



Public Service Company of Colorado

16805 Weld County Road 19 1/2, Platteville, Colorado 80651

October 31, 1979
Fort St. Vrain
Unit No. 1
P-79252

Mr. Karl V. Seyfrit, Director
Nuclear Regulatory Commission
Region IV
Office of Inspection and Enforcement
611 Ryan Plaza Drive
Suite 1000
Arlington, Texas 76012

REF: Facility Operating License
No. DPR-34

Docket No. 50-267

Dear Mr. Seyfrit:

Enclosed please find a copy of Reportable Occurrence Report No. 50-267/79-42/03-L-0, Final, submitted per the requirements of Technical Specification AC 7.5.2(b)3.

Also, please find enclosed one copy of the Licensee Event Report for Reportable Occurrence Report No. 50-267/79-42/03-L-0.

Very truly yours,

Don Warembourg
Don Warembourg
Manager, Nuclear Production

DW/alk

cc: Director, MIPC

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REPORT DATE: October 31, 1979
OCCURRENCE DATE: October 2, 1979

REPORTABLE OCCURRENCE 79-42
ISSUE 0
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FORT ST. VRAIN NUCLEAR GENERATING STATION
PUBLIC SERVICE COMPANY OF COLORADO
16805 WELD COUNTY ROAD 19 1/2
PLATTEVILLE, COLORADO 80651

REPORT NO. 50-267/79-42/03-L-0

Final

IDENTIFICATION OF
OCCURRENCE:

At approximately 1200 hours on October 2, 1979, with the plant operating at approximately 24% thermal power, three penetration interspace pressurization valves were observed to be closed. These valves should have been open to supply pressurized helium to the penetrations.

This is reportable per Fort St. Vrain Technical Specification AC 7.5.2(b)3.

EVENT
DESCRIPTION:

At approximately 1200 hours on October 2, 1979, with reactor power at approximately 24%, it was observed that three penetration interspace pressurization valves (one to each of the high temperature filter adsorbers and one to the top access penetration) were closed. This condition was first brought to the attention of plant personnel as the result of a Nuclear Regulatory Commission audit. Per approved plant operating procedures, these valves are called out to be in the open position to provide helium supply. Although a supply of purified helium via these valves is not specifically addressed in the Technical Specifications, the basis of LCO 4.2.9, PCRV Closure Leakage, states that the gas supply to the penetrations is monitored for flow so that an increase in closure leakage can be sensed and alarmed.

Refer to Figure 1 for typical flow path. Under normal operating conditions, gas is supplied to the penetrations via the purified helium header, (1), through a flow element, (2), and a pressurized helium supply valve, (3), to the penetration, (4). With the helium supply valve open as required, any increase in helium flow due to primary/secondary seal leakage would be sensed by the flow element, (2), thereby providing flow indication, (5), and a high flow alarm, (6). However, with the supply valve closed, flow indication and alarm capability associated with these three penetrations was not available. Other penetrations were not affected.

Surveillance testing associated with PCRV closure leakage determination both prior to and following this occurrence indicated that the total interspace leakage for all penetrations was zero acfm. Based on this information, there is no evidence that any closure leakage occurred during the time in question. Had any leakage occurred during power operation since the performance of the last pre-operational valve lineup, it would have been detected by radiation monitoring equipment or a decrease in helium inventory; however, no such indications were observed.

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CAUSE
DESCRIPTION:

The reason for these valves being closed is not known.

