

3150-0011

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CON'TEVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

SYSTEM CODE		CAUSE CODE		CAUSE SUBCODE		COMPONENT CODE				COMP. SUBCODE		VALVE SUBCODE					
0	9	Z	Z	B	B	V	A	L	V	O	P	A	Z				
7	8	9	10	11	12	13	14	15	16	17	18	19	20				
LER/RO REPORT NUMBER		EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.							
17		8	3		0	1	1	0	1		0						
21	22	23	24	25	26	27	28	29	30	31	32						
ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER	
Z	X	Z	Z	Z	Z	0	0	0	0	N	N	L	L	Z	Z	0	0
33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

FACILITY STATUS		% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1	5	B (28)	0 0 0 (29)	NA	B (31) During maintenance activity

PERSONNEL EXPOSURES			
NUMBER	TYPE	DESCRIPTION	
17	000	Z	NA

7	8	9	11	12	80
LOSS OF OR DAMAGE TO FACILITY					
TYPE		DESCRIPTION			
1	9	Z	42	NA	IE22

PUBLICATION		ISSUED		DESCRIPTION		NRC USE ONLY	
2	0	N	44	NA			

NAME OF PREPARER William J. Kelly

PHONE: 805/595-7351

PACIFIC GAS AND ELECTRIC COMPANY

PG&E

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JAMES D. SHIFFER
MANAGER

DEPARTMENT OF NUCLEAR PLANT OPERATIONS
NUCLEAR POWER GENERATION

June 9, 1983

RECEIVED
NRC
1983 JUN 10 AM 11:31
REGION VISE

Mr. John B. Martin, Regional Administrator
U.S. Nuclear Regulatory Commission, Region V
1450 Maria Lane, Suite 210
Walnut Creek, CA 94596-5368

Re: Docket No. 50-275, OL-DPR-76
Diablo Canyon Unit 1
Licensee Event Report 83-014/01T-0
Malfunction of Limitorque Valve Operator

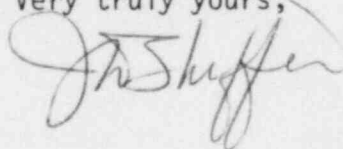
Dear Mr. Martin:

Pursuant to Section 6.9.1.12.i of the Technical Specifications, Appendix A to the Diablo Canyon Unit 1 Operating License, the enclosed Licensee Event Report is submitted concerning the malfunction of a Limitorque valve operator.

When I originally notified you of this event on May 26, 1983, it appeared that the cause was manual overtorquing of the valve operator, resulting in the torque switch arm wedging against the mounting bolt. The proposed corrective action at that time was to replace the existing mounting bolts with the original type. Subsequent investigation in conjunction with Limitorque, however, indicates that we need to evaluate the cause of the event in greater detail to prevent exacerbating the situation and to identify the specific valves susceptible to this phenomena. Therefore, a revised Licensee Event Report will be submitted once the investigation is completed.

This event in no way affects the public health and safety.

Very truly yours,



Enclosure

cc w/enc.: Mr. George W. Knighton, Chief
Licensing Branch No. 3
Division of Licensing
Office of Nuclear Reactor Regulation
U.S. Nuclear Regulatory Commission
Washington, D. C. 20555

Director, Office of Management
Information and Program Control
U.S. Nuclear Regulatory Commission, Washington, D. C. 20555
Service List

1/1
IE-22
83-124