSTRUCTION/INSTALLATION I.T.T. PHILLIPS DRILL DIVISION	05000277 79-043/01T-0 026821	090679 092079 2-WEEK	THE INSPECTION PROGRAM PERFORMED IN RESPONSE TO IE BULLETIN 79-02 IDENTIFIED TWO ANCHORS IN ONE SUPPORT WHICH HAD CONTACT BETWEEN THE BOLT SHELLS AND THE SUPPORT PLATE. THESE ANCHORS ARE ASSOCIATED WITH THE HIGH PRESSURE SERVICE WATER (HPSW) SYSTEM LINE IN THE UNIT 2 A RHR ROOM. EVEN THOUGH FAILURE OF THE PIPE DURING A SEISMIC EVENT WOULD AFFECT TWO HPSW CONTAINMENT COOLING SUBSYSTEMS THE SAFETY SIGNIFICANCE IS CONSIDERED MINIMAL BECAUSE LPCI AND REDUNDANT RHR SUBSYSTEMS ARE AVAILABLE. CONTACT BETWEEN THE BOLT SHELLS AND SUPPORT PLATE WAS CAUSED BY IMPROPER INSTALLATION OF THE BOLT ANCHOR SHELLS. THE DEFECTIVE BOLT SHELLS HAVE BEEN REMOVED AND REPLACED BY WEDGE TYPE ANCHOR BOLTS AND HAVE BEEN SUCCESSFULLY TORQUE TESTED. THE RESULTING ANCHOR BOLT SAFETY FACTOR ATTAINED IS GREATER THAN 5.
PEACH BOTTOM-2 CONTNMNT COMBUS GAS CONTROL SYS INSTRUMENTATION + CONTROLS POWER SUPPLY DESIGN/FABRICATION ERROR DESIGN OTHER	05000277 79-042/01T-0 026938	090679 092079 2-WEEK	SEISMIC AND REDUNDANCY DESIGN DEFICIENCIES INVOLVING ELECTRICAL FEEDS DISCOVERED ON CAD SYSTEM VALVES AND INSTRUMENTATION. SAFETY SIGNIFICANCE MINIMIZED BY THE AVAILABILITY OF ALTERNATE METHODS OF ENSURING SYSTEM OPERABILITY.
			DEFICIENCIES RESULTED FROM INADEQUATE DESIGN BY ARCHITECT-ENGINEER. CORRECTIVE ACTION IN PROGRESS TO INSTALL AND RELOCATE THE CAD SYSTEM POWER AND CONTROL CABLES.
PEACH BOTTOM-2 OTHER ENGNRD SAFETY FEATR SYS HANGERS,SUPPORTS,SHOCK SUPPRSS HANGERS DESIGN/FABRICATION ERROR CONSTRUCTION/INSTALLATION I.T.T. PHILLIPS DRILL DIVISION	05000277 79-044/01T-0 026858	090779 092179 2-WEEK	INSPECTION PROGRAM PERFORMED IN RESPONSE TO BULLETIN 79-02 IDENTIFIED A FAILURE OF ONE SUPPORT ASSOCIATED WITH EMERGENCY SERVICE WATER SYSTEM PIPING IN UNIT 2 REACTOR BLDG. CLOSED COOLING WATER ROOM. 2 BOLTS WERE CONSIDERED FAILED BECAUSE OF EXCESSIVE SHELL PROJECTION FROM WALL. BECAUSE 3 OF THE 4 BOLTS ACHIEVED THE REQUIRED TORQUE AND SAFETY FACTOR WAS 2.88, POSSIBILITY OF FAILURE OF RELATED PIPING SYSTEMS DURING A SEISMIC EVENT WAS MINIMAL.
			IMPROPER INSTALLATION IS MOST PROBABLE CAUSE OF TEST FAILURE. FOLLOWING NOTIFICATION OF TEST FAILED ANCHOR BOLTS, ESU LINE WAS ISOLATED BY MANUALLY CLOSING VALVE 0-517 & SHUTDOWN WAS INITIATED. FAILED BOLTS WERE REPLACED WITH 1"X9" HILTI KWIK BOLTS. REPLACEMENT BOLTS WERE SUCCESSFULLY TORQUE TESTED. THE RESULTANT SAFETY FACTOR WAS 5.33.
PEACH BOTTOM-3 GAS RADIOACT WSTE MANAGMNT SYS VALVE OPERATORS ELECTRIC MOTOR - DC COMPONENT FAILURE MECHANICAL LIMITORQUE CORP.	05000278 79-002/04T-0 026763	010879 012279 2-WEEK	ROOF VENT STACK INSTANTANEOUS RELEASE RATE ABOVE TECH. SPEC. LIMIT. DURING A MAINTENANCE OUTAGE COOLANT VAPOR LEAKED FROM REACTOR THRU OPEN & PARTIALLY DISMANTLED RCIC ISOLATION VALVES VIA THE MSIV ROOM TO THE VENT STACK. WORK ON BOTH VALVES WAS PERMISSIBLE SINCE UNIT WAS IN COLD SHUTDOWN. TOTAL RELEASE WAS 1.5 HRS LONG WITH RATE EXCEEDING TECH. SPEC. FOR APPROX. 15 MIN. (PEAK 270% OF LIMIT). CONSEQUENCES MINIMAL BECAUSE OF SHORT DURATION AND CONTENT OF RELEASE (NOBLE GASES). VALVE OPERATOR FAILURE (M016A) CAUSED LOSS OF INSERVICE RHR LOOP, RISE IN COOLANT TEMP, & GASEOUS RELEASE VIA RCIC VALVES UNDERGOING MAINTENANCE. SHUTDOWN COOLING RE-ESTABLISHED, REACTOR COOLANT TEMP. REDUCED, THUS ENDING RELEASE. OPERATING PERSONNEL INSTRUCTED TO LIMIT COOLANT TEMP. TO 170 F WHEN RELEASE FLOW PATH EXISTS. PROCEDURE MODS PROVIDE GUIDANCE.

1543 089

NOV 08, 1979

LER MONTHLY REPORT SORTED BY FACILITY
PROCESSED DURING OCTOBER, 1979 FOR POWER REACTORS

PAGE 68

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
PEACH BOTTOM-3 EMERG CORE COOLING SYS + CONT HANGERS,SUPPORTS,SHOCK SUPPRSS SUPPORTS DESIGN/FABRICATION ERROR CONSTRUCTION/INSTALLATION I.T.T. PHILLIPS DRILL DIVISION	05000278 79-024/01T-0 026723	081579 082979 2-WEEK	INSPECTION PROGRAM PERFORMED IN RESPONSE TO IE BULLETIN 79-02 IDENTIFIED 3 OF 4 ANCHOR BOLTS TESTED IN ONE SUPPORT ON THE 3D RHR PUMP SUCTION PIPING FAILED. DURING A SEISMIC EVENT THE ANCHOR SUPPORT PIPING SYSTEM COULD POSSIBLY FAIL AND CAUSE FLOODING IN ONE OF FOUR RHR ROOMS. BECAUSE REDUNDANT RHR PUMPS AND BACKUP CORE SPRAY SYSTEM ARE AVAILABLE, SAFETY SIGNIFICANCE IS CONSIDERED MINIMAL. THE MOST PROBABLE CAUSE OF FAILURE WAS IMPROPER INSTALLATION. THE THREE TEST FAILED ANCHOR BOLTS WERE REPLACED WITH WEDGE TYPE ANCHORS AND SUCCESSFULLY TORQUE TESTED.
PEACH BOTTOM-3 EMERG CORE COOLING SYS + CONT RELAYS CONTROL, GENERAL PURPOSE COMPONENT FAILURE ELECTRICAL GENERAL ELECTRIC CO.	05000278 79-025/03L-0 026937	082979 092879 30-DAY	WHILE AT POWER AND DURING A SURVEILLANCE TEST OF REACTOR VESSEL LEVEL INSTRUMENTATION (LSLL3-2-3-72B), RELAY (2E-K18) FAILED TO MAKE CONTACT. THIS RELAY PROVIDES REACTOR VESSEL LOW LEVEL TRIP (-130 IN.) TO ADS INITIATION LOGIC. SAFETY CONSEQUENCES WERE MINIMAL SINCE THE REDUNDANT LOGIC CHANNEL WAS OPERABLE. THE CAUSE OF THIS OCCURRENCE WAS A WORN CONTACT ON A GE HFA RELAY. THE LOGIC HAS BEEN PLACED IN THE TRIPPED CONDITION AND THE RELAY WILL BE REPLACED DURING THE CURRENT REFUELING AND MAINTENANCE OUTAGE.
PEACH BOTTOM-3 EMERG CORE COOLING SYS + CONT HANGERS,SUPPORTS,SHOCK SUPPRSS OTHER DESIGN/FABRICATION ERROR CONSTRUCTION/INSTALLATION I.T.T. PHILLIPS DRILL DIVISION	05000278 79-026/01T-0 026833	090479 091879 2-WEEK	ANCHOR 3-23-DDN-S25 WAS IDENTIFIED AS A FAILURE AND REPAIRED IN CONJUNCTION WITH THE SEISMIC SUPPORT PROGRAM REQUIRED BY NRC BULLETIN 79-02. THIS IS SUPPORT GUIDES A SECTION OF THE PIPING BETWEEN THE HPCI PUMP DISCHARGE AND M0-20 VALVE. BECAUSE THE FAILURE OF THIS ANCHOR MAY NOT HAVE RESULTED IN FAILURE OF THE SUPPORTED PIPING SYSTEM DURING A SEISMIC EVENT, AND BECAUSE REDUNDANT ECCS SYSTEMS WERE SATISFACTORILY TESTED FOR OPERABILITY, THE SAFETY SIGNIFICANCE OF THIS FAILURE WAS MINIMAL. THE MOST PROBABLE CAUSE OF FAILURE WAS IMPROPER INSTALLATION. THE ORIGINAL ANCHOR PLATES WERE ATTACHED TO NEW PLATES BY MEANS OF FILLET WELDS. THE LARGER PLATES WERE BOLTED TO THE WALL USING 7" X 3/4" HILTI KNIK BOLTS. THIS REPAIR RAISED THE CALCULATED SAFETY FACTOR TO 6.5. ANCHOR BOLTS WERE SUCCESSFULLY TORQUE-TESTED. DURING AN IE INSPECTION IT WAS DISCOVERED THAT ON JUNE 12, 1979 WHILE PERFORMING REPAIRS ON THE "A" CORE SPRAY SYSTEM MINIMUM FLOW LINE, A DEGRADATION OF PRIMARY CONTAINMENT OCCURRED. WHEN THE MINIMUM FLOW LINE CHECK VALVE WAS REMOVED, THE TORUS WAS OPENED TO ATMOSPHERE.
PILGRIM-1 EMERG CORE COOLING SYS + CONT VALVES CHECK PERSONNEL ERROR LICENSED & SENIOR OPERATORS VELAN VALVE CORP.	05000293 79-029/01T-0 026759	061279 082479 2-WEEK	THIS EVENT WAS CAUSED BY INADEQUATE REVIEW OF PLANNED MAINTENANCE ACTIVITIES. THIS INCIDENT WILL BE REVIEWED, ADDITIONAL TRAINING CONDUCTED AND PROCEDURES REVISED TO STRENGTHEN BOTH PROCEDURAL AND MANAGEMENT CONTROLS.

