

## (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0	1	C	O	F	S	V	1	2	0	0	-	0	0	0	0	0	-	0	0	3	4	1	1	2	0	4			5	
7	8	LICENSEE CODE						14	15	LICENSE NUMBER										25	26	LICENSE TYPE					30	37	CAT	58

CON'T

0	1
---	---

REPORT SOURCE

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

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

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 With the reactor operating at approximately 1.4%, plant operations personnel observed  
03 a dual position indication for HV-4153 (tie between circulating water system and ser-  
04 vice water system). Subsequent investigation revealed the valve was closed, but not  
05 fully seated, and was not operable from its associated hand switch. Because of Final  
06 Safety Analysis Report references in basis of LCO 4.2.4, this is reportable under de-  
07 graded mode operation per Technical Specification AC 7.5.2(b)2. No accompanying occur-  
08 rence or probable consequences. No affect on public health or safety.

SYSTEM CODE H F 11		CAUSE CODE E 12		CAUSE SUBCODE B 13		COMPONENT CODE V A L V E X 14		COMP. SUBCODE B 15		VALVE SUBCODE D 16							
EVENT YEAR 7 9		SEQUENTIAL REPORT NO. 0 1 8		OCCURRENCE CODE 0 3		REPORT TYPE L		REVISION NO. 0									
ACTION TAKEN Z 18		FUTURE ACTION X 19		EFFECT ON PLANT Z 20		SHUTDOWN METHOD Z 21		HOURS 0 0 0 0 22		ATTACHMENT SUBMITTED Y 23		NPRD-4 FORM SUB. N 24		PRIME COMP. SUPPLIER N 25		COMPONENT MANUFACTURER P 3 4 0 26	

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1	0	Cause of occurrence presently undetermined. No corrective action has as yet been
1	1	initiated. Cause information and corrective action will be reported in a future
1	2	supplement.

1 3

1	4	
---	---	--

1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16		17		18		19		20	
FACILITY STATUS				% POWER				OTHER STATUS				METHOD OF DISCOVERY				DISCOVERY DESCRIPTION																							
1	5	C	28	0	0	1	29	N/A				A	31	Operator Observation																									

ACTIVITY CONTENT  
RELEASED OF RELEASE AMOUNT OF ACTIVITY (35)

1 6 Z (33) Z (34) N/A

LOCATION OF RELEASE (36)

N/A

PERSONNEL EXPOSURES												
NUMBER			TYPE	DESCRIPTION (39)								
1	2	0	0	0	(37)	Z	(38)	N/A			519	242

PERSONNEL INJURIES										
NUMBER			DESCRIPTION							
1	3	0	0	0	40	N/A				

LOSS OF OR DAMAGE TO FACILITY		(43)
TYPE	DESCRIPTION	
1 9	2 (42) N/A	7908070 518 5

7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30	
PUBLICATION																																															
ISSUED DESCRIPTION																																															
2		0		44		N/A		45		NRC USE ONLY																																					
7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30	

NRC USE ONLY

(303) 785-2253

J. W. G. hm

REPORT DATE: July 30, 1979

REPORTABLE OCCURRENCE 79-18

OCCURRENCE DATE: June 30, 1979

ISSUE 0

Page 1 of 2

FORT ST. VRAIN NUCLEAR GENERATING STATION  
PUBLIC SERVICE COMPANY OF COLORADO  
P. O. BOX 361  
PLATTEVILLE, COLORADO 80651

REPORT NO. 50-267/79-18/03-L-0

Preliminary

IDENTIFICATION OF  
OCCURRENCE:

On June 30, 1979, with the reactor operating at approximately 1.4%, HV-4153, one of two motor operated butterfly valves which provide a tie between the circulating water system and the service water system, was found inoperable by remote manual control. Because the basis of LCO 4.2.4, Service Water Pumps, references operability of this valve by remote manual action as outlined in Final Safety Analysis Report Section 10.3, this constitutes operation under a degraded mode of LCO 4.2.4, and is reportable per Technical Specification AC 7.5.2(b)2.

EVENT  
DESCRIPTION:

On June 30, 1979, while operating at approximately 1.4% thermal power, plant operations personnel observed dual position indication for HV-4153, where ZI-4153 on I-06 was indicating both open and closed. Further investigation revealed that the valve was closed, but was not fully seated. Subsequent attempts to operate the valve from its associated hand switch were unsuccessful. Although this valve would not operate from the motor drive due to the amount of torque required, it could be operated locally with the handjack.

The basis of Technical Specification LCO 4.2.4, Service Water Pumps, states that the availability of the service water system ensures the capability of supplying essential components with cooling water, as described in Final Safety Analysis Report Sections 1.4, 10.3, and 14.4. Section 10.3.9 of the Final Safety Analysis Report, Cooldown with Safe Shutdown List Equipment Items Following "Safe Shutdown Earthquake" or Maximum Tornado, references the fact that makeup pump discharge is connected by remote manual action (via this valve as operated from the hand switch) to the service water pump suction pit. With this valve inoperable from the switch, the tie between the two systems is still available by manual operation of the valve; thus requirements for cooling water to essential components could still be met.

CAUSE  
DESCRIPTION:

The reason for the inability to operate this valve from the associated hand switch is presently unknown. Attempts to cycle the valve indicate that it would partially open by operation of the hand switch.

## CAUSE

DESCRIPTION (continued):

As further information becomes available, a supplemental report will be submitted.

## CORRECTIVE

ACTION:

No corrective action has as yet been initiated. Upon determination of the cause of occurrence and completion of required corrective action, a future supplement to this report will be issued.

Prepared by:

Cathy C. Collard  
Cathy C. Collard  
Technical Services Technician

Reviewed by:

Roger Heller for  
J. W. Gahm  
Technical Services Supervisor

Reviewed by:

Frank M. Mathie  
Frank M. Mathie  
Operations Manager

Approved by:

Don Warembourg  
Don Warembourg  
Manager, Nuclear Production