NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

LER 79-24/3L

CONTROL BLOCK: | | | | | | | (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1	LICENSEE CODE: V T V Y S 1 (2)	LICENSE NUMBER: 0 0 - 0 0 0 0 0 - 0 0 (3)	LICENSE TYPE: 4 1 1 1 1 (4)	CAT (5)

CON'T

0 1	REPORT SOURCE: L (6)	DOCKET NUMBER: 0 5 0 0 0 2 7 1 (7)	EVENT DATE: 0 9 2 0 7 9 (8)	REPORT DATE: 1 0 1 8 7 9 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 3 See attached sheet

0 9	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
	I B (11)	A (12)	F (13)	I N S T R U (14)	T (15)	Z (16)

(17) LER/RO REPORT NUMBER

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
7 9	—	0 2 4	/	0 3	L	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
B (18)	H (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	Y (24)	N (25)	R 2 9 0 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 1 See attached sheet

1 5	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
	Z (28)	0 8 8 (29)	NA	A (31)	Operator Observation

1 6	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
	Z (33)	Z (34)	NA	NA

PERSONNEL EXPOSURES

1 7	NUMBER	TYPE	DESCRIPTION (39)
	0 0 0 (37)	Z (38)	NA

PERSONNEL INJURIES

1 8	NUMBER	DESCRIPTION (41)
	0 0 0 (40)	NA

1149 114

LOSS OF OR DAMAGE TO FACILITY (43)

1 9	TYPE	DESCRIPTION
	Z (42)	NA

PUBLICITY

2 0	ISSUED	DESCRIPTION (45)
	Z (44)	NA

7910220243

NRC USE ONLY

NAME OF PREPARER W. F. Conway PHONE: 802-257-7711

GPO 917-926

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES

During steady state operation, Control Room personnel observed an abrupt change in indicated torus water level on Control Room Indicators LI-16-19-46A/B. Channel A increased from 1.15' to 4.54' while Channel B increased from 1.15' to 6.13'. Additionally, the HPCI suction valves shifted line-up from the condensate storage tank to the torus.

Upon investigation, it was revealed that contractor personnel, while erecting staging, dislodged a fitting on the torus level transmitters thereby draining the leg and causing the erroneous readings. Technical Specification 3.2.G requires this post-accident instrumentation be operable during reactor operation. At no time was the torus water inventory out of specification. Since this indication was restored within the limiting 6 hours of Tech. Spec. Table 3.2.6, the plant continued power operation. The potential based on the above consequences to the health and safety of the public were minimal.

CORRECTIVE ACTION TAKEN

The fitting was repaired, the reference leg refilled, and the instruments returned to operation. It has been further reemphasized to all contract personnel of the necessity to proceed with caution during all phases of their work activities.