1543 89

090

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
PILGRIM-1 RESIDUAL HEAT REMOV SYS + CONT VALVES GLOBE COMPONENT FAILURE OTHER ANCHOR/DARLING VALVE CO.	05000293 79-030/03L-0 026760	072579 081679 30-DAY	ON JULY 25, 1979 WHILE PLACING THE "B" RHR LOOP IN SUPPRESSION POOL COOLING, MOV-1001-36B WAS GIVEN A SIGNAL TO OPEN AND ITS MOTOR CONTROL CENTER BREAKER TRIPPED ON OVERLOAD. SURVEILLANCE TESTING WAS CONDUCTED FOR ONE CONTAINMENT COOLING SUBSYSTEM INOPERABLE AND THE BREAKER OVERLOAD TRIP WAS INVESTIGATED. IT WAS DISCOVERED THAT THE VALVE STEM GUIDE KEY HAD SHEARED. THIS WAS THE 4TH SUCH FAILURE SINCE JULY, 1974 FOR MOV'S 1001-36A & B. VALVE STEM GUIDE KEY FOUND TO BE OF MARGINAL DESIGN FOR THE APPLICATION. STEM CLAMPS PREVIOUSLY HELD IN PLACE USING THIS KEY WILL BE MODIFIED TO USE SET SCREWS.
PILGRIM-1 EMERG GENERATOR SYS + CONTROLS COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE DESIGN/FABRICATION ERROR DESIGN ITEM NOT APPLICABLE	05000293 79-031/01T-0 026761	081679 082879 2-WEEK	DURING A SEISMIC EVENT WITH OR WITHOUT LOCA, THE UNIT AUXILIARY TRANSFORMER BREAKERS A505 AND A605 MAY NOT BE TRIPPED OPEN AUTOMATICALLY BY THE EXISTING TRIP SIGNALS BECAUSE THESE TRIP SIGNALS COME FROM NON SEISMICALLY QUALIFIED SOURCES. HENCE THE EMERGENCY DIESEL GENERATOR BREAKERS A509 AND A609 COULD NOT CLOSE AUTOMATICALLY SINCE THE UNIT AUXILIARY BREAKERS ARE NOT TRIPPED.
PILGRIM-1 ENGRD SAFETY FEATR INSTR SYS INSTRUMENTATION + CONTROLS SWITCH COMPONENT FAILURE ELECTRICAL BARNSDALE COMPANY	05000293 79-034/03L-0 026711	082179 083079 30-DAY	AUX. TRIP RELAYS ASSOCIATED WITH TRIP LOGIC FOR UNIT AUX. BREAKERS WERE NOT ORIGINALLY SPECIFIED TO BE SEISMICALLY QUALIFIED. UNIT AUX. TRANSFORMER BREAKER CONTROL CIRCUITS MODIFIED SO A TRIP WILL OCCUR FROM AN UNDERVOLTAGE AT A5 & A6 BUSES BY UTILIZING SPARE CONTACTS OF SEISMICALLY QUALIFIED UNDERVOLTAGE RELAYS. TRIPS ARE BACKUP TO ORIGINAL TRIP CIRCUITS. AT 2200 ON AUGUST 21, 1979 WHILE PERFORMING SURVEILLANCE TEST 8.M.1-16 REACTOR PRESSURE PERMISSIVE IT WAS OBSERVED THAT PRESSURE SWITCHES 263-51B AND 263-51D ACTUATED AT PRESSURES BEYOND THE TECH. SPEC. LIMIT OF 613 PSI.
PILGRIM-1 REAC COOL PRES BOUN LEAK DETEC OTHER COMPONENTS SUBCOMPONENT NOT APPLICABLE COMPONENT FAILURE OTHER NUCLEAR MEASUREMENTS CORP.	05000293 79-035/03L-0 026866	082679 091479 30-DAY	CALIBRATION CHECKS REVEALED THAT P.S. 263-51B ACTUATED AT 625 PSI AND P.S. 263-51D ACTUATED AT 615 PSI. THESE INSTRUMENTS HAD EXPERIENCED A SET POINT DRIFT. THEY WERE RECALIBRATED, SATISFACTORILY TESTED AND RETURNED TO SERVICE.
PILGRIM-1 REAC COOL PRES BOUN LEAK DETEC OTHER COMPONENTS SUBCOMPONENT NOT APPLICABLE COMPONENT FAILURE OTHER NUCLEAR MEASUREMENTS CORP.	05000293 79-035/03L-0 026866	082679 091479 30-DAY	ON AUGUST 26, 1979 AT 0912 THE DRIVE BELT ON THE REACTOR COOLANT LEAK DETECTION AIR SAMPLING SYSTEM (PANEL C-19) WAS FOUND BROKEN.
			THE DRIVE SYSTEM SHEAVES WERE FOUND MISALIGNED. THIS CAUSED THE DRIVE BELT TO WEAR AND EVENTUALLY BREAK. THE SHEAVES WERE REALIGNED, A NEW BELT WAS INSTALLED AND THE SYSTEM RETURNED TO NORMAL ON AUGUST 28, 1979.

1543-09

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
PILGRIM-1 OFFSITE POWER SYSTEMS + CONTRL COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE EXTERNAL CAUSE NOT APPLICABLE ITEM NOT APPLICABLE	05000293 79-033/01T-0 026781	082879 091179 2-WEEK	ON AUGUST 18, 1979 AT 0030 HRS, A REACTOR SCRAM OCCURRED AS A RESULT OF A LOSS OF ALL OFF-SITE POWER. THE EMERGENCY DIESEL GENERATORS FUNCTIONED AS REQUIRED AND ASSUMED EMERGENCY LOADS. A RELIEF VALVE WAS MANUALLY ACTUATED TO CONTROL PRESSURE AND MANEUVER THE REACTOR TO A SAFE SHUTDOWN
			THE CAUSE OF THIS EVENT WAS LIGHTNING STRIKING THE STATION SWITCHYARD CAUSING A HIGH SPEED RELAY OPERATION FOR A LINE TO GROUND FAULT. POWER WAS RESTORED TO THE STARTUP TRANSFORMER AND STATION LOADS RETURNED TO NORMAL AFTER APPROXIMATELY 30 MINUTES.
PILGRIM-1 CONTNMENT ISOLATION SYS + CONT VALVE OPERATORS SOLENOID - AC DESIGN/FABRICATION ERROR MANUFACTURING ASCO	05000293 79-032/01T-0 026863	082879 091179 2-WEEK	DURING EVALUATION PERFORMED IN RESPONSE TO IE BULLETIN 79-01, DRYWELL SUMP CONTAINMENT ISOLATION VALVES AO-7011A&B AND AO-7017A&B WERE DETERMINED TO BE UNQUALIFIED FOR SERVICE. POSTULATED FAILURE CONSIDERED IS UNDETECTED CARRYOVER (SYPHON) OF DRYWELL SUMP CONTAMINATED WATER DUE TO CONCURRENT HIGH DRYWELL PRESSURE AND HIGH RADIATION EXPOSURE IN THE TORUS COMPARTMENT FOLLOWING LOCA.
			FAILURE IDENTIFIED IS VIA HIGH RADIATION EXPOSURE TO SOLENOID VALVE INTERNALS, SYNTHETIC MATERIALS, FOLLOWING LOCA. FORMAL LICENSED OPERATOR TRAINING IS BEING CONDUCTED CONCENTRATING ON SYMPTOM RECOGNITION AND CORRECTIVE RESPONSES. APPLICABLE EMERGENCY PROCEDURES ARE BEING REVISED TO ASSURE OP ACTION. QUALIFIED REPLACEMENT SOLENOID VALVES WILL BE INSTALLED.
POINT BEACH-1 REACTOR CONTAINMENT SYSTEMS MECHANICAL FUNCTION UNITS SUBCOMPONENT NOT APPLICABLE COMPONENT FAILURE MECHANICAL PITTSBURGH-DES MOINES STEEL CO	05000266 79-011/01T-0 026743	080479 081479 2-WEEK	AT 0615 HRS, 8-3-79, WHILE PROCEEDING TO A COLD SHUTDOWN CONDITION WITH REACTOR COOLANT SYSTEM AT 393 PSIG & 343 DEG, CONTAINMENT INTEGRITY WAS BRIEFLY VIOLATED. VIOLATION OCCURRED WHEN THE INSIDE CONTAINMENT DOOR WAS OPENED WITH THE OUTSIDE DOOR ALREADY OPEN. CONTAINMENT INTEGRITY WAS QUICKLY REESTABLISHED BY SHUTTING INSIDE DOOR. TS 15.3.6.A.A REQUIRES THAT CONTAINMENT INTEGRITY NOT BE VIOLATED UNLESS THE REACTOR IS IN A COLD SHUTDOWN CONDITION.
			ORDINARILY INSIDE & OUTSIDE DOORS ARE PREVENTED FROM BEING OPENED SIMULTANEOUSLY BY A MECHANICAL INTERLOCK. IN THIS INSTANCE THE INTERLOCK FAILED DUE TO A ROLL PIN FALLING OUT OF A CONNECTING ROD IN THE MECHANISM. THE INTERLOCK WAS REPAIRED AND SATISFACTORILY TESTED ALONG WITH A QUALIFYING AIR TEST OF THE PERSONNEL HATCH BY 2045 HOURS, 8-4-79.
POINT BEACH-1 COOLANT RECIRC SYS + CONTROLS HEAT EXCHANGERS STEAM GENERATOR COMPONENT FAILURE MECHANICAL WESTINGHOUSE ELECTRIC CORP.	05000266 79-013/01T-0 026917	083079 091479 2-WEEK	AT 1158 HRS, 8/29/79, UNIT 1 WAS TAKEN OFF LINE FOR REPAIR OF 324 GALLON PER DAY STEAM GENERATOR PRIMARY-TO-SECONDARY LEAKAGE. THE LEAKAGE HAD INCREASED GRADUALLY FROM A 150 GALLON PER DAY RATE WHICH WAS DISCOVERED AFTER THE UNIT HAD RECOVERED FROM A PREVIOUS STEAM GENERATOR REPAIR OUTAGE ON 8/18/79. THIS EVENT IS REPORTABLE PER T.S. 15.6.9.2.A.3 AND SIMILAR TO LER'S 78-001/01T-0, 78-010/01T-1, 79-003/01T-0 AND 79-012/01T-0.
			LEAK TESTING REVEALED ONE LEAKING TUBE AT R20C37 IN THE "A" STEAM GENERATOR INLET. REANALYSIS OF EDDY CURRENT TESTING DATA TAKEN DURING THE PREVIOUS STEAM GENERATOR REPAIR OUTAGE REVEALED INDICATIONS OF AN 88 PERCENT DEFECT LOCATED JUST BELOW THE TOP OF THE TUBESHEET BURIED IN A NOISY SIGNAL. THE TUBE WAS MECHANICALLY PLUGGED.

