NRC FORM 366 (7.77)

	LICENSEE EVENT REPORT
	CONTROL BLOCK:
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CON'T	REPORT LG 0 5 0 0 2 9 5 0 0 9 1 9 8 2 3 1 0 1 9 8 2 0 SOURCE 60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80
0 2	During steady state operation at 100% power, it was noticed that charg
03	ling flow was 30gpm less than letdown flow. Increasing demand on the
04	charging flow control valve did not increase the charging flow rate.
0 5	15 minutes later charging flow dropped to 0 and motor current increased
06	Ito 130 amps. The operator tripped the 1B pump and declared it inoper-
07	able, and started the 1A charging pump. All other ECCS pumps were ver-
08 78	Lified operable, therefore the health and safety of the public were not j 9 SYSTEM CAUSE
09 78	CODE SUBCODE S
	Image: Construct state EVENT YEAR REPORT 100. CODE Type NO. Image: Code
	ACTION PUTURE EFFECT SHUTDOWN HOURS 22 ATTACHMENT FORM SUB. PRIME COMP. COMPONENT MANUFACTURER TAKEN ACTION ON PLANT METHOD HOURS 22 ATTACHMENT FORM SUB. SUPPLIER MANUFACTURER 33 18 34 19 2 20 2 2 2 1 0 0 0 0 0 1 2 23 20 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
10	CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27) [Immediate corrective action was to replace the rotating element. The
11	normal periodic test was performed and the pump curve was found to be
12	within an acceptable limit of the original pump curve. A follow-up
1 3	[report will be written.
14	80
1 5	E 28 100 29 N/A A 31 Operator Observation 32
7 8 1 6 7 8	$\begin{array}{c} \begin{array}{c} \begin{array}{c} \begin{array}{c} \begin{array}{c} 12 \\ \text{CIVITY} \end{array} \end{array} \end{array} \end{array} \end{array} \begin{array}{c} \begin{array}{c} 12 \\ \text{CONTENT} \end{array} \end{array} \end{array} \\ \begin{array}{c} \begin{array}{c} \begin{array}{c} 12 \\ \text{CONTENT} \end{array} \end{array} \end{array} \end{array} \\ \begin{array}{c} \begin{array}{c} \begin{array}{c} 12 \\ \text{CONTENT} \end{array} \end{array} \end{array} \end{array} \begin{array}{c} \begin{array}{c} \begin{array}{c} \begin{array}{c} 12 \\ \text{CONTENT} \end{array} \end{array} \end{array} \\ \begin{array}{c} \begin{array}{c} \begin{array}{c} \begin{array}{c} 12 \\ \text{CONTENT} \end{array} \end{array} \end{array} \end{array} \end{array} \begin{array}{c} \begin{array}{c} \begin{array}{c} \begin{array}{c} 12 \\ \text{CONTENT} \end{array} \end{array} \end{array} \end{array} \\ \begin{array}{c} \begin{array}{c} \begin{array}{c} \end{array} \end{array} \\ \begin{array}{c} \begin{array}{c} \end{array} \end{array} \end{array} \end{array} \\ \begin{array}{c} \begin{array}{c} \begin{array}{c} \end{array} \end{array} \end{array} \end{array} \begin{array}{c} \begin{array}{c} \begin{array}{c} \end{array} \end{array} \end{array} \end{array} \end{array} \begin{array}{c} \begin{array}{c} \end{array} \end{array} \end{array} \end{array} \\ \begin{array}{c} \end{array} \end{array} \end{array} \end{array} \\ \begin{array}{c} \begin{array}{c} \end{array} \end{array} \end{array} \end{array} \end{array} \begin{array}{c} \begin{array}{c} \end{array} \end{array} \end{array} \end{array} \\ \begin{array}{c} \end{array} \end{array} \end{array} \end{array} \end{array} \begin{array}{c} \end{array} \end{array} \end{array} \end{array} \begin{array}{c} \end{array} \end{array}$
1 7	PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION 39 0 0 0 0 37 Z 38 80 9 11 12 12 13 80
118	
7 8	9 11 12 LOSS OF OR DAMAGE TO FACILITY (43) TYPE DESCRIPTION
1 9	2 42 N/A 9 10 8210260411 821019 80
20	ISSUED DESCRIPTION (46) 5 PDR ADDCK C5000295 PDR N/A 68 59 86.5
7 8	NAME OF PREPARER Benson L. Binggeli PHONE 312-746-2084 ext. 328

ATTACHMENT TO LER No. 82-30/03 L-0

Commonwealth Edison Co. Zion Generating Station 50-295

Description of Event: During steady state operation at 100% power on 9-19-82 at 1440 hours the "Pressurizer control level high low" alarm came in. At that time, the charging flow control valve (1FCV-121) was at 100% demand, charging flow was at 70 gpm, and letdown flow as at 100 gpm. 1FCV-121 was placed in manual and the demand increased, but no charging flow increase was noted. Letdown was switched to a 45 gpm orifice and IFCV-121 was inspected locally. Pressurizer level stopped dropping, but it was decided to secure letdown. Charging at 70 gpm continued for 5 minutes until the operator noticed the aux. lube oil pump auto-starting for the 1B pump. The motor current jumped to 130 amps (normal running current = 60 amps) and charging flow dropped to zero. The 1B charging pump was manually tripped and 1A charging pump was started. Charging flow responded normally with 1A pump in operation. 1B charging pump was declared inoperable placing the unit in a degraded mode per Tech Spec 3.8.1.B.

Consequence of Occurrence: lA charging pump was operable at the time when lB charging pump was declared inoperable, therefore HHSI was available and the health and safety of the public were not adversely affected. lB charging pump was repaired and declared operable within the period allowed for system limiting condition for operation.

Cause of Occurrence: Preliminary investigation showed that the failure occurred between the 10th and 11th stages in the split ring area. Preliminary investigation indicates this failure was attributed to fatique. Charging pump shaft failures are a significant generic problem involving W supplied auxiliary nuclear pumps. The failed 1B pump incorporated the Westinghouse recommended 1150 °F shaft temper temperature as well as the two piece balance drum locknut. The 1150 °F heat treatment was recommended over the original design (1000 °F) heat treatment to improve fracture toughness. The two piece balance drum locknut was recommended over the original design (1 piece) to more evenly distribute the load over all the locknut threads.

Previous Occurrences: There are no previous occurrences of this type at Zion Station.

Corrective Action: Immediate corrective action was to replace the rotating element. The normal periodic test was performed and the pump flow was found to be within an acceptable limit of the curve. This curve was for the 1B charging pump prior to rotating element replacement. Further action will be taken once the exact cause of shaft failure can be determined. Any further corrective action will be indicated in the follow-up report.