NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

UPDATE REPORT - Previous Report 2/28/83

LICENSEE EVENT REPORT

LER 83-6/1X

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

Line	Field	Value
01	Licensee Code (2)	V T V Y S 1
01	License Number (3)	0 0 - 0 0 0 0 0 - 0 0
01	License Type (4)	4 1 1 1 1
01	CAT (5)	
CON'T 01	Report Source (6)	L
01	Docket Number (7)	0 5 0 0 0 2 7 1
01	Event Date (8)	0 2 2 5 8 3
01	Report Date (9)	0 3 1 4 8 3

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02–08: See Attached.

Line	Field	Value
09	System Code (11)	E C
09	Cause Code (12)	X
09	Cause Subcode (13)	X
09	Component Code (14)	C K T B R K
09	Comp. Subcode (15)	D
09	Valve Subcode (16)	
(17) LER/RO Report Number	Event Year	8 3
		—
	Sequential Report No.	0 0 6
		/
	Occurrence Code	0 1
	Report Type	X
		—
	Revision No.	0
	Action Taken (18)	X
	Future Action (19)	Z
	Effect on Plant (20)	Z
	Shutdown Method (21)	Z
	Hours (22)	0 0 0 0
	Attachment Submitted (23)	Y
	NPRD-4 Form Sub. (24)	N
	Prime Comp. Supplier (25)	A
	Component Manufacturer (26)	W 1 2 1

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10–14: See Attached.

Line	Field	Value
15	Facility Status (28)	E
15	% Power (29)	0 8 1
15	Other Status (30)	NA
15	Method of Discovery (31)	B
15	Discovery Description (32)	Observation by Electrician
16	Activity Released (33)	Z
16	Content of Release (34)	Z
16	Amount of Activity (35)	NA
16	Location of Release (36)	NA
17	Personnel Exposures Number (37)	0 0 0
17	Type (38)	Z
17	Description (39)	NA
18	Personnel Injuries Number (40)	0 0 0
18	Description (41)	NA
19	Loss of or Damage to Facility Type (42)	Z
19	Description (43)	NA
20	Publicity Issued (44)	N
20	Description (45)	NA

NRC USE ONLY

NAME OF PREPARER James P. Pelletier PHONE: (802) 257-7711

UPDATE REPORT - Previous report 2/28/82

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES

During normal operation, V13-18 failed to close while performing a valve lineup for surveillance testing. While performing troubleshooting to determine the cause for the valve not closing, the door for the cubical in the Motor Control Center was observed to be binding the interlock mechanism. Looking at other cubicals revealed that they could potentially have the same problem if the covers are tightened. This was suspected to be a generic problem with the D. C. Motor Control Centers and was reported per T. S. 6.7.B.1.i. There were no significant consequences as a result of this event. There were no adverse affects to public health or safety as a result of this event. There have been no similar occurrences.

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS

On March 5th, additional troubleshooting was performed to further evaluate the failure of February 25th. The troubleshooting attempted to reproduce the suspected cause of the failure of V13-18 and to determine if the failure could be common to other cubicals.

The testing on March 5th failed to reproduce the failure of February 25th. Failure of the contactor to pick up was achieved only by misaligning and tightening the interlock mechanism against each contactor such that the contactors were not free to move. This procedure created binding whether the cubical door was loose or tight. The testing concluded that the failure has no relation to whether the cubical door was tight or loose but was related to the position and tightness of the mechanical interlock.

Inspection of the interlock mechanism on other cubicals showed that they were correctly aligned.

Based upon the above testing, we have concluded that the failure of V13-18 on February 25th was caused by the mechanical interlock mechanism being out of adjustment, therefore, causing the contactors to bind which in turn prevented valve operation. We now believe this to be an isolated event and not indicative of a generic problem with the D. C. Motor Control Centers.