1543 092

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
PRAIRIE ISLAND-1 CIRCULATING WATER SYS + CON COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000282 79-001/04L-0 026791	031379 040279 30-DAY	AVERAGE BLOWDOWN FLOW EXCEEDED THE ETS LIMIT OF 150 CFS EACH DAY FROM 3/ 13 TO 3/30/79. EXCESS BLOWDOWN FLOWS RANGED FROM 155 CFS TO 1011 CFS.
PRAIRIE ISLAND-1 CIRCULATING WATER SYS + CON COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000282 79-005/04L-0 026792	063079 070279 30-DAY	A SPECIAL OPERATIONAL TEST PROGRAM TO VALIDATE A PROPOSAL FOR EXTENSIVE DESIGN CHANGES FOR THE INTAKE AND DISCHARGE CANAL WAS IN EFFECT. INCREA SED BLOWDOWN FLOW WAS NECESSARY FOR LOW CONDENSER INLET TEMP. TO OBTAIN DATA AND EXPERIENCE WITH WINTER-TIME RIVER AMBIENT TEMP. IN PARTIAL RECYCLE MODE DAILY AVERAGE BLOWDOWN FLOW EXCEEDED ETS LIMIT O F 150 CFS ON 26 DAYS IN JUNE. EXCESS FLOW RAHOED FROM 155 CFS ON 6/18/7 9 TO 452 CFS ON 6/20/79. DAILY BLOWDOWN FLOW RATE AVERAGED 268 CFS FOR THE MONTH. HIGHER FLOWS WERE REQUIRED TO ACCOMMODATE COOLING TOWER PREVENTATIVE MAI NTENANCE AND TO MAINTAIN COOLING WATER INLET TEMPERATURES AT LESS THAN 8 5 DEGREES F.
PRAIRIE ISLAND-1 FEEDWATER SYSTEMS + CONTROLS RELAYS SWITCHGEAR, AUXILIARY DESIGN/FABRICATION ERROR DESIGN ITEM NOT APPLICABLE	05000282 79-023/03L-0 026837	072679 082479 30-DAY	WHILE INVESTIGATING A LOSS OF 345KV BUS #1 DUE TO SPURIOUS DIFFERENTIAL RELAY ACTUATION, A DESIGN DEFICIENCY WAS DISCOVERED IN THE MOTOR-DRIVEN AUXILIARY FEEDWATER PUMP LOW LUBE OIL PRESSURE CIRCUITRY FOR THE PUMP IN EACH UNIT. THE LOCKOUT RELAY IS LOCATED IN UNRELATED CIRCUITRY SUCH TH AT A MOMENTARY LOSS OF POWER TO THE RELAY COULD CAUSE A PUMP MOTOR LOCKO UT. REDUNDANT TURBINE-DRIVEN PUMPS IN EACH UNIT ARE UNAFFECTED. NO EFF ECT ON PUBLIC HEALTH AND SAFETY. DESIGN. THE LOCKOUT RELAYS WERE IMMEDIATELY BYPASSED. A DESIGN CHANGE HAS BEEN INITIATED WHICH WILL REMOVE THE RELAYS FROM THE LOCKOUT CIRCUIT RY.
PRAIRIE ISLAND-1 EMERG CORE COOLING SYS + CONT COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR OTHER ITEM NOT APPLICABLE	05000282 79-024/03L-0 026980	073179 082479 30-DAY	DURING A REVIEW OF PLANT STATUS ON AUGUST 2ND AT HOT SHUTDOWN, IT WAS DI SCOVERED THAT SP 1088, SAFETY INJECTION PUMPS TEST, HAD NOT BEEN DONE PR IOR TO LEAVING COLD SHUTDOWN ON JULY 31ST. THE TEST WAS DONE ON AUGUST 2ND AND WAS ACCEPTABLE, SO THERE IS REASON TO BELIEVE THE PUMPS WERE CAP ABLE OF PERFORMING THEIR INTENDED FUNCTION. NO EFFECT ON PUBLIC HEALTH AND SAFETY. PERSONNEL ERROR IN ESTABLISHING THE PRE-HEATUP SURVEILLANCE REQUIREMENTS . INVOLVED PERSONNEL WILL REVIEW THIS REPORT.

1543 09
093

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
PRAIRIE ISLAND-2 REACTOR CORE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR LICENSED & SENIOR OPERATORS ITEM NOT APPLICABLE	05000306 79-026/01T-0 026975	091979 100379 2-WEEK	DURING A POWER REDUCTION TO BELOW 90% FOR AXIAL OFFSET CALIBRATION, AXIAL FLUX DIFFERENCE WAS ALLOWED TO LEAVE THE TARGET BAND WHILE REACTOR POWER WAS STILL ABOVE 90%. POWER WAS REDUCED TO BELOW 90% IN HALF AN HOUR. SUBSEQUENT FLUX MAPS SHOWED THAT THE SAME FLUX DISTRIBUTION AT 100% POWER WOULD NOT HAVE PRODUCED UNACCEPTABLE PEAKING FACTORS. NO EFFECT ON PUBLIC HEALTH OR SAFETY. PERSONNEL ERROR. POWER WAS REDUCED TO BELOW 90%. THE EVENT WAS DISCUSSED WITH INVOLVED PERSONNEL. ALL LICENSED OPERATORS AND LICENSE CANDIDATES WILL REVIEW THE EVENT REPORT.
RANCHO SECO-1 OTHER AUX WATER SYS + CONTROLS INSTRUMENTATION + CONTROLS SENSOR/DETECTOR/ELEMENT COMPONENT FAILURE OTHER ITEM NOT APPLICABLE	05000312 79/001/04T-0 026816	052979 061379 2-WEEK	WHILE SHUTDOWN IN MAY OF 1979, A REVIEW OF EFFLUENT MONITORING CHARTS INDICATED THE PLANT LIQUID EFFLUENT PH EXCEEDED THE 8.5 LIMIT ESTABLISHED BY TECHNICAL SPECIFICATIONS, APPENDIX B, SECTION 2.4 ON ONE OCCASION. THIS OCCURRED MAY 29 AND LASTED FOR APPROXIMATELY 5 HOURS. MAXIMUM PLANT WATER DISCHARGE PH WAS 8.9. SUSPECTED CAUSE BEING THE ERROR BAND ASSOCIATED WITH THE PH ALARM SETPOINT. DISTRICT IS INVESTIGATING FEASIBILITY OF REDUCING ERROR BAND ON THIS INSTRUMENT. IN ADDITION, UTILIZING INDIVIDUAL ALARMS RATHER THAN A COMMON ALARM ON EFFLUENT PARAMETERS IS BEING CONSIDERED.
RANCHO SECO-1 RESIDUAL HEAT REMOV SYS + CONT PUMPS CENTRIFUGAL COMPONENT FAILURE MECHANICAL BABCOCK & WILCOX CANADA LTD.	05000312 79-008/03L-0 026886	071979 080979 30-DAY	WHILE PERFORMING MONTHLY DHR PUMP SURVEILLANCE (SP 203.05G) ON "B" DHR PUMP, LEAKAGE IN EXCESS OF 0.63GPH ALLOWABLE PER T.S. SECTION 4.5.3.1 WAS OBSERVED AT THE PUMP SEAL. SYSTEM WAS DECLARED INOPERABLE AND ITS REDUNDANT SYSTEM TESTED SATISFACTORY. SIMILAR EVENTS OCCURRED WITH THIS PUMP ON 10-18-76 AND 6-22-78. THESE WERE REPORTED TO YOUR OFFICE AS LER'S NO. 'S 76-13 AND 78-07. THE LEAKING SEAL WAS REPLACED AND THE SYSTEM TESTED PER APPLICABLE SURVEILLANCE TESTS. THE TEST RESULTS WERE ACCEPTABLE AND THE SYSTEM WAS DECLARED OPERABLE.
RANCHO SECO-1 CHEM, VOL CONT + LIQ POISN SYS COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR LICENSED & SENIOR OPERATORS ITEM NOT APPLICABLE	05000312 79-009/03L-0 026915	081479 090679 30-DAY	ON AUGUST 14, 1979, CONTRARY TO TECH. SPEC. SECTION 3.3.1, THE BORATED WATER STORAGE TANK (BWST) HAD LESS THAN 1800 PPM BORON CONCENTRATION. REACTOR SHUTDOWN WAS COMMENCED SIMULTANEOUSLY WITH ADDITION OF CONCENTRATED BORIC ACID TO THE TANK. UPON ACHIEVING >1800 PPMB, THE SHUTDOWN WAS TERMINATED. PREVIOUS DAYS SAMPLE SHOWED LESS THAN NORMAL, BUT ABOVE TECH SPEC LIMIT. OPERATIONS PERSONNEL RECIRCULATED THE TANK. THIS WAS INEFFECTIVE. WHEN INFORMED OF LESS THAN 1800 PPMB, ADDED CONCENTRATED BORIC ACID TO BRING CONCENTRATION BACK ABOVE THE 1800 PPMB LIMIT.

