

LICENSEE EVENT REPORT

CONTROL BLOCK: [][][][][][][][] (1)

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

[0][1] | C | T | M | N | S | I | [2] | 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | - | 0 | 0 | [3] | 4 | 1 | 1 | 1 | 1 | 1 | [4] | [][] | [5]

CON'T
[0][1] | REPORT SOURCE [L][6] | 0 | 5 | 0 | 0 | 0 | 2 | 4 | 5 | [7] | 0 | 6 | 1 | 0 | 2 | 7 | 9 | [8] | 0 | 6 | 1 | 2 | 8 | 7 | 9 | [9]

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)
[0][2] | On June 2, 1979, at 1600 hours, while performing routine surveillance (Steam
[0][3] | Tunnel High Temperature Functional and Calibration) on the steam tunnel tempera-
[0][4] | ture switches, it was found that one of the temperature switches tripped at a
[0][5] | setpoint higher than that specified in Technical Specifications. The other
[0][6] | switches would have initiated the isolation logic.
[0][7] |
[0][8] |

[0][9] | SYSTEM CODE [C][C][11] | CAUSE CODE [E][12] | CAUSE SUBCODE [E][13] | COMPONENT CODE [I][N][S][T][R][U][14] | COMP. SUBCODE [S][15] | VALVE SUBCODE [Z][16]

[17] | LFR/RO REPORT NUMBER [7][9] | EVENT YEAR [7][9] | SEQUENTIAL REPORT NO. [] | OCCURRENCE CODE [0][3] | REPORT TYPE [L] | REVISION NO. [0]

ACTION TAKEN [E][18] | FUTURE ACTION [Z][19] | EFFECT ON PLANT [Z][20] | SHUTDOWN METHOD [Z][21] | HOURS [0][0][0][0] | ATTACHMENT SUBMITTED [Y][23] | NRRD-4 FORM SUB. [Y][24] | PRIME COMP. SUPPLIER [N][25] | COMPONENT MANUFACTURER [F][0][8][0][26]

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)
[1][0] | The failure of the switch to trip at the proper setpoint was attributed to setpoint
[1][1] | drift. The switch was adjusted and tested satisfactorily.
[1][2] |
[1][3] |
[1][4] |

[1][5] | FACILITY STATUS [H][28] | % POWER [0][0][0][29] | OTHER STATUS [NA][30] | METHOD OF DISCOVERY [B][31] | DISCOVERY DESCRIPTION [Routine Surveillance][32]

[1][6] | ACTIVITY RELEASED OF RELEASE [Z][33] | CONTENT [Z][34] | AMOUNT OF ACTIVITY [NA][35] | LOCATION OF RELEASE [NA][36]

[1][7] | PERSONNEL EXPOSURES NUMBER [0][0][0][37] | TYPE [Z][38] | DESCRIPTION [NA][39]

[1][8] | PERSONNEL INJURIES NUMBER [0][0][0][40] | DESCRIPTION [NA][41]

[1][9] | LOSS OF OR DAMAGE TO FACILITY TYPE [Z][42] | DESCRIPTION [NA][43]

[2][0] | PUBLICITY ISSUED [Z][44] | DESCRIPTION [NA][45]

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Failure of the subject switch to trip, at the desired setpoint, did not impair the system's ability to perform its intended function as the remaining switches were tripping at the desired setpoint and would have initiated the isolation closure.

CORRECTIVE ACTION

The subject switch was adjusted and tested satisfactorily.

The switch that failed to operate at the required setpoint was a Fenwal Model Number 17002-40 with a range of minus 100°F to plus 700°F.

This occurrence is similar in nature to RO-76-35/3L and RO-78-9/3L.

ATTACHMENT TO LER 79-17/3L
NORTHEAST NUCLEAR ENERGY COMPANY
MILLSTONE NUCLEAR POWER STATION - UNIT 1
DOCKET NUMBER 50-245

IDENTIFICATION OF OCCURRENCE

Reactor protection system instrument setting, which was found to be less conservative than the value established by the Technical Specifications.

CONDITIONS PRIOR TO OCCURRENCE

The unit was shutdown and cooled down in the refuel mode.

DESCRIPTION OF OCCURRENCE

On June 2, 1979, at 1600 hours, while performing routine surveillance (Steam Tunnel High Temperature Functional and Calibration) on the steam tunnel temperature switches, it was found that one of the temperature switches (261-17c) was tripping at a setpoint higher than that specified in Technical Specifications. Technical Specifications require these switches to trip at a value less than or equal to 200°F. The subject switch tripped at 213.3°F.

APPARENT CAUSE OF OCCURRENCE

The failure of the switch to trip at the proper setpoint was attributed to setpoint drift.

ANALYSIS OF OCCURRENCE

Sixteen temperature switches are provided in the steam tunnel to detect steam in the event of excessive steam leakage. These switches, when activated, cause a closure of the Group I isolation valves.