CORRECTIVE
ACTION:

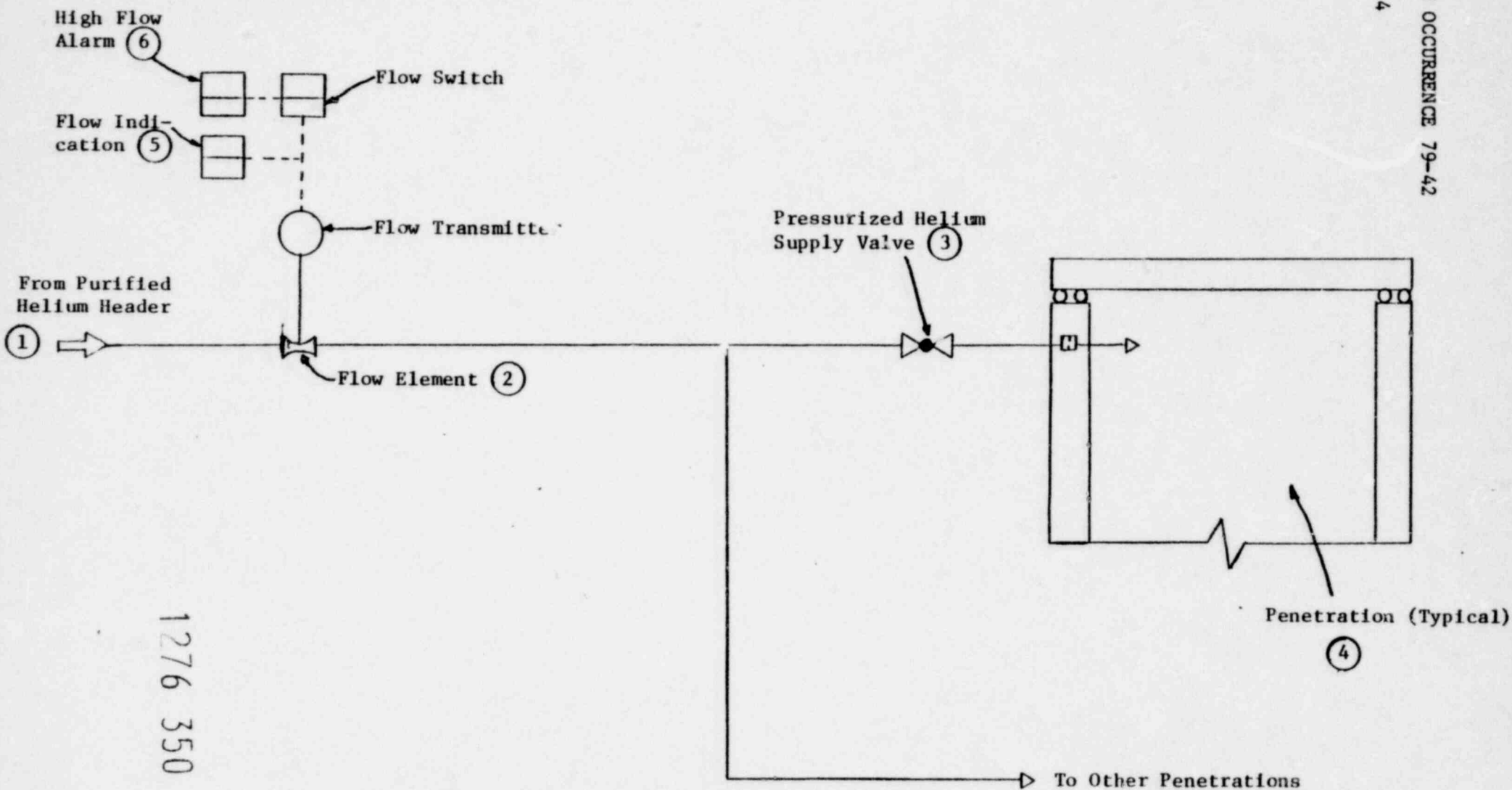
Upon notification that these valves had been found closed, they were reopened by operations personnel.

Surveillance testing performed following the return of the valves to the open position indicated no evidence of penetration closure leakage.

All personnel have been notified that valve positions are not to be altered without the express knowledge and permission of the Shift Supervisor. Personnel were also advised that any abnormal conditions observed are to be reported to the Shift Supervisor immediately.

No further corrective action is anticipated or required.

FIGURE 1



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