1543 094

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
RANCHO SECO-1 ONSITE POWER SYSTEM + CONTROL CIRCUIT CLOSERS/INTERRUPTERS CIRCUIT BREAKER PERSONNEL ERROR MAINTENANCE & REPAIR PERSONNEL I-T-E CIRCUIT BREAKER	05000312 79-010/03L-0 026929	082979 091279 30-DAY	DURING ROUTINE PLANT OPERATIONS, IT WAS NOTICED THAT THE BLPB'S FOR THE HSCW PUMP P-482B WERE NOT LIT. AFTER CHANGING LIGHT BULBS WITH NO CHANGE THE BREAKER CUBICLE WAS CHECKED. IT WAS DISCOVERED THAT THE D.C. CONTROL POWER BREAKER WAS IN THE OFF POSITION CONTRARY TO T.S. SECTION 3.3.1.D.1. ONLY ONE NSCW PUMP COULD BE CONSIDERED OPERABLE AT THAT TIME. SINCE BREAKER MAINTENANCE HAD BEEN IN PROGRESS FOR SEVERAL DAYS, IT IS FELT THE BREAKER WAS INADVERTENTLY SHUT OFF WHILE PERFORMING MAINTENANCE ON A BREAKER IN THE SAME CUBICLE. THE D.C. CONTROL POWER WAS RESTORED AND THE UNIT SUCCESSFULLY TESTED PRIOR TO BEING DECLARED OPERABLE.
RANCHO SECO-1 ONSITE POWER SYSTEM + CONTROL CIRCUIT CLOSERS/INTERRUPTERS SWITCH (OTHER THAN SENSOR) PERSONNEL ERROR NONLIC. OPERATIONS PERSONNEL I-T-E CIRCUIT BREAKER	05000312 79-011/03L-0 026928	083079 091379 30-DAY	DURING ROUTINE OPERATION AN OPERATOR OBSERVED THE SPRING CHARGING DISCONNECT SWITCH ON BREAKER 523A14 IN THE OFF POSITION. UPON PLACING THE SWITCH IN THE ON POSITION THE CHARGING MOTOR STARTED AND CHARGED THE SPRING. THIS INDICATED THAT THE SPRINGS WERE UNCHARGED AND UP UNTIL THEN THE BREAKER WOULD HAVE TO BE CONSIDERED INOPERABLE. THE BREAKER SUPPLIES THE RX BLDG. EMERG. COOLER A-500C. INOPERABILITY OF THIS UNIT IS CONTRARY TO T.S. SECTION 3.3.1.C.3. IT IS FELT THAT INADVERTENT REPOSITIONING OF THE DISCONNECT SWITCH WAS THE CAUSE. TO MINIMIZE RECURRENCE, LOG SHEETS HAVE BEEN INITIATED WHICH WILL VERIFY THE SWITCHES IN THE PROPER POSITION ON ALL NUCLEAR SERVICE BUSES ONCE EACH SHIFT.
ROBERT E. GINNA-1 CHEM. VOL CONT + LIQ POISN SYS PIPES, FITTINGS LESS THAN 4 INCHES COMPONENT FAILURE METALLURGICAL ITEM NOT APPLICABLE	05000244 79-008/04L-0 026806	040679 050779 30-DAY	DURING MAINTENANCE ON BORIC ACID, FLOW CONTROL VALVE LEAK WAS NOTED ON VALVE OUTLET 1" NIPPLE. (T.S. 6.9.2.B.(4)) TWO FLOW PATHS FROM BORIC ACID TANKS TO RCS WERE VERIFIED. INTERNAL WELD FLOWTHROUGH DEFECTS AND DEEP EXTERNAL PITTING. THE 1" NIPPLE IS 3 1/2" LONG SCH 10 STAINLESS. IT IS HEAT TRACED, AND NORMAL OPERATING PRESSURE IS 100 PSIG. THE NIPPLE WAS REPLACED WITH A SCH 40 NIPPLE. LATER MAINTENANCE IN THIS SECTION OF PIPING RESULTED IN REPLACEMENT OF NIPPLES, CHECK VALVE & COUPLING FROM FLOW CONTROL VALVE TO THE COUPLING.
ROBERT E. GINNA-1 CHEM. VOL CONT + LIQ POISN SYS PIPES, FITTINGS LESS THAN 4 INCHES COMPONENT FAILURE METALLURGICAL ITEM NOT APPLICABLE	05000244 79-008/03X-1 027007	040679 082179 OTHER	DURING MAINTENANCE ON BORIC ACID FLOW CONTROL VALVE LEAKS WERE NOTED ON VALVE OUTLET 1" NIPPLE. (T.S. 6.9.2.B.(4)) TWO FLOW PATHS FROM BORIC ACID TANKS TO RCS WERE VERIFIED. NIPPLE WAS REPLACED WITH SCH 40 NIPPLE. LATER, NIPPLES, CHECK VALVE AND COUPLING FROM CONTROL VALVE TO COUPLING WERE REPLACED.
			SEVERE EXTERNAL CAUSTIC PITTING PROBABLY STARTED PROCESS CAUSING LEAKS. METALLURGICAL ANALYSIS IDENTIFIED THIS COMBINED WITH THROUGHWALL CHLORIDE STRESS CORROSION CRACKING. 1" NIPPLE IS 3 1/2" LONG SCH 10 SS, HEAT TRACED, NORMAL OPERATING PRESSURE 100 PSIG. OTHER HEAT TRACED PIPING AREAS INVOLVING SIMILAR CONDITIONS EXAMINED; NO PROBLEMS FOUND.

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
SALEM-1 CIRCULATING WATER SYS + CON COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR OTHER ITEM NOT APPLICABLE	05000272 79-023/04L-0 026885	031279 041279 30-DAY	A PROGRAM BEING RUN ON THE PLANT COMPUTER TO CALIBRATE A CONTROL ROOM RECORDER DISRUPTED NORMAL CONDENSER TEMPERATURE INDICATION IN THE CONTROL ROOM. LOCAL TEMPERATURE READINGS WERE NOT MONITORED PER ETS 2.1.1.A, 2.1.1.B, 2.1.2 & 2.1.3. PLANT WAS OPERATING AT 65% POWER WHILE CONDENSER WATER BOXES WERE CLEANED. EVENT LASTED 2 HOURS 32 MINUTES. NO DANGER TO PUBLIC HEALTH AND SAFETY.
SALEM-1 FEEDWATER SYSTEMS + CONTROLS HANGERS,SUPPORTS,SHOCK SUPPRS SNUBBERS COMPONENT FAILURE MECHANICAL PACIFIC SCIENTIFIC CO.	05000272 79-054/01T-0 026978	082479 090779 2-WEEK	COMPUTER OPERATOR DEVELOPING THE CALIBRATION PROCEDURE DID NOT OBSERVE NECESSARY PRECAUTIONS TO INSURE THAT MONITORING REQUIREMENTS WERE MET. CALIBRATION PROCEDURE FOR CONDENSER CIRCULATING WATER TEMPERATURE RECORDER HAS BEEN PROPERLY WRITTEN, REVIEWED AND APPROVED AND WILL INSURE MONITORING CONTINUITY DURING SUCH PROCEDURES. DURING FIRST REFUELING OUTAGE, AS FOLLOW-UP TO NRC INSPECTION 50-311/79-19, THREE SNUBBERS ON NO. 14 MAIN FEEDWATER LINE WERE FOUND TO HAVE FAILED IN PLACE. THESE SNUBBERS WERE INCLUDED IN STRESS CALCULATIONS FOR SEISMIC SAFETY ANALYSIS OF NUCLEAR PORTION OF MAIN FEEDWATER PIPING. PUBLIC SERVICE ENGINEERING DEPARTMENT IS PERFORMING A SAFETY ANALYSIS OF THIS OCCURRENCE WHICH WILL BE SUBMITTED IN A SUPPLEMENTAL REPORT. THIS IS THE FIRST OCCURRENCE OF THIS TYPE. THE THREE FAILED SNUBBERS WERE REPLACED IN KIND. SNUBBERS ON NO. 11, 12 AND 13 MAIN FEEDWATER SYSTEMS WERE CHECKED SATISFACTORY. THE CAUSE OF THE FAILURE IS BEING INVESTIGATED AND WILL BE REPORTED IN A SUPPLEMENTAL REPORT.
SALEM-1 CONTAINMENT ISOLATION SYS + CONT VALVE OPERATORS PNEUMATIC/DIAPHRAGM/CYLINDER OTHER NOT APPLICABLE OTHER	05000272 79-055/01T-0 026993	083079 091379 2-WEEK	IN RESPONSE TO A NRC QUESTION CONCERNING OPERATION OF CONTAINMENT VENTILATION ISOLATION VALVES, A REVIEW OF THE OPERATING CHARACTERISTICS OF VALVES IN THE 10 INCH & 36 INCH CONTAINMENT PENETRATION LINES SHOWED THAT UNDER CERTAIN ACCIDENT CONDITIONS THE VALVE ACTUATORS MAY HAVE INSUFFICIENT TORQUE TO FULLY CLOSE THE VALVES FROM THE FULLY OPEN POSITION. THIS IS THE FIRST OCCURRENCE OF THIS TYPE. THIS OCCURRENCE IS UNDER INVESTIGATION BY THE ENGINEERING DEPARTMENT. WHEN THE EVALUATION IS COMPLETE, THE CAUSE, CORRECTIVE ACTION AND SAFETY ANALYSIS WILL BE SUBMITTED IN A SUPPLEMENTAL REPORT.
SALEM-1 RESIDUAL HEAT REMOV SYS + CONT COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE DESIGN/FABRICATION ERROR DESIGN ITEM NOT APPLICABLE	05000272 79-056/01T-0 026992	083179 091479 2-WEEK	IN RESPONSE TO A NRC QUESTION ON SALEM UNIT 2 REGARDING RHR PUMP NPSH DURING POST LOCA OPERATION, TESTS PERFORMED ON UNIT 2 RHR SYSTEM INDICATED RHR PUMP FLOW EXCEEDED DESIGN RUNOUT FLOW. SINCE UNIT 1 HAS AN IDENTICAL CONFIGURATION AS UNIT 2, THIS UNACCEPTABLE CONDITION EXISTS ON UNIT 1. ENGINEERING DEPARTMENT IS EVALUATING THIS CONDITION & A SUPPLEMENTAL REPORT WILL BE SUBMITTED. THIS IS THE FIRST OCCURRENCE OF THIS TYPE. IT IS EVIDENT BY TEST RESULTS THAT THE RHR SYSTEM FLOW RESISTANCE IS LOW. A DESIGN CHANGE TO INCREASE FLOW RESISTANCE BY RESIZING THE ORIFICES IN THE FLOW ELEMENTS UPSTREAM AND DOWNSTREAM OF THE HEAT EXCHANGER IS IN PREPARATION. ESTIMATED TIME TO COMPLETE THIS CHANGE IS THREE WEEKS.

