

LICENSEE EVENT REPORT

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0	1	N	Y	N	M	P	1	2	0	0	-	0	0	0	0	0	-	0	0	3	4	1	1	1	1	4			5																
7	8	9						14						15						25						26						30						57						58	
		LICENSEE CODE												LICENSE NUMBER												LICENSE TYPE																			

0	1
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0	1	REPORT SOURCE										6	0	5	0	0	0	2	2	0	7	0	3	0	3	8	0	8	0	3	2	0	8	0	9													
7	8											60	61	DOCKET NUMBER										68	69	EVENT DATE										74	75	REPORT DATE										80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0	2	SEE ATTACHED SHEET
0	3	
0	4	
0	5	
0	6	
0	7	
0	8	

7 8 9

SYSTEM CODE C D 11		CAUSE CODE E 12		CAUSE SUBCODE D 13		COMPONENT CODE V A L V O P 14				COMP. SUBCODE J 15		VALVE SUBCODE D 16					
EVENT YEAR 8 0 22		SEQUENTIAL REPORT NO. 0 0 7 26		OCCURRENCE CODE 0 3 29		REPORT TYPE L 30		REVISION NO. 0 32									
ACTION TAKEN B 18		FUTURE ACTION G 19		EFFECT ON PLANT Z 20		SHUTDOWN METHOD Z 21		HOURS 0 0 0 22		ATTACHMENT SUBMITTED Y 23		NPRD-4 FORM SUB. Y 24		PRIME COMP. SUPPLIER L 25		COMPONENT MANUFACTURER N 4 1 7 26	

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | Disassembly of the pilot valves revealed that rust buildup had occurred

1 1 | in the pilot shuttle. The rust was probably from the instrument air sys-

1 2 | tem. At present, a new instrument air system is being installed which

1 3 | should eliminate the moisture problem. Procedures are also being changed

1 4 | to require cleaning & inspection of the pilot shuttle valve internals.

FACILITY STATUS		% POWER			OTHER STATUS		METHOD OF DISCOVERY		DISCOVERY DESCRIPTION			
1	5	D	28	0	0	0	29	NA	A	31	OPERATOR OBSERVATION	32
ACTIVITY RELEASED		CONTENT OF RELEASE			AMOUNT OF ACTIVITY		LOCATION OF RELEASE					
1	6	Z	33	Z	34	NA	35	NA	36			
PERSONNEL EXPOSURES		NUMBER		TYPE		DESCRIPTION						
1	7	0	0	0	37	Z	38	NA	39			
PERSONNEL INJURIES		NUMBER		DESCRIPTION								
1	8	0	0	0	40	NA	41					
LOSS OF OR DAMAGE TO FACILITY		TYPE		DESCRIPTION								
1	9	A	42	NA	43							
PUBLICITY ISSUED		DESCRIPTION										
2	0	44	NA	45								
NRC USE ONLY												

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EVENT DESCRIPTION AND PROBABLY CONSEQUENCES

While shut down for maintenance, attempts to close both air operated outside main steam isolation valves failed. Technicians disconnected the bleed off line to the air operator of one MSIV and jarred the pilot shuttle valve. At this time the MSIV closed. Without any changes, a second attempt was made to close the other MSIV. The attempt succeeded. Subsequent testing revealed that both valves opened and closed properly. The event occurred with the reactor mode switch in "refuel" at zero power. As a result, the consequences were insignificant.

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