

PHILADELPHIA ELECTRIC COMPANY

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February 10, 1983

Docket Nos. 50-278

Mr. R. C. Haynes, Administrator
Office of Inspection and Enforcement
U. S. Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, PA 19046

SUBJECT: Licensee Event Report Narrative Description

Dear Mr. Haynes:

The following occurrence was reported to Mr. A. R. Blough of Region I U.S. Nuclear Regulatory Commission on February 1, 1983.

Reference:	Docket No. 50-278
Report Number:	3-83-006/IT-0
Report Date:	February 10, 1983
Event Date:	January 31, 1983
Facility:	Peach Bottom Atomic Power Station RD 1, Delta, PA 17314

Technical Specification Reference:

Technical Specification 3.7.D.2 requires that whenever a containment isolation valve becomes inoperable reactor power may continue provided that "at least one valve in each line having an inoperable valve shall be in the mode corresponding to an isolated condition."

10 CFR 50 Appendix J Section III.C.3 requires that the combined leakage for all penetrations and valves subject to Type B&C tests shall be less than 0.6 La.

Description of the Event:

During local leak rate testing of the B CAD nitrogen injection to torus penetration (N211 B), the test valve located between the inboard and outboard isolation valves was determined to be leaking in excess of 80 SCFH. When this result was used to calculate total leakage, utilizing the conservative technique of ignoring the best series valve leakage for each penetration, the results exceeded the 0.6 La limit of 10 CFR 50 Appendix J.

Probable Consequences of the Event:

The valve in question, a test connection, is an outboard containment isolation valve. If the calculation were redone using the leakage rate of the inboard valve of this penetration (tested at 5000 scc/min) the results would be only 41,000 scc/min which is less than the 0.6 La limit of 71193 scc/min. In addition, threaded caps are normally used to seal the test connections between test cycles. For the above cited reasons, it is believed that primary containment integrity was not lost and that the significance of this event is minimal.

Cause of the Event:

The valve would not properly seat due to a build-up of foreign material and scored seating surfaces.

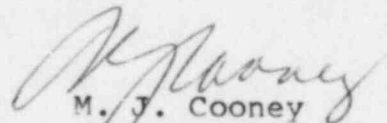
Immediate Corrective Action:

Upon discovery of the excessive leakage, the in-series manual valve was closed.

Corrective Action:

The valve was disassembled, approximately one teaspoon of material (thought to be corrosion products from the carbon steel lines) was removed; the plug, stem and bonnet were replaced, the seats were lapped and the valve was satisfactorily retested on February 2, 1983.

Sincerely



M. J. Cooney
Superintendent
Generation Division-Nuclear

cc: Document Control Desk

A. R. Blough
Site Inspector
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