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
SALEM-1 SYSTEM CODE NOT APPLICABLE HANGERS,SUPPORTS,SHOCK SUPPRSS HANGERS OTHER NOT APPLICABLE OTHER	05000272 79-057/01T-0 026835	090779 092079 2-WEEK	DURING INSPECTION OF PIPE HANGERS ON SEISMIC I SYSTEMS IN ACCORDANCE WITH H NRC BULLETIN 79-14, THREE HANGERS ON THE SI AND CVC SYSTEMS WERE FOUND TO HAVE A BROKEN WELD, BROKEN BOLT AND A BROKEN PIPE GUIDE. FURTHER INVESTIGATION IS PRESENTLY UNDERWAY. THIS IS THE FIRST OCCURRENCE OF THIS TYPE. WORK ORDERS ARE BEING INITIATED BY MAINTENANCE DEPARTMENT TO REPAIR THE DEFECTIVE HANGERS AS THEY ARE IDENTIFIED. RESULTS OF THE INSPECTION, CAUSE AND SAFETY ANALYSIS WILL BE SUBMITTED IN A SUPPLEMENTAL REPORT.
SALEM-1 SYS REQD FOR SAFE SHUTDOWN COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE WESTINGHOUSE ELECTRIC CORP.	05000272 79-058/01T-0 026836	090779 092079 2-WEEK	WESTINGHOUSE HAS NOTIFIED US THAT A REVIEW OF THE ENVIRONMENTAL QUALIFICATION OF NSSS EQUIPMENT HAS IDENTIFIED THAT CONDITIONS ASSOCIATED WITH HIGH ENERGY LINE BREAKS INSIDE OR OUTSIDE CONTAINMENT AND THEIR IMPACT ON NON-SAFETY CONTROL SYSTEMS MAY CONSTITUTE AN UNREVIEWED SAFETY QUESTION THIS IS THE SECOND OCCURRENCE OF THIS TYPE (79-52). PUBLIC SERVICE ENGINEERING DEPARTMENT IS EVALUATING THE SALEM CONTROL SYSTEMS IDENTIFIED BY WESTINGHOUSE. THE RESULTS OF THE INVESTIGATION WILL BE REPORTED AT A LATER DATE.
SALEM-1 DC ONSITE POWER SYS + CONTROLS CIRCUIT CLOSERS/INTERRUPTERS CIRCUIT BREAKER DESIGN/FABRICATION ERROR DESIGN HEINEMANN ELECTRIC CO.	05000272 79-060/03L-0 026969	090779 100579 30-DAY	DURING PERFORMANCE OF 18 MONTH SURVEILLANCE OF SAFEGUARDS SYSTEMS AND RMS CONTAINMENT ISOLATION FUNCTIONAL TEST, SEVERAL SAFEGUARD SYSTEMS COULD NOT BE RESET DUE TO THE 28 VOLT DC CONTROL POWER BREAKERS BEING TRIPPED. PERFORMANCE DEPARTMENT INVESTIGATED THE PROBLEM AND INITIATED CORRECTIVE ACTION. FUNCTIONAL TESTS OF THE SAFEGUARD SYSTEM DURING NORMAL OPERATION HAVE BEEN PERFORMED SATISFACTORILY TO VERIFY SYSTEM OPERABILITY. THIS IS THE FIRST OCCURRENCE OF THIS TYPE. THE CAUSE OF THIS OCCURRENCE WAS THE 28 VOLT DC BREAKER WHICH IS A 1 AMP LOAD BREAKER WHILE POSSIBLE CIRCUIT LOAD IS APPROXIMATELY 2 AMPS. THE BREAKERS ARE BEING REPLACED UNDER DCR 1PD-0153 WITH 2 AMP BREAKERS. THE DCR WILL BE IMPLEMENTED PRIOR TO ENTRY INTO MODE 4.
SALEM-1 SYSTEM CODE NOT APPLICABLE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR CONTRACT. & CONSULT. PERSONNEL ITEM NOT APPLICABLE	05000272 79-061/03L-0 027008	091079 100979 30-DAY	DURING THE Q.A. SURVEILLANCE OF THE AUXILIARY BUILDING, TWO (2) FOUR INCH CONDUITS PENETRATING THE E1. 84 FLOOR WERE FOUND NOT SEALED OR CAPPED AND NO FIRE WATCH WAS POSTED. THE SENIOR SHIFT SUPERVISOR AND THE MAINTENANCE CONTRACTOR WERE NOTIFIED. THE CONDUITS WERE PROPERLY SEALED BY 1 120 HOURS. THE PENETRATIONS HAD BEEN OPEN WITH NO FIRE WATCH FOR APPROXIMATELY 96 HOURS. THIS INCIDENT WAS DUE TO A MISINTERPRETATION OF THE REQUIREMENTS OF MAINTENANCE PROCEDURE M3Y. A MEMORANDUM HAS BEEN ISSUED TO CLARIFY THE PROCEDURE AND ALL SUPERVISORS AND CRAFT FOREMEN, WHO MAY BECOME INVOLVED IN BREAKING FIRE BARRIERS, HAVE BEEN REINSTRUCTED IN THE REQUIREMENTS OF THE FIRE AND FLOOD BARRIER PROCEDURE.

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
SAN ONOFRE-1 SYSTEM CODE NOT APPLICABLE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR OTHER ITEM NOT APPLICABLE	05000206 79-004/04L-0 026813	010979 041979 30-DAY	ANNUAL AUDIT OF THE ENVIRONMENTAL TECHNICAL SPECIFICATIONS DETERMINED THAT ON TWO SEPARATE OCCASIONS 30 DAY WRITTEN REPORTS WERE NOT SUBMITTED PER ETS 5.6.3.B(3) REPORTING THE LOSS OF QUARTERLY BENTHIC SURVEY DATA. DURING THE 1ST AND 2ND QUARTERLY BENTHIC SURVEYS IN 1978, DATA COULD ONLY BE COLLECTED FROM ONE OF ELEVEN AND FIVE OF ELEVEN BENTHIC STATIONS, RESPECTIVELY. NO EFFECT ON THE ENVIRONMENT OR PLANT SAFETY.
SAN ONOFRE-1 SYSTEM CODE NOT APPLICABLE INSTRUMENTATION + CONTROLS RECORDER COMPONENT FAILURE MECHANICAL OTHER	05000206 79-005/04L-0 026814	040279 050179 30-DAY	PERSONNEL RESPONSIBLE FOR IMPLEMENTATION OF ETS FAILED TO REALIZE NECESSITY OF REPORTING OCCURRENCES. THIS EVENT AND REPORTING REQUIREMENTS HAVE BEEN REVIEWED WITH COGNIZANT PERSONNEL STRESSING THE NEED FOR RECOGNIZING REPORTABLE OCCURRENCES.
SAN ONOFRE-1 SYSTEM CODE NOT APPLICABLE INSTRUMENTATION + CONTROLS RECORDER COMPONENT FAILURE MECHANICAL OTHER	05000206 79-005/04L-0 026814	040279 050179 30-DAY	SEA TEMPERATURE DATA FROM THREE SENSORS WERE NOT OBTAINED FOR THE FOLLOWING TIME PERIODS: STATION C25, SURFACE TEMP., 9/28-10/10/78; STATION C22S, SURFACE TEMP., 1/10-2/8/79; STATION C22S, MID-DEPTH TEMP., 2/8-3/12/79. THESE SENSORS PROVIDE TEMPERATURE DATA FOR DEFINING THE DISCHARGE PULSE AS REQUIRED BY ETS 3.1.1A(5). LOSS OF DATA FOR THE ABOVE STATIONS AND TIME PERIODS HAD NO EFFECT ON THE ENVIRONMENT OR PLANT SAFETY.
SAN ONOFRE-1 SYSTEM CODE NOT APPLICABLE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR OTHER ITEM NOT APPLICABLE	05000206 79-012/03L-0 026890	080579 083079 30-DAY	STATION C25 SURFACE TEMP.: DOUBLE FILM IMAGE ON CARTRIDGE PROHIBITED ACCURATE DATA RETRIEVAL. STATION C22S SURFACE TEMP.: JAMMED FILM CARTRIDGE. STATION C22S MID-DEPTH TEMP.: TORN FROM ANCHORAGE. ALL UNITS HAVE BEEN REPAIRED OR REPLACED. DUPLICATE BACKUP SYSTEMS TO IMPROVE RELIABILITY ARE UNDER INVESTIGATION.
SAN ONOFRE-1 AREA MONITORING SYSTEMS COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR RADIATION PROTECTION PERSONNEL ITEM NOT APPLICABLE	05000206 79-011/03L-0 026887	080679 083179 30-DAY	DURING A CIRCULATING WATER SYSTEM HEAT TREATMENT, WITH THE UNIT AT REDUCED LOAD, IT WAS NOTED THAT FISH IMPINGEMENT DATA, WHICH INCLUDES NUMBER, SIZE, WEIGHT, CONDITION AND REPRODUCTIVE STATE OF ALL FISH SPECIES, WAS NOT COLLECTED AS REQUIRED BY ETS 3.1.2 A(2)A. THERE WAS NO EFFECT ON THE ENVIRONMENT OR PLANT SAFETY.
			PERSONNEL RESPONSIBLE FOR THE ACTIVITY WERE NOT NOTIFIED OF THE HEAT TREATMENT NOR WAS THEIR PRESENCE ON SITE VERIFIED. APPROPRIATE PROCEDURES ARE BEING REVISED OR PREPARED, AS APPLICABLE, TO NOTIFY AND VERIFY THAT THE PROPER PERSONNEL ARE PRESENT TO COLLECT THE DATA. THIS SAME INFORMATION HAS BEEN REVIEWED AND STRESSED WITH COGNIZANT PERSONNEL.
			ROUTINE MONTHLY DRINKING WATER SAMPLES FOR TRI-CITIES MUNICIPAL WATER DISTRICT FOR THE MONTH OF MAY, 1979 WAS LOST. LOSS OF DATA HAS NO EFFECT ON THE ENVIRONMENT OR PLANT SAFETY.
			REPLACEMENT OF LOST DATA WAS DUE TO PERSONNEL ERROR IN CONJUNCTION WITH LACK OF ADMINISTRATIVE CONTROLS. APPROPRIATE PROCEDURES HAVE BEEN REVISED AND COGNIZANT PERSONNEL HAVE BEEN MADE AWARE OF THE REQUIREMENTS AND ADMINISTRATIVE CONTROLS HAVE BEEN ESTABLISHED.

