

September 15, 1977

PRN-LI-77-293

Continued
50-335

Mr. James P. O'Reilly, Director, Region II
Office of Inspection and Enforcement
U. S. Nuclear Regulatory Commission
230 Peachtree Street, N. W., Suite 1217
Atlanta, Georgia 30303


Dear Mr. O'Reilly:

REPORTABLE OCCURRENCE 335-77-34
ST. LUCIE UNIT 1
DATE OF OCCURRENCE: AUGUST 17, 1977

CONTAINMENT SPRAY HEADER VALVE

The attached Licensee Event Report is being submitted in accordance with Technical Specification 6.9 to provide 30 day notification of the subject occurrence.

Very truly yours,


A. D. Schmidt
Vice President
Power Resources

WAK/cpc

Attachment

cc: Robert Lowenstein, Esquire
Director, Office of Inspection and Enforcement (30)
Director, Office of Management Information and
Program Control (3)

LICENSEE EVENT REPORT

CONTROL BLOCK: 1 6

(PLEASE PRINT ALL REQUIRED INFORMATION)

LICENSEE NAME										LICENSE NUMBER										LICENSE TYPE					EVENT TYPE	
F L S L S 1										0 0 - 0 0 0 0 0 - 0 0										4 1 1 1 1					0 3	
8 9 14										15 25										26 30					31 32	

CATEGORY		REPORT TYPE	REPORT SOURCE	DOCKET NUMBER					EVENT DATE					REPORT DATE				
CONT		L	L	0 5 0 - 0 3 3 5					0 8 1 7 7 7					0 9 1 5 7 7				
57 58		59	60	61 68					69 74					75 80				

EVENT DESCRIPTION

2	8	9	During surveillance testing, 1 containment spray header valve did not indicate fully open																																																																						80
3	8	9	when tested. The problem was corrected well within the time limit of Specification																																																																						80
4	8	9	3.6.2.1.a. This is the first occurrence of this type. (335-77-34)																																																																						80
5	8	9																																																																							80
6	8	9																																																																							80

SYSTEM CODE		CAUSE CODE	COMPONENT CODE					PRIME COMPONENT SUPPLIER	COMPONENT MANUFACTURER				VIOLATION
S B		F	V A L V O P					A	W 2 5 5				N
8 9 10		11	12 17					43	44 47				46

CAUSE DESCRIPTION

3	8	9	Unknown - the manual handwheel used to override the valve was found to be about 10%																																																																						80
4	8	9	closed. The (two) handwheels have been locked open.																																																																						80
5	8	9																																																																							80

FACILITY STATUS		% POWER		OTHER STATUS		METHOD OF DISCOVERY		DISCOVERY DESCRIPTION	
E		1 0 0		NA		b		NA	
8 9		10 12		13 44		45 46		80	

FORM OF ACTIVITY RELEASED		CONTENT OF RELEASE		AMOUNT OF ACTIVITY		LOCATION OF RELEASE	
Z		Z		NA		NA	
8 9		10 11		44 45		80	

PERSONNEL EXPOSURES

NUMBER	TYPE	DESCRIPTION
0 0 0	Z	NA
8 9 11	12	13 80

PERSONNEL INJURIES

NUMBER	DESCRIPTION
0 0 0	NA
8 9 11	12 80

PROBABLE CONSEQUENCES

4	8	9	None - the gate valve was about 90% open and would have passed very nearly full flow.																																																																						80
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LOSS OR DAMAGE TO FACILITY

TYPE	DESCRIPTION
Z	NA
8 9 10	80

PUBLICITY

5	8	9	NA																																																																						80
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ADDITIONAL FACTORS

6	8	9	PROBABLE CONSEQUENCES (Cont'd): Other redundant systems were operable.																																																																						80
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