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LICENSEE EVENT	REPORT (LER)	TEXT CONTINUATION
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U.S. NUCLEAR REGULATOR + COMMINSION

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Millstone Nuclear Power Station Unit 3		YEAR SEQUENTIAL REVISION NUMBER INUMBER										
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On 2/14/86, at 1008 hours, while operating at 0% power in the Hot Standby mode, the plant experienced a feedwater isolation due to high-high level in Steam Generator A. The feedwater isolation resulted when opening the Main Steam Isolation Valve (MSIV) on Steam Generator A caused a swell in the generator.

Prior to opening the A MSIV, Operations personnel pressurized the main steam header downstream of the MSIV using the Main Steam Isolation Bypass Valve, as required by procedure. When the differential pressure across the isolation valve was 40 psid, as indicated by main board instruments and the plant process computer, the A Main Steam Isolation Valve was opened. This caused level in the A Steam Generator to swell to 92% of narrow range level. A feedwater isolation occurred when narrow range level reached the high-high setpoint of 80%. The feedwater isolation also resulted in the motor driven feedwater pump tripping off line.

The high-high steam generator level condition rapidly cleared, and was manually reset. Within 4 minutes the motor driven feedwater pump was restarted, and the remaining three MSIV's opened. This is the first feedwater isolation that has occurred as a result of swelling in a steam generator caused by opening a MSIV. To prevent this from reoccurring, the operating procedure has been revised to include a caution warning of a possible feedwater isolation when opening an MSIV, and specifying several courses of action operators may take to prevent it.

This report is being submitted in accordance with 10CFR50.73 (a) (2) (iv).

General Offices . Selden Street. Berlin, Connecticut

File

P.O. BOX 270 HARTFORD, CONNECTICUT 06141-0270 (203) 666-6911

June 16, 1986 MP-9180

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

Reference: Facility Operating License No. NPF-49 Docket No. 50-423 Licensee Event Report 50-423/86-036-00

Gentlemen:

This letter forwards Licensee Event Report 86-036-00 required to be submitted within thirty days pursuant to 10CFR50.73 (a) (2) (i) (B), any operation or condition prohibited by the Plant's Technical Specifications.

Yours truly,

NORTHEAST NUCLEAR ENERGY COMPANY

Won Wayne D. Retoberg

Station Superintendent Millstone Nuclear Power Station

WDR/BMP:se

Attachment: LER 86-036-00

cc: Dr. T. E. Murley, Region I

FOIA-87-512

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NRC Form 366 19 83

LICENSEE EVENT RE	PORT (LER) TEXT CONTIN	UATION	US NUCLEAR RED APPROVED DI EXPIRES 8/31	WEND 3180-0104	
PACILITY NAME (1)	DOCKET NUMBER (2)	LER NU	M48 E R (8)	PAGE (3)	
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TEXT (If more aporte le majourned, une additionner MARC Form 20064 & (17)

On 5/19/86 at 1415 hours while operating at 100% power, it was discovered that the plant had been operating in the Action Statement of Plant Technical Specification 3.8.2.1.b in that battery bank 301A-2 was not operable due to an unperformed modification to battery charger 301A-2 to correct a potential seismic interaction between charger 301A-2 and inverter INV-3. Affected battery bank 301A-2 was immediately declared inoperable. Within the 24 hours allowed by Technical Specification 3.8.2.1.b seismic bracing was designed and installed on battery bank 301A-2 restoring the equipment to operability. The three remaining safety related battery banks had their modifications complete. For the long term, the permanent modification will be performed at the next convenient outage and the bracing removed.

There were no safety implications to the public as only one channel of a four independent channel system was inoperable. The failure of this one power supply would not prevent the reactor protection system or engineered safety feature system from performing their functions nor would it prevent the safe shutdown of the plant.

This report is being submitted in accordance with 10CFR50.73 (a) (2) (i) (B).

PACIFIC GAS AND ELECTRIC COMPANY

TO CHE - 77 BEALE STREET . SAN FRANCISCO, CALIFORNIA 94106 . (415) 781-4211 . TV X 910-372-6587

JAMES D. SHIFFER VICE PRESIDENT NUCLEAR POWER GENERATION

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May 4, 1987

PGandE Letter No.: DCL-87-098

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

Re: Docket No. 50-275, OL-DPR-80 Diablo Canyon Unit 1 Licensee Event Report 1-86-017-00 Tipped Fuel Assembly During Refueling

Gentlemen:

PGandE is submitting the enclosed voluntary Licensee Event Report concerning the tipping of a fuel assembly during refueling. This report is being submitted for information purposes only as described in Item 19 of Supplement Number 1 to NUREG-1022.

This event has in no way affected the public's health and safety.

Kindly acknowledge receipt of this material on the enclosed copy of this letter and return it in the enclosed addressed envelope.

