BC FOHM 366 UPDATE REPORT - PREVIOUS REPORT DATE 8/11/81
PI FASE PRINT OR TYPE ALL REQUIRED INFORMATION
CONTROL BLOCK:
CON'T REPORT L 6 0 5 0 0 0 2 6 0 7 0 5 2 0 8 1 8 0 9 2 5 8 1 9
EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (1) During review of ISI performed on unit 2, HPCI piping, it was found that one ISI
Oli During review of 1st periods
to 1971 edition, Summer 1971 addenda of section XI. (T.S. 4.6.G) There was no
danger to the health or safety of the public. There were no previous similar events.
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O 8 COMP. VALVE SYSTEM CAUSE CAUSE CONTONENT CODE SUBCODE
SYSTEM CODE CODE SUBCODE SUBCO
17 REPORT 8 1
TAKEN ACTION FUTURE ON PLANT METHOD HOURS (22) SUBMITTED FORM SUB. SUPPLIER Z 9 9 9 9 9 (26)
CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27) Previous calibration reflector comparison between 5 percent notch and side drilled
deducted acceptable sensitivity when used with the summer 1971 recording
levels applicable to units 1 and 2. The weld was reexamined during the scheduled
levels applicable to differ the procedures have been clarified to rectify this problem.
outage in May 1981. The procedures
FACILITY STATUS OTHER STATUS 30 METHOD OF DISCOVERY DESCRIPTION 32 STATUS STATUS IN B 31 Engineering study and review
ACTIVITY CONTENT HELEASED OF RELEASE AMOUNT OF ACTIVITY 35 AMOUNT OF ACTIVITY 35 AMOUNT OF ACTIVITY 35
1 6 Z 33 Z 34 NA 45 80
NUMBER OF TYPE DESCRIPTION 39 NA SO
PERSONNEL INJURIES NUMBER DESCRIPTION 41 NA NA 80
1005 OF CH DAMAGE TO FACILITY 43
NAC USE ONLY
NA DESCRIPTION NA SA
B110010159 B10925 Gene Holder (205) 726134 PDR ADGCK 05000260 PDR

LER SUPPLEMENTAL INFORMATION

BFRO-50- 260 / 81026 R2 Technical Specification Involved 4.6.G
Reported Under Technical Specification 6.7.2.b(3) *Date due NRC: NA
Date of Occurrence 5/20/81 Time of Occurrence 0720 Unit 2
Identification and Description of Occurrence: One ISI ultrasonic exam performed on unit 2 piping did not receive evaluation required to meet TVA's commitment to 1971 edition, summer 1971 addenda of section XI.

Conditions Prior to Occurrence: Unit 1 regueling outage.

Unit 2 at 99%.

Unit 3 at 100%.

Action specified in the Technical Specification Surveillance Requirements met due to inoperable equipment. Describe.

None

Apparent Couse of Occurrence: Previous calibration reflector comparison between 5% notch and side drilled holes had indicated comparable sensitivity when used with summer 1971 recording levels. The effect of the reduced recording level required by the summer 1975 code was not recognized until recent review of ultrasonic testing raised questions in this area.

Analysis of Occurrence: There was no danger to the health or safety of the public, no release of activity, no damage to the plant or equipment, and no resulting significant chain of events.

Corrective Action: The weld was reexamined during the scheduled outage in May 19c1. The procedures have been clarified to rectify this problem.

Failure Data: None

Retention: Period - Lifetime; Responsibility - Document Control Supervisor

*Revision