

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CONT

0	1
---	---

REPORT SOURCE

L	6	0	5	0	0	0	3	2	8	7	0	4	1	9	8	3	8	0	5	1	8	8	3	9
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

0 2 With unit 2 in mode 1 (98% Rx power) at 1030 CST on 04/19/83, one automatic control valve (2-LCV-3-156) in the auxiliary feedwater system was declared inoperable due to failing to open on demand. The unit complied with action statement (a) of LCO 3.7.1.2. There was no effect upon public health and safety. Previous occurrences - three (SQR0-50-327/82036, SQR0-50-328/82038, 83042).

0 7		0 8		0 9	
SYSTEM CODE		CAUSE CODE		CAUSE SUBCODE	
W	B	E	E	I N S T R U	
COMP. SUBCODE		VALVE SUBCODE		SEQUENTIAL REPORT NO.	
C	Z	0 6 0		O C C U R R E N C E CODE	
REPORT TYPE		REVISION NO.		ACTION TAKEN	
L	0	X		FUTURE ACTION	
PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER		HOURS	
L	M 1 2 0	0 0 0 0		ATTACHMENT SUBMITTED	
N		Y		NPRD 4 FORM SUB.	

1 0 Investigation revealed that the metering orifice in the pneumatic relay was the

1 1 incorrect size as supplied by the manufacturer. After consulting with the

1 2 manufacturer, the correct parts were obtained and installed. Procedures are being

1 3 revised to ensure that a check is made of the metering orifice size prior to

1 4 installation.

FACILITY STATUS (1) 5 (2) 8 (3) 0 (4) 9 (5) 8 (6) 29 NA (30)
 METHOD OF DISCOVERY (31) B (32) Surveillance test
 ACTIVITY CONTENT RELEASED OF RELEASE (33) Z (34) Z (35) NA
 AMOUNT OF ACTIVITY (36) LOCATION OF RELEASE (37)
 PERSONNEL EXPOSURES NUMBER (38) 0 (39) 0 (40) 0 (41) Z (42) NA (43)
 PERSONNEL INJURIES NUMBER (44) 0 (45) 0 (46) 0 (47) 0 (48) NA (49)
 LOSS OF OR DAMAGE TO FACILITY TYPE (50) Z (51) NA (52)
 PUBLICITY ISSUED (53) N (54) NA (55)
 8305250342 830518
 PDR ADOCK 05000328
 S PDR
 NRC USE ONLY

Phone: (615) 870-6422

LER SUPPLEMENTAL INFORMATION

SQRO-50-328/83060

Technical Specification Involved: 3.7.1.2

Reported Under Technical Specification: 6.9.1.13.b

Date of Occurrence: 04/19/83

Time of Occurrence: 1030 CDT

Identification and Description of Occurrence:

During the performance of SI-276 at 1030 CDT on 04/19/83, auxiliary feedwater automatic valve 2-LCV-3-156 failed to fully open on demand from the control board. The valve was declared inoperable and the unit complied with action statement (a) of LCO 3.7.1.2.

Conditions Prior to Occurrence:

Unit 2 in mode 1 at 98% Rx power.

Apparent Cause of Occurrence:

The failure of the valve to fully open was caused by an incorrectly sized metering orifice in the pneumatic relay for the valve positioner.

Analysis of Occurrence:

Upon investigation, it was found that the pneumatic relay assembly on the valve positioner was leaking air through the relay to the valve actuator, preventing the valve from fully opening. The supply air pressure was set at 60 psig. A new pneumatic relay was installed, but the supply air pressure had to be reduced to 56 psig to make the valve operate properly. The manufacturer stated that a minimum of 48 psig was required to adequately operate the valve at system flow and pressures.

After further discussions with the manufacturer, it was discovered that the wrong metering orifice subassemblies were installed in the relays. Both the old and new relays were rated at 35 psig supply instead of 60 psig. This allowed the higher pressure to leak through the relay.

A safety evaluation was performed by EN DES using input from the valve manufacturer. It was concluded that the valves were operable even though the incorrectly sized metering orifice was installed since the valve stroked properly at a slightly reduced supply pressure (4 psig).

An inspection was made on both units of auxiliary feedwater valves and found one other valve with an incorrectly sized metering orifice. Operation of this valve, 1-LCV-3-164, on unit 1 was verified.

Corrective Action:

At 0815 CDT on 04/20/83, valve 2-LCV-3-156 was returned to service using a new relay with a 35 psig rated metering orifice and a slightly reduced supply pressure of 56 psig. On 04/22/83, after receiving new correctly sized metering orifices, valves 2-LCV-3-156 and 1-LCV-3-164 were repaired. Pneumatic relays rated at

60 psig were installed and the supply pressure returned to its normal 60 psig setting.

To prevent further recurrence, a tag will be placed on the positioner to indicate that a 60 psig metering orifice should be used if replacement is necessary. Also, a statement will be incorporated in the surveillance instruction to verify the proper metering orifice on replacement parts.

Failure Data:

None.

TENNESSEE VALLEY AUTHORITY

CHATTANOOGA, TENNESSEE 37401
1750 Chestnut Street Tower II

May 18, 1983

Mr. James P. O'Reilly, Director
U.S. Nuclear Regulatory Commission
Suite 2900
101 Marietta Street, NW
Atlanta, Georgia 30303

Dear Mr. O'Reilly:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 2 - DOCKET
NO. 50-328 - FACILITY OPERATING LICENSE DPR-79 - REPORTABLE OCCURRENCE
REPORT SQRO-50-328/83060

The enclosed report provides details concerning the inoperability of an
auxiliary feedwater automatic control valve. This report is submitted
in accordance with Sequoyah unit 2 Technical Specification 6.9.1.13.b.

Very truly yours,

TENNESSEE VALLEY AUTHORITY



H. J. Green
Director of Nuclear Power

Enclosure

cc (Enclosure):

Document Control Desk
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

Records Center
Institute of Nuclear Power Operations
Suite 1500
1100 Circle 75 Parkway
Atlanta, Georgia 30339

NRC Inspector, Sequoyah

83 MAY 23 AIO: 33

REGION 1
ATLANTA, GEORGIA

OFFICIAL COPY

Te 22