

TELEGRAPHIC MESSAGE

NAME OF AGENCY US NUCLEAR REGULATORY COMMISSION OFFICE OF INTERNATIONAL PROGRAMS WASHINGTON, DC 20555 TELEX NO: 710-824-0415		PRECEDENCE ACTION: PRIORITY INFO:	SECURITY CLASSIFICATION UNCLASSIFIED
ACCOUNTING CLASSIFICATION	DATE PREPARED 6/26/79		TYPE OF MESSAGE <input checked="" type="checkbox"/> SINGLE <input type="checkbox"/> BOOK <input type="checkbox"/> MULTIPLE-ADDRESS
FOR INFORMATION CALL			
NAME <i>H. J. Faulkner</i> H. J. FAULKNER, RESEARCH AGREEMENTS COORDINATOR	PHONE NUMBER 492-7788		
THIS SPACE FOR USE OF COMMUNICATION UNIT			

MESSAGE TO BE TRANSMITTED (Use double spacing and all capital letters)

TO:  
 MR. F. WEEHUIZEN  
 NUCLEAR SAFETY DIVISION  
 EIDG. AMT FUR ENERGIEWIRTSCHAFT  
 5303 WUERENLINGEN, SWITZERLAND  
 TELEX: 59058

THANK YOU FOR YOUR EARLIER TELEGRAM OF JUNE 15, 1979.

IN ADDITION TO SHARING INFORMATION RELATING TO 1974 INCIDENT WITH WESTINGHOUSE AND NRC LICENSEES AND CONTRACTORS, WE BELIEVE IT WOULD BE BENEFICIAL TO SHARE THIS INFORMATION WITH THE NUCLEAR SAFETY ANALYSIS CENTER. THE CENTER IS OPERATED BY THE ELECTRIC POWER RESEARCH INSTITUTE (EPRI) FOR THE U.S. ELECTRIC UTILITY INDUSTRY. WE REQUEST YOUR PERMISSION TO SHARE THE INFORMATION WITH THIS ORGANIZATION.

A SLIGHT REVISION TO THE TEXT PROPOSED IN YOUR TELEGRAM OF JUNE 15 FOLLOWS. WE HOPE THIS IS SATISFACTORY TO YOU.

QUOTE. WE ARE AWARE OF ONE EVENT AT A FOREIGN REACTOR DESIGNED BY WESTINGHOUSE, WHICH OCCURRED A NUMBER OF YEARS AGO IN WHICH A PORV WAS CHALLENGED DURING A TURBINE TRIP TRANSIENT AND FAILED TO RECLOSE WHEN PRESSURE DECREASED. THE FAILURE TO CLOSE WAS DETECTED IN A FEW MINUTES BY THE OPERATORS, WHO IMMEDIATELY ISOLATED THE VALVE BY CLOSING

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TO: MR. F. WEEHUIZEN (CONTINUED)

THE BLOCK VALVE IN SERIES WITH THE PORV. THIS ACTION TERMINATED THE INCIDENT. THE FAILURE TO RECLOSE WAS DUE TO THE RUPTURE OF THE CAST-IRON FRAME BETWEEN THE VALVE OPERATER AND THE VALVE BODY WHICH WAS CAUSED BY A WATER SLUG HITTING THE VALVE. THE SOURCE OF THE WATER SLUG WAS THE LOOP SEAL LOCATED BETWEEN THE PRESSURIZER AND THE RELIEF VALVE. INVESTIGATION OF THIS EVENT IDENTIFIED THE CAUSE OF THE VALVE FAILURE TO BE DESIGN ERROR WHICH, WE UNDERSTAND, HAS BEEN SUBSEQUENTLY REMEDIED. UNQUOTE.

H. J. FAULKNER, NRC.

END

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