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FILE: INCIDENT REPORT FILE

FROM: Metropolitan Edison Co. Reading, Pa R.C. Arnold			DATE OF DOC 6-25-75	DATE REC'D 6-30-75	LTR xx	TWX	RPT	OTHER
TO: NRC			ORIG 1-signed	CC	OTHER	SENT AEC PDR <u>xxx</u>		
						SENT LOCAL PDR <u>xxx</u>		
CLASS	UNCLASS	PROP INFO	INPUT	NO CYS REC'D 1		DOCKET NO: 50-289		

DESCRIPTION:

Ltr reporting abnormal occurrence #75-17 on
6-15-75 concerning failure of reactor building
purge isolation valve to pass local leak test
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ENCLOSURES:

PLANT NAME: Three Mile Island #1

FOR ACTION/INFORMATION

6-30-75 JGB

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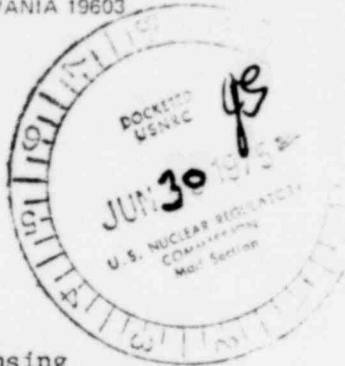


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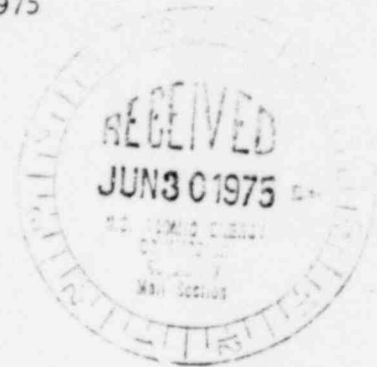
SUBSIDIARY OF GENERAL PUBLIC UTILITIES CORPORATION

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TELEPHONE 215 - 929-3601



June 25, 1975
GQL 1195



Director
Directorate of Licensing
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

Dear Sir:

Docket No. 50-289
Operating License No. DPR-50

In accordance with Technical Specifications for the Three Mile Island Nuclear Station Unit I, we are herewith submitting abnormal occurrence report number AO 50-289/75-17.

(1) Report Number: AO 50-289/75-17

(2a) Report Date: June 25, 1975

(2b) Occurrence Date: June 15, 1975

(3) Facility: Three Mile Island Nuclear Station Unit I

(4) Identification of Occurrence:

Title: Failure of Reactor Building Purge Isolation Valve to Pass
Local Leak Rate Test

Type: An abnormal occurrence as defined by Technical Specifications paragraph 1.8e, in that the failure of the Reactor Building purge isolation valve (AH-V1A) to pass the local leak rate test constituted an abnormal degradation of one of the several boundaries designed to contain the radioactive materials resulting from the fission process.

(5) Conditions Prior to Occurrence:

Power: Core: 89.5% (2270 MWt)
Elect.: 740 MWe

RC Flow: 138×10^6 lb/hr.

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RC Pressure: 2155 psi

RC Temp.: 579°F

PRZR Level: 240 in.

PRZR Temp.: 650°F

(6) Description of Occurrence:

During the yearly leak rate test of the Reactor Building Purge Isolation Valves, valve AH-V1A leakage prevented test pressure from increasing to 55 psi. Inspection of the valve seating surfaces showed that there was approximately a 1/16 inch gap between seating surfaces in the closed position. This gap was caused by misadjustment of the operator for this valve.

Valve AH-V1B was determined to be seating properly when checked with soap solution.

The operating mechanism for AH-V1A was adjusted and subsequent leak rate testing indicated that the leak rate was considerably within the requirements of Technical Specification 4.4.1.2.3.

(7) Designation of Apparent Cause of Occurrence:

The apparent cause of this occurrence is not known. However, it is believed that the possible cause is either:

- (a) procedure in that the valve operator adjustment procedure may not be adequate to assure proper long term valve adjustment, or
- (b) material in that the valve and/or valve operator design may not permit proper adjustment and/or long term retention of adjustment.

(8) Analysis of Occurrence:

Although valve AH-V1A did not meet acceptance criteria, the in series valve (AH-V1B) was shown to have acceptable leakage such that the combined leakage did not exceed acceptance criteria and, therefore, containment integrity was maintained. Since containment integrity was maintained, there was no potential threat to the health and safety of the public as a result of this occurrence.

(9) Corrective Actions:

Immediate:

The seating surfaces of AH-V1A and B were visually inspected. The hydraulic operator of AH-V1A was re-adjusted to assure tight closure of this valve using normal operating methods.

Valves AH-V1A and B were successfully retested and met acceptance criteria.

Long Term:

The seating surfaces of valve AH-VIA will be inspected approximately once every two weeks until confidence is gained that the valve is and will remain properly adjusted. In the event that any procedural or material inadequacies are discovered, appropriate corrective actions will be taken.

The Plant Operations Review Committee and Station Superintendent reviewed and approved the above listed actions, and steps have been taken to ensure implementation of the yet to be completed long term corrective actions.

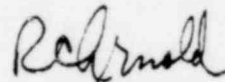
(10) Failure Data:

Previous Failures: None

Equipment Identification: Valve: Pratt 48 in.
Butterfly Valve

Actuator: Bettis Corp.
Robotarm Actuator
80889B K DC
1074 - 15R75

Sincerely,


R. C. Arnold
Vice President

RCA/CWS/cas

File: 20.1.1/7.7.3.5.1

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