1543 098

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
SEQUOYAH-1 EMERG GENERATOR SYS + CONTROLS GENERATORS NO SUBCOMPONENT PROVIDED DESIGN/FABRICATION ERROR CAUSE SUBCODE NOT PROVIDED ELECTRO - MOTIVE DIV. OF G. M.	05000327 79- /02L- 026720	062179 072079 30-DAY	DEFICIENCY OCCURS WHEN A DIESEL GENERATOR IS BROUGHT TO OPERATING TEMPERATURE, SHUTDOWN FOR LESS THAN 3 HRS. THEN RESTARTED. DAMAGE CAN THEN OCCUR TO THE TURBOCHARGER THRUST BEARING. LEADING TO A DIESEL GENERATOR FAILURE. THIS FAILURE COULD REDUCE RELIABILITY AND AVAILABILITY OF EMERGENCY ONSITE POWER SOURCE THAT IS REQUIRED FOR THE PLANT TO ACHIEVE SAFE SHUTDOWN. CAUSE OF THE DEFICIENCY IS THE "SOAKBACK" PUMP, WHICH, DUE TO LUBE OIL VISCOSITY, IS UNABLE TO KEEP THE ACCESSORY LUB. OIL SYSTEM PRIMED. PROCEDURES ARE IN EFFECT TO PREVENT RESTART DAMAGES WHILE MODIFICATIONS TO THE PUMP ARE BEING PLANNED.
ST. LUCIE-1 REACTOR TRIP SYSTEMS INSTRUMENTATION + CONTROLS POWER SUPPLY COMPONENT FAILURE ELECTRICAL LAMBDA ELECTRONICS	05000335 79-026/03L-0 026867	080179 083179 30-DAY	WHILE PERFORMING A NORMAL MONTHLY FUNCTIONAL TEST IN ACCORDANCE WITH I&C PROCEDURE 1400050, THE MINUS 18 VOLT POWER SUPPLY PS-1 IN CHANNEL A RPS CPC-2 (CORE PROTECTION CALCULATOR) WAS FOUND TO BE AT APPROXIMATELY MINUS 13 VOLTS. ACTION IN ACCORDANCE WITH T.S. 3.3.1.1 WAS INITIATED, & POWER SUPPLY WAS REPLACED. CPC CHANNEL WAS RESTORED TO OPERABLE STATUS WITH IN TIME LIMIT SPECIFIED. NO ADVERSE EFFECTS RESULTED FROM THIS OCCURRENCE. SPECIFIC ROOT CAUSE OF POWER SUPPLY FAILURE IS NOT KNOWN. IT IS MOST LIKELY THAT A NORMAL END OF LIFE FAILURE OF AN ELECTRONIC COMPONENT WAS THE CAUSE. A NEW POWER SUPPLY WAS INSTALLED. NO ADDITIONAL ACTION IS REQUIRED. THIS WAS THE SECOND OCCURRENCE OF A FAILED POWER SUPPLY IN THE CPC. (REFER TO LER 335-79-25).
SURRY-1 SYSTEM CODE NOT APPLICABLE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000280 79-026/01T-0 026844	082979 091379 2-WEEK	WITH BOTH UNITS AT COLD SHUTDOWN, WESTINGHOUSE NOTIFIED VEPCO THAT A GENERIC REVIEW INDICATES THE POSSIBILITY THAT CERTAIN BALANCE OF PLANT EQUIPMENT, WHEN SUBJECTED TO AN ADVERSE ENVIRONMENT, COULD LEAD TO CONTROL SYSTEM OPERATIONS WHICH MAY IMPACT PROTECTIVE FUNCTIONS. A REVIEW HAS BEEN INITIATED AND RESULTS WILL FOLLOW IN A SUPPLEMENTARY REPORT.
THREE MILE ISLAND-2 POTABLE + SAN WATER SYS + CONT COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR NONLIC. OPERATIONS PERSONNEL ITEM NOT APPLICABLE	05000320 79-001/04T-0 026811	030779 031579 2-WEEK	ON 3/7/79 A SAMPLE TAKEN FROM THE INDUSTRIAL WASTE FILTER SYSTEM (IWFS) DISCHARGE YIELDED AN OIL AND GREASE CONC. OF 153 MG/LITER, EXCEEDING THE ETS LIMIT OF 20 MG/L. APPROXIMATELY 5,000 GALLONS WERE DISCHARGED. DUE TO RELATIVELY SMALL AMOUNT OF FLOW, TOTAL AMOUNT OF OIL AND GREASE RELEASED WILL NOT HAVE A SIGNIFICANT ADVERSE IMPACT. OPERATOR LEFT SLUDGE FROTH TANK DRAIN VALVES OPEN, ALLOWING OIL AND GREASE FROM IWTS TO DRAIN TO IWFS WITH THE SLUDGE. DRAIN VALVE OPERATION WILL BE RE-EMPHASIZED TO OPERATORS. AUTOMATIC DRAIN VALVES WILL BE INSTALLED.

0-1 2421

1543 099

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
TROJAN-1 CNTNMNT AIR PURI + CLEANUP SYS HANGERS,SUPPORTS,SHOCK SUPPRSS SUPPORTS OTHER NOT APPLICABLE BERGEN-PATTERSON PIPE SUPPORT	05000344 79-013/03L-0 026889	080779 090679 30-DAY	DURING AN INSPECTION OF THE PLANT, A SEISMIC RESTRAINT ON THE CONTAINMENT SPRAY SUCTION PIPING WAS FOUND TO BE NONFUNCTIONAL WHICH COULD HAVE RESULTED IN FAILURE OF THAT SECTION OF LINE.
VERMONT YANKEE-1 REACTOR CORE FUEL ELEMENTS SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000271 79-018/03L-0 026788	080279 083079 30-DAY	THE BASE PLATE OF THE PEDESTAL SUPPORT SLID OFF THE GRAPHITE PLATE AND CRACKED THE GRAPHITE PLATE. THE SUPPORT HAS BEEN REDESIGNED, REPAIRED, AND RETURNED TO SERVICE. AN ADJACENT SUPPORT WAS ALSO REDESIGNED AND REPAIRED. MCPR WAS BELOW TECH SPEC LIMITS ON TWO OCCASIONS. SIMILAR OCCURRENCES WERE REPORTED AS RO 78-17 AND RO 78-28.
VERMONT YANKEE-1 EMERG CORE COOLING SYS + CONT HANGERS,SUPPORTS,SHOCK SUPPRSS SUPPORTS COMPONENT FAILURE MECHANICAL ITT GRINNELL	05000271 79-015/03L-0 026789	080279 083079 30-DAY	ATTRIBUTED TO XENON TRANSIENT. BOTH EVENTS FOLLOWED POWER CHANGES. IN BOTH CASES ACTION WAS TAKEN TO INCREASE MCPR BY INSERTING CONTROL RODS AND/OR INCREASING CORE FLOW. ANCHOR BOLTS ASSOCIATED WITH SEISMIC HANGER MS-H-A10 WERE FOUND PULLED FROM THE WALL. THIS HANGER IS ON THE HPCI TURBINE STEAM LINE. TECH. SPEC. 3.6.I.1 REQUIRES ALL SAFETY RELATED SNUBBERS TO BE OPERABLE AT POWER.
VERMONT YANKEE-1 SYSTEM CODE NOT APPLICABLE RELAYS SWGEAR, PROTECT., SLOW ACTING PERSONNEL ERROR RADIATION PROTECTION PERSONNEL ITEM NOT APPLICABLE	05000271 79-019/03L-0 026787	080679 090579 30-DAY	HANGER WAS REPAIRED WITHIN 72 HOURS AS ALLOWED BY TECH. SPEC. 3.6.I.2. A REVIEW OF SEISMIC CLASS I SYSTEMS IS UNDERWAY AND ANY APPROPRIATE MODS TO THIS HANGER WILL BE MADE FOLLOWING THIS REVIEW. NO AIR PARTICULATE AND RADIOIODINE SAMPLES WERE COLLECTED AT THE HINSDALE SUBSTATION FROM JULY 30 TO AUGUST 6 BECAUSE THE SAMPLING PUMP WAS OFF. T.S. TABLE 3.9.1 REQUIRES CONTINUOUS AIR SAMPLING. PREVIOUS EVENTS INVOLVING MISSED ENVIRONMENTAL SURVEILLANCE WERE REPORTED AS LERS 76-39, 78-18, AND 78-1.
			A TECHNICIAN DID NOT SWITCH THE AIR SAMPLING PUMP ON FOLLOWING A SERVICE VISIT TO THE STATION. THE TECHNICIAN HAS BEEN REINSTRUCTED.

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
VERMONT YANKEE-1 MAIN STEAM ISOL SYS + CONTROLS VALVE OPERATORS PNEUMATIC/DIAPHRAGM/CYLINDER COMPONENT FAILURE MECHANICAL ROCKWELL-INTERNATIONAL	05000271 79-020/03L-0 026868	081579 091379 30-DAY	DURING ROUTINE SURVEILLANCE TESTING, INBOARD MSIV V2-80A WOULD NOT COME FULL OPEN FOLLOWING CLOSURE. MAIN STEAM FLOW AND VALVE POSITION LIGHTS GAVE CONFLICTING INFORMATION ON VALVE STATUS WHEN THE VALVE WAS AGAIN CLOSED. SIMILAR EVENT REPORTED IN LER 79-11/3L.
VERMONT YANKEE-1 ENGRD SAFETY FEATR INSTR SYS INSTRUMENTATION + CONTROLS TRANSMITTER OTHER NOT APPLICABLE ROBERTSHAW CONTROLS CO.	05000271 79-021/03L-0 026959	081679 091779 30-DAY	DURING SURVEILLANCE TESTING FOUND BOTH TORUS LEVEL TRANSMITTERS HAD UNDERGONE A ZERO SHIFT AND WERE INDICATING TORUS LEVEL HIGHER THAN ACTUAL. ACTUAL LEVEL WAS BELOW TECH. SPEC. MINIMUM.
VERMONT YANKEE-1 ENGINTEER ISOLATION SYS + CONTROLS VALVES GLOBE COMPONENT FAILURE MECHANICAL MASONERILAN INTERNATIONAL, INC.	05000029 79-020/03L-0 026770	081379 091279 30-DAY	DURING TESTING, WHILE PERFORMING LEAK RATE SURVEILLANCE ON VD-TV-202, LEAKAGE PAST THE UPSTREAM ISOLATION VALVES RESULTED IN ABANDONMENT OF THE TESTING. IT HAS BEEN MORE THAN 24 MONTHS SINCE A LEAK TEST HAS BEEN COMPLETED ON THE VALVE AS REQUIRED BY T.S. 4.6.1.2.D. THIS IS THE FIRST EVENT OF THIS NATURE ASSOCIATED WITH THIS TEST. THIS EVENT DID NOT AFFECT THE ABILITY OF THE TRIP VALVE TO PERFORM ITS INTENDED FUNCTION, THEREFORE, NO ADVERSE EFFECT UPON THE PUBLIC HEALTH OR SAFETY RESULTED. ROOT CAUSE OF THIS EVENT IS LEAKAGE BY THE SEAT OF ONE OR MORE OF THE UPSTREAM ISOLATION VALVES. THE TRIP VALVE WILL BE TESTED DURING A SHUTDOWN SCHEDULED FOR 9/8/79 WHEN THE PRESSURE ACROSS THE ISOLATION VALVES IS LOWER. FUTURE LEAK TESTING WILL BE SCHEDULED FOR REFUELING OUTAGES WHICH IS WELL WITHIN THE 24 MONTH TIME INTERVALS REQUIRED BY T.S.
VERMONT YANKEE-1 FEEDWATER SYSTEMS + CONTROLS HEAT EXCHANGERS STEAM GENERATOR OTHER NOT APPLICABLE WESTINGHOUSE ELECTRIC CORP.	05000029 79-022/03L-0 026998	090879 100879 30-DAY	DURING A SCHEDULED SHUTDOWN, WHILE PERFORMING SECONDARY PLANT CHEMISTRY, STEAM GENERATORS' 3 & 4 CHLORIDE CONCENTRATION WAS > 0.5 PPM. TECH. SPEC. SECTION 3.7.1.6, LIMITS CHLORIDE CONCENTRATION TO <= 0.5 PPM DURING MODES 1-3. SIMILAR OCCURRENCES WERE REPORTED AS LER 79-7, 3, 78-36, 27, 24, 20, 77-22, 18, 17, AND 13. SECONDARY WATER CHEMISTRY REMAINED OPTIMUM FOR INHIBITION OF CHLORIDE REDUCED STRESS CORROSION, THUS THERE WAS NO ADVERSE EFFECTS TO THE HEALTH OR SAFETY OF THE PUBLIC. THE ROOT CAUSE OF THIS EVENT IS STEAM GENERATOR'S CHEMICAL HIDEOUT. STEAM GENERATOR BLOWDOWN RATE WAS INCREASED AND THE STEAM GENERATORS DRAINED AND REFILLED WHICH INDUCED THE CHLORIDE CONCENTRATION TO < 0.5 PPM. IN THAT THIS IS A NORMAL PLANT CHARACTERISTIC NO FURTHER ACTIONS ARE PLANNED AT THIS TIME.

