

LICENSEE EVENT REPORT

CONTROL BLOCK / / / / / / / (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)
 /0/1/ /V/A/N/A/S/2/ (2) /0/0/-/0/0/0/0/0/-/0/0/ (3) /4/1/1/1/1/ (4) / / / (5)
 LICENSEE CODE LICENSE NUMBER LICENSE TYPE CAT
 /0/1/ REPORT SOURCE /L/ (6) /0/5/0/0/0/3/3/9/ (7) /0/1/0/1/8/2/ (8) /0/1/2/6/8/2/ (9)
 DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

/0/2/ / On January 1, 1982, with Unit 2 at 100% power, it was observed that identified /
 /0/3/ / RCS leakage had increased to approximately 15-30 GPM. The identified leakage /
 /0/4/ / allowed by Technical Specification is <= 10 GPM. Since the leak was confined /
 /0/5/ / to the containment and the unit was placed in Hot Standby within 6 hours as re- /
 /0/6/ / quired by the Action Statement, the public health and safety were not affected. /
 /0/7/ / This event is contrary to T.S. 3.4.6.2 and reportable pursuant to T.S. 6.9.1.9.b./
 /0/8/ /

SYSTEM CAUSE CAUSE COMP. VALVE
 CODE CODE SUBCODE COMPONENT CODE SUBCODE SUBCODE

/0/9/ /C/F/ (11) /E/ (12) /B/ (13) /V/A/L/V/E/X/ (14) /E/ (15) /D/ (16)
 LER/RO EVENT YEAR SEQUENTIAL OCCURRENCE REPORT REVISION
 REPORT REPORT NO. REPORT NO. NO.
 (17) NUMBER /8/2/ /-/ /0/0/1/ / \ / /0/3/ /L/ /-/ /0/

ACTION FUTURE EFFECT SHUTDOWN ATTACHMENT NPRD-4 PRIME COMP. COMPONENT
 TAKEN ACTION ON PLANT METHOD HOURS SUBMITTED FORM SUB. SUPPLIER MANUFACTURER
 /A/ (18) /Z/ (19) /A/ (20) /A/ (21) /0/0/6/9/ (22) /Y/ (23) /N/ (24) /N/ (25) /C/6/3/5/(26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

/1/0/ / The cause of the excessive RCS leakage was due to missing packing on the RHR /
 /1/1/ / isolation valve (MOV-2700). Apparently the packing deteriorated and passed /
 /1/2/ / through the valve leak off line. The valve was repacked, leak tested and cycled /
 /1/3/ / in accordance with the appropriate maintenance procedure. Subsequent to satis- /
 /1/4/ / factory testing the affected RHR isolation valve was returned to service. /

FACILITY METHOD OF
 STATUS %POWER OTHER STATUS (30) DISCOVERY DISCOVERY DESCRIPTION (32)
 /1/5/ /E/ (28) /1/0/0/ (29) / NA / (30) /A/ (31) / Operator Observation /

ACTIVITY CONTENT
 RELEASED OF RELEASE AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36)
 /Z/ (33) /Z/ (34) / NA / / NA /

PERSONNEL EXPOSURES
 NUMBER TYPE DESCRIPTION (39)
 /0/0/0/ (37) /Z/ (38) / NA /

PERSONNEL INJURIES
 NUMBER DESCRIPTION (41)
 /0/0/0/ (40) / NA /

LOSS OF OR DAMAGE TO FACILITY (43)
 TYPE DESCRIPTION
 /Z/ (42) / NA /

PUBLICITY
 ISSUED DESCRIPTION (45)
 /N/ (44) / NA /

NAME OF PREPARER W. R. CARTWRIGHT PHONE (703) 894-5151

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 PDR ADDCK 05000339
 PDR

Description of Event

On January 1, 1982, with Unit 2 in Mode 1 at 100% power, it was observed that the Primary Drain Transfer Tank (PDTT) level was increasing more rapidly than normal with charging flow also increasing a significant amount. A makeup - letdown flow balance indicated that RCS identified leakage was greater than the allowed 10 GPM; leakage was estimated to be between 15-30 GPM. This condition resulted in the unit being ramped down and the turbine brought off the line and reactor shutdown. A RCS cooldown commenced and the unit was placed in Hot Shutdown. With Tavg at less than 350 °F and RCS pressure less than 430 psig, the affected Residual Heat Removal System isolation valve was opened and placed on its backseat. The valve was repacked and RCS identified leakage was observed to have dropped to less than 10 GPM. The excessive RCS identified leakage is contrary to T.S. 3.4.6.2 and reportable pursuant to T.S. 6.9.1.9.b.

Probable Consequences of Occurrence

Since the leakage was confined to the Primary Drains Transfer Tank in the containment and the unit was brought to Hot Standby within 6 hours as required by Technical Specifications, the health and safety of the public were not affected.

Cause of Event

The excessive RCS identified leakage was caused by deterioration of the packing on the RHR isolation valve MOV-2700. The bottom 8 layers of packing below the lantern ring deteriorated and passed through the valve leakoff line to the PDTT.

The valve in question is a 14" motor operated gate valve manufactured by Copes-Vulcan, Inc.

Immediate Corrective Action

Upon determining that the RCS identified leakage was greater than the allowed leakage, the affected unit was ramped down and placed in Hot Standby. A containment entry was made and it was determined that the leaking valve was the RHR isolation valve (MOV-2700). A maintenance report was issued and the plant was placed in Hot Shutdown with Tavg < 350 °F and RCS pressure at 430 psig. When the affected valve was opened and repacked the RCS identified leakage fell to < 10 GPM and the Action Statement was cleared. The valve was then cycled and leak tested in order to prove operability. Upon successful completion of testing the valve was restored to service.

Scheduled Corrective Action

No other corrective action is scheduled.

Actions Taken to Prevent Recurrence

No further action is required.

Generic Implications

There are no generic implications to this event.