

NRC FORM 386
(12-81)

U.S. NUCLEAR REGULATORY COMMISSION
LICENSEE EVENT REPORT

APPROVED BY OMB
3150-0011
EXPIRES 4-30-82

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

01 M D C C N 1 2 0 0 - 0 0 0 0 0 0 - 0 0 0 3 4 1 1 1 1 1 4 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 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

CONT

01 REPORT SOURCE L 6 0 5 0 0 0 3 1 7 7 0 2 2 6 8 1 8 0 7 1 4 8 3 9
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 At 1245 the Shift Supervisor was informed that the sample pump for the
03 Control Room (CR) rad monitor had been out of service since 0700 ren-
04 dering auto recirc of the CR inoperable on high radiation (T.S. 3.7.6.1).
05 The CR HVAC was placed in recirc and 11 POST LOCA filter was started
06 at 1315. The pump was repaired and CR HVAC returned to normal at 1530.
07 Both CR HVAC trains were otherwise operable during the event. Unit 2
08 was in Mode 5 during the event. Similar events: none.

09 SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP. SUBCODE VALVE SUBCODE
B B 11 E 12 F 13 P U M P X X 14 G 15 Z 16
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

17 LER/RO REPORT NUMBER 8 1 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

ACTION TAKEN FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED NPRO-4 FORM SUB. PRIME COMP. SUPPLIER COMPONENT MANUFACTURER
C 18 Z 19 Z 20 Z 21 0 0 0 0 22 Y 23 N 24 A 25 C 5 2 1 26
33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The sample pump seized during operation and was removed from service.
11 It was replaced with a spare. It appears that due to oxidation on the
12 bore, the pump vanes bound up and broke off causing seizure. This is
13 a normal end of life failure. Pump fails at regular intervals, PM
14 was instituted.

15 FACILITY STATUS % POWER OTHER STATUS METHOD OF DISCOVERY DISCOVERY DESCRIPTION
E 28 1 0 0 29 N/A A 31 Operator Observation
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

16 ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY LOCATION OF RELEASE
Z 33 Z 34 N/A N/A
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

17 PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION
0 0 0 37 Z 38 N/A
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

18 PERSONNEL INJURIES NUMBER DESCRIPTION
0 0 0 40 N/A
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

19 LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION
Z 42 N/A
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

20 PUBLICITY ISSUED DESCRIPTION
N 44 N/A
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

8308090365 830714
PDR ADOCK 05000317
S PDR

NRC USE ONLY

NAME OF PREPARER S. M. Davis/W. B. Cartwright PHONE: 301-269-4802

BALTIMORE GAS AND ELECTRIC COMPANY

P.O. BOX 1475

BALTIMORE, MARYLAND 21203

NUCLEAR POWER DEPARTMENT
CALVERT CLIFFS NUCLEAR POWER PLANT
LUSBY, MARYLAND 20657

July 14, 1983

Dr. Thomas E. Murley
Regional Administrator
U. S. Nuclear Regulatory Commission
Region 1
631 Park Avenue
King of Prussia, PA 19406

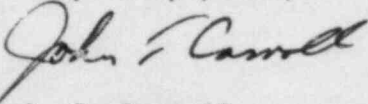
Docket No. 50-317
License No. DPR 53

Dear Dr. Murley:

Attached is LER 81-15/3X, Revision 1, as required by Technical Specification 6.9.

Should you have any questions regarding this report, we would be pleased to discuss them with you.

Very truly yours,


for L. B. Russell
Plant Superintendent

LBR:WBC:bsb

cc: Director, Office of Management Information
and Program Control
Messrs: A. E. Lundvall, Jr.
J. A. Tiernan

IE22
11

LER NO. 81-15/3X, Rev. 1
DOCKET NO. 50-317
LICENSE NO. DPR 53
EVENT DATE 02-26-81
REPORT DATE 07-14-83
ATTACHMENT

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (CONT'D)

During normal operation at approximately 1245 the Senior Control Room Operator informed the Shift Supervisor that the sample pump for the control room radiation monitor had been out-of-service since 0700 rendering automatic recirculation of the control room ventilation system on high radiation inoperable. Therefore at 1315, the control room ventilation system was placed in recirculation and 11 POST LOCA filter was started. Per the requirements of Technical Specification 3.7.6.1 the sample pump was repaired and the control room ventilation system was returned to normal operation at 1530.

Both trains of control room ventilation were otherwise operational during the event. Unit 2 (50-318) was in mode 5 during the event. This event did not affect the health or safety of the public. This is not a repetitive event.

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (CONT'D)

Due to the constant properties (temperature/low humidity) of the Control Room atmosphere, these pumps operate with a predictable lifetime. A preventive maintenance program has been developed and will be instituted to change the Control Room RMS pumps on a regular basis to prevent a recurrence of this event.