1543
101

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
ZION-1 SYSTEM CODE NOT APPLICABLE COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE ITEM NOT APPLICABLE	05000295 79-017/04T-0 026798	031479 032279 2-WEEK	ESTIMATED BORON USAGE LISTED IN APPENDIX B, TABLE B.4 OF THE ZION TECHNICAL SPECIFICATION IS 1000 LBS/YEAR. THIS AMOUNT WAS EXCEEDED BETWEEN MARCH 10 AND MARCH 14, 1979. DURING THIS PERIOD, 2100 LBS OF BORIC ACID WERE USED. PREVIOUS LER: 50-295/78-76.
			BORIC ACID USAGE IS DUE TO DRUMMED RADIOACTIVE WASTE CONSISTING OF BORATED WATER. THE BORIC ACID USAGE HAS NO BEARING ON PURPOSE OR INTENT OF THE WATER QUALITY PROGRAM IN APPENDIX B OF THE TECHNICAL SPECIFICATIONS.
ZION-1 EMERG CORE COOLING SYS + CONT COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE PERSONNEL ERROR LICENSED & SENIOR OPERATORS ITEM NOT APPLICABLE	05000295 79-042/99X-0 026756	052379 082079 OTHER	AT 1323 HRS. ON 5/23/79, WHILE PERFORMING SAFEGUARDS LOGIC TESTING AT 98% POWER, AN INADVERTANT RX. TRIP AND SAFETY INJECTION WAS INITIATED ON UNIT 1. TECH. SPEC. 3.3.2.F.3 REQUIRES A 90 DAY REPORT. VISUAL INSPECTIONS INDICATED THAT NO DAMAGE OCCURRED AS A RESULT OF THE SAFETY INJECTION. THE HEALTH AND SAFETY OF THE PUBLIC WERE NOT AFFECTED.
			AN OPERATOR ERROR IN TESTING TRAIN "A" SAFEGUARDS LOGIC CIRCUITS SIMULATED HIGH STEAM FLOW SIGNALS CONCURRENT WITH LOW STEAM PRESSURE. THIS COINCIDENCE INITIATED MAIN STEAM ISOLATION. WHEN 1B MAIN STEAM ISOL. VLV. FAILED TO CLOSE, STEAMLINE DIFF PRESSURE REACHED 100PSID AND SI INITIATED. OPERATOR WAS REINSTRUCTED.
ZION-1 REACTOR TRIP SYSTEMS INSTRUMENTATION + CONTROLS TRANSMITTER COMPONENT FAILURE INSTRUMENT FISCHER & PORTER CO.	05000295 79-053/03L-0 026755	071379 081079 30-DAY	WHILE PERFORMING MAINTENANCE ACTIVITIES, INSTRUMENT MECHANICS DISCOVERED THAT 1L-518 HAD DRIFTED HIGH BY 2.6% (2% IS OVERALL LOOP TOLERANCE). THIS IS NON-CONSERVATIVE FOR LO-LO S/G LEVEL AND STEAM/FEED FLOW MISMATCH COINCIDENT WITH LOW S/G LEVEL RX TRIPS (T.S. 3.1-1.17 AND 18). AS REDUNDANT PROTECTION WAS AVAILABLE, THE HEALTH AND SAFETY OF THE PUBLIC WERE NOT AFFECTED. FISCHER-PORTER TRANSMITTERS HAVE HAD A LONG HISTORY OF DRIFTING.
			CAUSE WAS INSTRUMENT DRIFT. MECHANICS ADJUSTED TRANSMITTER ZERO. MISALIGNMENT OF OSCILLATOR-AMPLIFIER HAS BEEN IDENTIFIED AS A CAUSE OF ZERO SHIFT, AND MECHANICS ARE BEING TRAINED HOW TO QUICKLY IDENTIFY IF THIS SITUATION EXISTS. T.S. CHANGE TO GIVE 1.5% TRANS. AND 3% LOOP TOL. WILL BE SUBMITTED.
ZION-1 REACTOR VES. + APPURTENANCES INSTRUMENTATION + CONTROLS SWITCH DESIGN/FABRICATION ERROR DESIGN NAMCO CONTROLS	05000295 79-056/01T-0 026753	080179 082079 2-WEEK	WHILE REVIEWING I&E BULLETIN 79-01, IT WAS DISCOVERED THAT THE REACTOR COOLANT ISOLATION VALVES HAVE D2400X LIMIT SWITCHES, USED IN TRAIN B REACTOR PROTECTION CIRCUITS. THESE SWITCHES IF FAILED WOULD BE BACKED UP BY TRAIN A INTERNAL GEAR DRIVEN LIMIT SWITCHES. THEREFORE THE HEALTH AND SAFETY OF THE PUBLIC WAS NOT AFFECTED.
			NAMCO D2400X LIMIT SWITCHES ARE NOT SUITABLE FOR POST LOCA ENVIRONMENT. THEY WILL BE REPLACED WITH QUALIFIED EA180-14302 AND EA180-15302 LIMIT SWITCHES DURING NEXT OUTAGES ON BOTH UNITS.

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
ZION-1 REACTOR TRIP SYSTEMS INSTRUMENTATION + CONTROLS TRANSMITTER COMPONENT FAILURE INSTRUMENT FISCHER & PORTER CO.	05000295 79-055/03L-0 026754	080579 033079 30-DAY	DURING NORMAL OPERATION, OPERATORS NOTICED THAT STEAM FLOW 1FI-523 READ 200K LB/HR LOWER THAN THE OTHER CHANNEL. (LIMIT 189K LB/HR) THIS IS NO N-CONSERVATIVE FOR STEAM/FEED FLOW MISMATCH COINCIDENT WITH LOW S/G LEVEL (REF. TS TABLE 3.1-1.17). AS THE ALTERNATE INSTRUMENTS WERE OPERABLE, THE HEALTH AND SAFETY OF THE PUBLIC WAS NOT AFFECTED. BISTABLES WERE TRIPPED PER AOP-9.
ZION-1 ONSITE POWER SYSTEM + CONTROL GENERATORS INVERTER COMPONENT FAILURE ELECTRICAL WESTINGHOUSE ELECTRIC CORP.	05000295 79-057/03L-0 026916	081179 090679 30-DAY	MECHANICS DISCOVERED THAT FISCHER-PORTER MODEL 10B2491 S/N 6904A4335A36 HAD DRIFTED. A 2% ZERO ADJUSTMENT WAS MADE. MECHANICS ARE BEING TRAINED IN AN IMPROVED CALIBRATION TECHNIQUE ON THESE TRANSMITTERS WHICH WILL REDUCE THE RATE OF ZERO DRIFT. DURING NORMAL OPERATION, INSTRUMENT INVERTER 114 FAILED AT 0615 HOURS. DG "0" WAS OOS FOR MAINTENANCE. AN IMMEDIATE PROCESSION TO HOT SHUTDOWN WAS STARTED AS REQUIRED BY T.S. 3.15.2.H. REDUNDANT COMPONENTS WERE AVAILABLE TO PERFORM ANY REQUIRED SAFETY FUNCTIONS SO THE HEALTH AND SAFETY WERE NOT AFFECTED. (REF LER #50-295-79-4)
ZION-1 REACTOR TRIP SYSTEMS INSTRUMENTATION + CONTROLS OTHER COMPONENT FAILURE OTHER FISCHER & PORTER CO.	05000295 79-058/03L-0 026752	081379 083079 30-DAY	THE 5KVA TRANSFORMER IN THE MASTER UNIT OF THE INVERTER CAT#23-25-250 WAS FOUND DEFECTIVE AND WAS REPLACED WITHIN 4 HOURS SO THERE WAS NO NEED TO GO TO HOT SHUTDOWN. DUE TO LOW FREQUENCY OF OCCURRENCE NO FURTHER ACTION IS CONSIDERED NECESSARY. DURING A 50% POWER INCREASE, OPERATORS OBSERVED FEEDWATER FLOW 1FI-520 READ 190K LB/HR HIGHER THAN THE OTHER CHANNEL (LIMIT IS 189K LB/HR). AFTER THE RAMP TO 100% POWER, CHANNEL WAS IN TOLERANCE, SO BISTABLES WERE RESET. REDUNDANT PROTECTION WAS AVAILABLE, SO THE PUBLIC'S HEALTH AND SAFETY WERE NOT AFFECTED. REF. T.S. 3.1-1.17 STEAM/FEEDFLOW MISMATCH WITH LOW S/G LEVEL. BISTABLES WERE TRIPPED PER AOP-9.
ZION-1 CONTNMT ISOLATION SYS + CONT VALVES PLUG PERSONNEL ERROR LICENSED & SENIOR OPERATORS MASONEILAN INTERNATIONAL, INC.	05000295 79-063/03L-0 026751	081679 083079 30-DAY	THE TRANS. SIGNAL GOES TO A SQUARE ROOT EXTRACTOR WHICH MAGNIFIES ANY TRANS. ERROR BELOW 50% FULL FLOW RANGE. MECHANICS ADJUSTED TRANS. ZERO 0.8% AT 100% POWER. IMPROVED TRANS. CALIBRATION TECHNIQUE SHOULD REDUCE THE RATE OF DRIFT. T.S. CHANGES WILL BE SUBMITTED TO INCREASE ALLOWABLE TRANS. DRIFT FROM .5 TO 1.5%. ON 8/15/79 AT 1900 HRS WHILE PERFORMING SAFEGUARD TEST PT-10A, CONTAINMENT ISOL. VLV: 1A0V-PR21B, FAILED TO CLOSE. REDUNDANT VLV PR-21A, WAS OPERABLE BUT WAS NOT IMMEDIATELY SECURED IN CLOSED POSITION (VIOLATING CONT. INTEGRITY TECH. SPEC. 3.9.5). VALVE WAS SECURED 12 HOURS LATER BY NEXT SHIFT. PUBLIC HEALTH AND SAFETY WAS NOT AFFECTED. FAILURE TO PROMPTLY SECURE 1FCV-PR21A IN THE CLOSED POSITION WAS DUE TO PERSONNEL ERROR. OPERATORS HAVE BEEN INSTRUCTED TO TAKE PROMPT ACTION AND PROVIDE CLEAR NOTIFICATION OF FAILURES TO SHIFT SUPERVISOR. 1FCV-PR21A WAS SECURED BY NEXT SHIFT AND TAKEN OUT OF SERVICE. 1FCV-PR21B FAILURE IS UNDER INVESTIGATION.