Sincerely,

Enclosure

cc: L. J. Chandler J. B. Martin M. M. Mendonca P. P. Narbut B. Norton C. M. Trammell CPUC Diablo Distribution INPO

DC1-86-TN-N124 1243S/0050K/RHM/1271

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FOIA-87-512 3/6 w1 1.5 0: 7-162

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LICENSEE EVENT REPORT	T (LER)
PADILITY BANKE (1)	DISIDICIO DE TELECE
TITLE 44	
TIPPED FUEL ASSEMBLY DURING REFUELING	OTHER FACILITIES INVOLVED (8)
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LICENSEE CONTACT FOR THIS LER	R (12) TELEPHONE NUMBER
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RICHARD M. LUCKETT, REGULATORY COMPLIANCE ENGINEER	BDBBBFFBB
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ABETRACT (16)	aan oo ah
This voluntary LER is being submitted for informa Item 19 of Supplement Number 1 to NUREG-1022. On October 1, 1986, while Unit 1 was in 10de 6 (H tipped against the core baffle, damaging the corr The event occurred after the fuel assembly had be support plate to allow the resetting of the load manipulator crane. A problem developed with rese the fuel assembly was set back down. Subsequent shift personnel discovered that the fuel assembly upright position and was leaning against the corr	ation purposes only as described in kefueling), fuel assembly A-O6 ner of the assembly grid strap. een raised slightly above the core limit switch on the fuel etting the load limit switch, and ly the shift ended, and oncoming y had tipped from its normal e baffle plates.
The fuel assembly was righted and removed from the approved procedure. With the exception of a correct damage to the fuel assembly was identified.	he core in accordance with an ner on grid strap Number 4, no
To prevent recurrence, the core unloading sequence revised to emphasize the need for positive indicate assembly.	ce procedure (OP B-8DS1) was ation when reseating a fuel
This event had no safety consequences and in no wood of the public.	way affected the health and safety
1243S/0050K	

NRC Poems 3886.4. (9-63)	LICENSEE EVENT	EPORT (LER) TEXT CONTIN	NOITAUN	U.S NUCLEAR REG APPROVED OF EXPIRES: 8/31	ULATORY COMMISSION MB NO. 3150-0104 /68		
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I. Initial Conditions

Unit 1 was in Mode 6 (Refueling), at a temperature of 76°F and at atmospheric pressure.

II. Description of Event

A. Event:

On October 1, 1986, while Unit 1 was in Mode 6 (Refueling), fuel assembly A-O6 tipped against the core baffle plate, damaging the corner of the assembly (AC) grid strap. The event occurred after the fuel assembly was raised slightly to allow the resetting of the load limit switch (WIS) on the fuel manipulator crane (DF)(FHM). This resetting of the load limit switch is required by procedure prior to movement of the first fuel assembly containing a control rod (AA). A problem developed with resetting the load limit switch, and the process was halted. The fuel assembly was set back down and unlatched until the problem could be resolved. Subsequently the shift ended, and the oncoming shift discovered that the fuel assembly had tipped from its normal upright position sometime during the two-hour shift change period and was leaning against the core baffle plates. Further investigation determined that when the fuel assembly was set back down, it was not aligned with the index pins in the lower core support plate due to fuel rod bowing. The visual inspection prior to unlatching the assembly failed to detect this condition due to a combination of lighting conditions and the glow from the Cerenkov radiation.

The fuel assembly was righted and removed from the core in accordance with temporary procedure TP TO-8610. No radiation release was observed by airborne monitors or from sampling of the refueling cavity water. A followup inspection identified damage as a torn corner on assembly grid strap Number 4. No fuel rod damage occurred to assembly A-O6 or to any surrounding assemblies in the core. Assembly A-O6 was placed in the spent fuel pool for storage. This assembly was not used in the second cycle, and therefore no repair to the grid strap or corrective action was necessary.

B. Inoperable structures, components, or systems that contributed to the event:

None.

- C. Dates and approximate times for major occurrences:
 - 1. October 1, 1986, 0800 PDT: Event date
 - 2. October 1, 1986, 1000 PDT: Discovery date

1243S/0050K

RC Forse 286A -83)	LICENSEE EVENT REPORT (LER) TEXT CONTINUATION APPROVED ONB NO. 3150-010 EXPIRES: 8/31/88	HISSIO									
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BXT W anore apeae is req	Ndrod, Nov adddoornal WITC Parmi allann w/ (17)										
	3. October 3, 1986, 0356 PDT: Fuel assembly righted and placed in spent fuel pool										
D.	Other systems or secondary functions affected:										
	None										
E.	Method of discovery:										
	During inspection after shift change.										
F.	Operator actions:										
	None required										
G.	Safety system response:										
	None required										
III. Ca	use of Event										
Α.	Immediate cause:										
	Failure to reseat fuel assembly A-O6 on lower core support plate index pins.										
В.	Root cause:										
	A combination of bowed fuel rods and lighting conditions contributed to the operators' failure to detect that the assembly was not aligned with the index pins.										
IV. An	alysis of Event										
Ti to pr co as en co	pping of the fuel assembly against the core baffle did not cause any damage fuel rods nor compromise the integrity of the fission product barrier ovided by the fuel cladding. Grid strap damage during fuel evolutions is a mmon industry occurrence and presents no safety consequences unless the sembly is reused, at which time the grid strap damage would be evaluated to isure there is no potential for causing fuel rod damage. Thus, no adverse onsequences or implications resulted from this event.										
v. <u>Co</u>	prrective Actions										
Tore	prevent recurrence, the core unloading sequence procedure, OP B-8DS1, was evised to emphasize the need for positive indication when reseating a fuel sembly.										

12435/0050K

NRC Ferrer 2086A (9-8-3)	LICENSEE EVENT REPORT (LER) TEXT CONTIN								NU	ATIC	N			0.5	API	PPROVED OM8 NO. 3150-0104 XPIRES: 8/31/88				pello	
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- VI. Additional Information
 - A. Failed components:

None

B. Previous LERs on similar events:

None

12435/0050K