CENTRAL FILES

PHILADELPHIA ELECTRIC COMPANY
Peach Bottom Atomic Power Station
Delta, Pennsylvania
17314

December 4, 1980

Mr. Boyce H. Grier
Office of Inspection and Enforcement
Region I
United States Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, PA 19406

SUBJECT: REPORTABLE OCCURRENCE - PROMPT NOTIFICATION

Confirming D. C. Smith's conversation with Mr. Cowgill on December 3, 1980.

Reference: Docket No. 50-~~277~~ 278
Peach Bottom Unit 3
Technical Specification Reference: 3.5.C

Report No. 3-80-28/1P
Occurrence Date: December 3, 1980

Identification of Occurrence:

On November 24, 1980, during HPCI Surveillance Test 6.5, HPCI valve MO-3-23-14 kept driving in the closed direction causing the valve fuses to blow. The Unit 3 system was inoperable for approximately one half hour until the fuses were replaced. During this time all other ECCS systems were operable. The HPCI valve closing torque switch was inspected, readjusted, and the valve was stroked satisfactorily, as reported in LER 3-80-27/1P. On December 1, 1980, the valve did not fully close. Subsequent attempts to stroke the valve were successful. However, since it was felt that a problem might still exist in either the valve or valve operator, it was decided to declare the HPCI system inoperable. On December 3, 1980, after satisfactory testing of remaining ECCS systems and the RCIC system, the HPCI system was taken out of service and declared inoperable.

Conditions Prior to Occurrence:

Unit 3 operating at 100% power; Unit 2 operating at 99.6% power.

Apparent Cause of Occurrence:

The cause of occurrence is unknown at this time.

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Analysis of Occurrence:

The MO-14 valve is normally maintained closed, and opens on automatic initiation signal. At no time did the valve fail to operate in the open direction except during the short period on November 24, 1980 when the valve fuses blew. At all times when erratic valve operation was exhibited all ECCS systems and the RCIC system were either known to be operable or tested to verify operability. The safety significance is, therefore, minimal. Operation of this valve is not required for containment isolation.

Corrective Action:

On December 3, 1980, diagnostics were begun to determine the cause of erratic valve operation and provide appropriate corrective maintenance. Specific corrective action taken will be reported in the follow-up to this report.

Previous Failures:

3-80-27/1P

Very truly yours,

W T Ullrich

W. T. Ullrich
Station Superintendent

WTU:ljm

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

(2) LICENSEE CODE (3) LICENSE NUMBER (4) LICENSE TYPE (5) CAT

CON'T

REPORT SOURCE (6) 05000278 (7) 120380 (8) 120480 (9)

DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

SEE LETTER

SYSTEM CODE (11) CAUSE CODE (12) CAUSE SUBCODE (13) COMPONENT CODE (14) COMP. SUBCODE (15) VALVE SUBCODE (16)

(17) LER/RO REPORT NUMBER: EVENT YEAR 80 — SEQUENTIAL REPORT NO. 028 / OCCURRENCE CODE REPORT TYPE — REVISION NO.

ACTION TAKEN (18) FUTURE ACTION (19) EFFECT ON PLANT (20) SHUTDOWN METHOD (21) HOURS (22) ATTACHMENT SUBMITTED (23) NPRD-4 FORM SUB. (24) PRIME COMP. SUPPLIER (25) COMPONENT MANUFACTURER (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

FACILITY STATUS (28) % POWER (29) OTHER STATUS (30) METHOD OF DISCOVERY (31) DISCOVERY DESCRIPTION (32)

ACTIVITY RELEASED (33) CONTENT OF RELEASE (34) AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36)

PERSONNEL EXPOSURES NUMBER (37) TYPE (38) DESCRIPTION (39)

PERSONNEL INJURIES NUMBER (40) DESCRIPTION (41)

LOSS OF OR DAMAGE TO FACILITY TYPE (42) DESCRIPTION (43)

PUBLICITY ISSUED (44) DESCRIPTION (45)

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NAME OF PREPARER _____ PHONE: _____

NRC FORM 366