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
ZION-1 REACTOR TRIP SYSTEMS INSTRUMENTATION + CONTROLS TRANSMITTER COMPONENT FAILURE INSTRUMENT FISCHER & PORTER CO.	05000295 79-065/03L-0 027010	083179 092879 30-DAY	FOLLOWING UNIT TRIP, OPERATOR FOUND S/G LEVEL CHANNEL 1L-538 INDICATING HIGHER THAN NORMAL. CHANNEL WAS DECLARED INOPERABLE, PUTTING THE PLANT IN A MODE OF OPERATING AT AN LCO PERMITTED BY T.S. TABLE 3.1-1. REDUNDANT EQUIPMENT WAS OPERABLE AND AVAILABLE, AND THE HEALTH AND SAFETY OF THE PUBLIC WERE NOT AFFECTED.
			THE XMTR WAS MECHANICALLY STICKING. MAINTENANCE ADJUSTED TO ZERO. XMTR WILL BE MECHANICALLY REALIGNED AT UNIT REFUELING OUTAGE. NO FURTHER ACTION REQUIRED.
ZION-2 EMERG CORE COOLING SYS + CONT VALVES GATE COMPONENT FAILURE MECHANICAL DARLING VALVE & MFTG. CO.	05000304 79-038/03L-0 026750	071879 081479 30-DAY	WHILE PERFORMING PERIODIC TESTING, RECIRC. SUMP TO RHR PUMP SUCTION VALVE 2MOV-SI3811A FAILED TO STROKE OPEN. THIS WOULD HAVE RESULTED IN THE VALVE BEING IN THE WRONG POSITION FOR THE RECIRCULATION PHASE OF LOCA. (T.S. 3.8.3.B). HOWEVER, THE VALVE FOR THE OTHER TRAIN WAS OPERABLE AND AVAILABLE, SO THE HEALTH AND SAFETY OF THE PUBLIC WAS NOT AFFECTED.
			VALVE 8811A FAILED TO STROKE DUE TO FAILURE OF STEM MOUNTED LIMIT SWITCH INTERLOCK CONTACT ON VALVE 2MOV-RH8700A TO MAKE UP. LIMIT SWITCH FAILED DUE TO LOOSE STEM NUT. VALVE IS A 14 INCH SS DARLING VALVE MODEL D323 3A. A SECOND LOCKNUT AND LOCKWASHER WILL BE INSTALLED ON THESE VALVE STEMS, ON BOTH ZION UNITS. NO FURTHER ACTION IS CONSIDERED NECESSARY.
ZION-2 PRCS + EFF RADIOL MONITOR SYS COMPONENT CODE NOT APPLICABLE SUBCOMPONENT NOT APPLICABLE DEFECTIVE PROCEDURES NOT APPLICABLE ITEM NOT APPLICABLE	05000304 79-039/03L-0 026749	072379 082379 30-DAY	DURING NORMAL OPERATIONS, THE UNIT 2 CONT. PURGE PARTICULATE MONITOR, 2R T-PRO9C WAS TAKEN OOS FOR REPAIR. DURING THE TWO DAYS THE MONITOR WAS OOS, THE UNIT 2 CONT. WAS VENTED ONCE. THIS IS A TECH SPEC VIOLATION AS INDICATED PER TECH SPEC 3.12.1C.1. THERE WAS NO UNPLANNED RELEASE OF RADIOACTIVITY BECAUSE GRAB SAMPLES OF THE CONT. ATMOSPHERE WERE ANALYZED BEFORE THE RELEASE. HOWEVER, THE OOS MONITOR WAS ABLE TO BE USED TO QUANTIFY THE RELEASE PATH. THE HEALTH & SAFETY OF PUBLIC WAS NOT AFFECTED. THIS EVENT OCCURRED BECAUSE THE OPERATING PROCEDURE USED FOR VENTING THE CONT. DID NOT INDICATE WHAT MONITORS MUST BE OPERABLE. THIS PROCEDURE HAS BEEN REVISED TO INCLUDE THE MONITORS. ALSO, THE CHEMISTRY PROCEDURE FOR VENTING HAS BEEN CHANGED TO REFERENCE THE APPLICABLE VENTING PROCEDURE. NO FURTHER ACTION IS REQUIRED.
ZION-2 REACTOR TRIP SYSTEMS INSTRUMENTATION + CONTROLS TRANSMITTER COMPONENT FAILURE INSTRUMENT BARTON INSTRU CO., DIV OF ITT	05000304 79-044/03L-0 026745	080379 090479 30-DAY	DURING NORMAL OPERATION, PZR LEVEL CHANNEL 2L-459 WAS INDICATING LOWER THAN THE OTHER LEVEL CHANNELS. THIS PUT THE PLANT IN A MODE OPERATING AT AN LCO AS DEFINED IN T.S. TABLE 3.1-1. REDUNDANT EQUIPMENT WAS OPERABLE AND AVAILABLE, SO NO SAFETY IMPLICATIONS WERE INVOLVED. THE HEALTH AND SAFETY OF THE PUBLIC WAS NOT AFFECTED. PREVIOUS LER: 50-295/79-29.
			CAUSE OF THE CHANNEL OUT OF TOLERANCE WAS CAUSED BY XMTR ZERO SHIFT. THE TRANSMITTER ZERO WAS ADJUSTED AND THE CHANNEL RETURNED TO SERVICE. ACTION TO CORRECT THE PRESSURIZER LEVEL CHANNELS WAS IDENTIFIED IN THE REFERENCED LER. NO FURTHER ACTION IS REQUIRED.

1543 104

FACILITY/SYSTEM/COMPONENT/ COMPONENT SUBCODE/CAUSE CODE/ CAUSE SUBCODE/MANUFACTURER	DOCKET NO./ LER NO./ CONTROL NO.	EVENT DATE/ REPORT DATE/ REPORT TYPE	EVENT DESCRIPTION/ CAUSE DESCRIPTION
ZION-2 CNTNMNT ISOLATION SYS + CONT VALVES GLOBE COMPONENT FAILURE MECHANICAL MASONIELAN INTERNATIONAL, INC.	05000304 79-042/03L-0 026747	080579 083179 30-DAY	DURING MONTHLY CONTAINMENT ISOLATION VALVE OPERABILITY TEST (TT-300), 2A 0V-SS9354B FAILED TO CLOSE FROM CONTROL ROOM SWITCH. VALVE WOULD CLOSE WITH MANUAL ASSISTANCE. THIS PLACED CONTAINMENT ISOLATION SYSTEM IN A DEGRADED MODE (T.S. 3.9.3.A). THERE WERE NO PREVIOUS SIMILAR FAILURES. THE HEALTH AND SAFETY OF THE PUBLIC WERE NOT AFFECTED BECAUSE THE REDUNDANT ISOLATION VALVE WAS OPERABLE AND CLOSED AS REQUIRED. THE MANUAL DOWNS TREATMENT ISOLATION VALVE WAS ALSO CLOSED. CAUSE OF FAILURE WAS STICKING VALVE STEM. THE VALVE WAS CLOSED WITH MANUAL ASSISTANCE IMMEDIATELY AFTER THE FAILURE. LATER, THE VALVE STEM WAS CLEANED, LUBRICATED, AND THE PACKING WAS ADJUSTED. THE VALVE THEN STROKED SUCCESSFULLY AND WAS PROVEN OPERABLE. NO FURTHER CORRECTIVE ACTION IS REQUIRED DUE TO THE LOW FREQUENCY OF OCCURRENCE.
ZION-2 EMERG GENERATOR SYS + CONTROLS ENGINES, INTERNAL COMBUSTION SUBCOMPONENT NOT APPLICABLE OTHER NOT APPLICABLE COOPER PENJAX	05000304 79-043/03L-0 026746	080679 083079 30-DAY	WHILE ATTEMPTING DIESEL GENERATOR LOADING TEST (PT-11) ON 2B DG, ENGINE FAILED TO STAY RUNNING. THIS FAILURE CONSTITUTED A CONDITION OF OPERATION IN A DEGRADED MODE PERMITTED BY A LIMITING CONDITION FOR OPERATION. (TECH. SPEC. 3.15.2.C). THE HEALTH AND SAFETY OF THE PUBLIC WERE NOT AFFECTED BECAUSE REDUNDANT EQUIPMENT WAS VERIFIED OPERABLE BY REQUIRED TESTING.
ZION-2 REACTOR TRIP SYSTEMS INSTRUMENTATION + CONTROLS POWER SUPPLY COMPONENT FAILURE ELECTRICAL HAGAN CONTROLS	05000304 79-041/03L-0 026748	080679 083079 30-DAY	ACTUAL CAUSE UNKNOWN. PROBABLE CAUSE OVERSPEED TRIP. PREVIOUS LOW OIL LEVEL IN GOVERNOR COULD HAVE INTRODUCED AIR INTO COMPENSATING PISTON, ALLOWING DG TO OVERSPEED ON START. GOVERNOR EXERCISED TO BLEED AIR FROM PISTON AND DG DEMONSTRATED OPERABLE. PROCEDURE CHANGED TO CHECK GOVERNOR OIL LEVEL DAILY. NO FURTHER CORRECTIVE ACTION WARRANTED. OPERATORS DISCOVERED THAT S/G LEVEL 2LI-538 READ OVER 4% HIGHER (2% PER CHANNEL LIMIT) THAN OTHER CHANNELS. THIS IS NON-CONSERVATIVE FOR LOW-LOAD S/G TRIP AND LOW S/G COINCIDENT WITH STEAM/FEED FLOW (REF TS TABLE 3.1-1.17 AND 18). BISTABLES WERE TRIPPED PER AOP-9. AS REDUNDANT PROTECTION WAS AVAILABLE AND OPERATIONAL, THE HEALTH AND SAFETY OF THE PUBLIC WERE NOT AFFECTED.
			MECHANICS DISCOVERED THAT HAGAN POWER SUPPLY MODEL 4111085-G01 S.N. M0584 DRIFTED FROM 46V TO 49V; EXCEEDING THE TRANSMITTER MANUFACTURER'S RECOMMENDATIONS. THE POWER SUPPLY WAS REPLACED AND THE LOOP RETURNED TO NORMAL. SINCE THIS IS NOT A RECURRING PROBLEM, NO FURTHER ACTION IS PLANNED.

1543 105

UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D. C. 20555

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE, \$300

POSTAGE AND FEES PAID
U.S. NUCLEAR REGULATORY
COMMISSION



*Document Center
POLL*

~~120555031837 2 NJ
US NRC
SECY PUBLIC DOCUMENT ROOM
BRANCH CHIEF
HST LOBBY
WASHINGTON DC 20555~~

1543 1n6