ATTACHMENT TO LER 79-23/3L NORTHEAST NUCLEAR ENERGY COMPANY MILLSTONE NUCLEAR POWER STATION, UNIT 1 PROVISIONAL LICENSE NUMBER DPR-21 DOCKET NUMBER 50-245

Identification of Occurrence

Failure of a primary containment isolation valve to go closed.

Conditions Prior to Occurrence

Prior to the occurrence, the plant was operating at a steady-state power level of 100 percent. Venting of the pressure suppression chamber, using the vent bypass, was in progress.

Description of Occurrence

On August 8, 1979, at 0600 hours, after venting the pressure suppression chamber, the vent bypass valve (1-AC-12) failed to close. The required surveillance for an inoperable containment isolation valve was performed.

Designation of Apparent Cause of Occurrence

The failure of 1-AC-12 to close was initially attributed to particle contamination in the air operator. Disassembly and inspection revealed no such contamination.

Analysis of Occurrence

The two-inch pressure suppression chamber vent bypass valve, 1-AC-12, is one of the primary containment isolation valves and has a requirement to go fully closed in 15 seconds upon receipt of an isolation signal. Closure of this valve, in an emergency, is designed to minimize the potential leakage paths from the pressure suppression chamber.

Failure of this valve to go closed did not create a condition which had not been previously analyzed. Closure of the other isolation valve in this line would be sufficient to maintain the required integrity.

Corrective Action

Disassembly of the air operator did not reveal any foreign material or obvious explanation as to the valve's failure to close. The operator was inspected, lubricated, reinstalled and stroked repeatedly. The valve was stroked manually with no abnormal resistance or friction felt.

This valve is exercised frequently and will be continually monitored for satisfactory performance.

The subject valve and operator are manufactured by the DEZURIK COMPANY, MODEL NUMBER 256.

This occurrence is similar in nature to LER 79-22/3L.

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ERC FORM 7.797 LICENSEE EVENT REPORT (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION) CONTROL BLOCK: LOISO002450080808798082479 CON'T REPORT 0 1 SOURCE EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10) On August 8, 1979, at 0600 hours, after venting the pressure suppression chamber, 0 2 the vent bypass valve (1-AC-12) failed to close. The required surveillance for 0 3 an inoperable containment isolation valve was performed. No consequences, the 0 4 downstream valve was closed. 0 5 0 6 0 7 0 8 COMP VALVE SYSTEM CAUSE CAUSE SUBCODE COMPONENT CODE SUBCODE CODE CODE IV 10 [P 104 E 1 (15 Z-1 (13) 5101 XI (11 9 30 18 13 REVISION OCCURRENCE REPORT SEQUENTIAL NO. CODE TYPE REPORT NO. EVENT YEAR 0 LER/RO 0 2 2 REPORT 9 NUMBER COMPONENT MANUFACTURER PRIME COMP. ATTACHMENT SUBMITTED NPRD-4 FORM SUB METHOD HOURS (22) SUPPLIER ACTION FUTURE TAKEN ACTION D114 IA (25 Y 23 0 0 0 0 Z (21) (18) 7 CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27 The exact cause of the failure of 1-AC-12 to close could not be identified. The 10 valve operator was disassembled, inspected, lubricated, and bench tested satis-1 1 factorily. The valve was stroked manually with no abnormal resistance or fric-1 tion felt. This occurrence is similar in nature to LER 79-22/3L. 4 METHOD OF DISCOVERY DISCOVERY DESCRIPTION (32) FACILITY OTHER STATUS % POWER NA A (31) NA 10 0 3:3 44 10 13 LOCATION OF RELEASE CONTENT ACTIVITY AMOUNT OF ACTIVITY 35 RELEASED OF RELEASE NA 2(34) Z (33) 20 1.1 10 11 PERSONNEL EXPOSURES DESCHIPTION (39) NA 01 PERSONNEL INJURIES DESCRIPTION (41) NUMBER 010(0) 13 12 11 303222 LOSS OF OR DAMAGE TO FACILITY (43) DESCRIPTION (42 NA NRC USE ONLY 10 PUBLICITY DESCRIPTION (45 1(44) 0 2 68 6.9