

## LICENSEE EVENT REPORT

CONTROL BLOCK: 1 2 3 4 5 6 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

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 NYREG 100-000000-000341111105  
7 8 9 14 15 25 26 30 57 CAT 58CON'T  
01 REPORT SOURCE L05000244703238380407839  
7 8 60 61 66 69 74 75 80

## EVENT DESCRIPTION AND PROBABLE CONSEQUENCES 10

02 While at 100% steady state operation, scheduled local leak testing of the containment

03 personnel hatch was being performed as required every 6 months by Tech. Specs. Upon

04 initial pressurization an audible exterior door shaft leak was found. The leakage

05 sounded as though it may have been greater than allowable. The test was stopped and

06 packing adjustments were made on the exterior door. The local leak test was performed

07 again with unacceptable results. Adjustments were made on the interior door and the

08 test performed with very low leakage found. Based on review of the test data and

(cont'd.)

09 SYSTEM CODE SA11 CAUSE CODE A12 CAUSE SUBCODE C13 COMPONENT CODE PENETR14 COMP. SUBCODE A15 VALVE SUBCODE Z16

17 LEAK REPORT NUMBER 83 EVENT YEAR 83 SEQUENTIAL REPORT NO. 012 OCCURRENCE CODE 01 REPORT TYPE T REVISION NO. 0

ACTION TAKEN B18 FUTURE ACTION Z19 EFFECT ON PLANT Z20 SHUTDOWN METHOD Z21 HOURS 0000 ATTACHMENT SUBMITTED Y23 NRPD-4 FORM SUB. N24 PRIME COMP. SUPPLIER A25 COMPONENT MANUFACTURER C31026

## CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27

10 During investigation of these test results it was identified in the plant Operations

11 Review Committee, that previous maintenance, including repacking, had been performed

12 without proper testing of the packing area. The maintenance procedure was reviewed

13 and it only required seal testing on the doors. This procedure was revised, and

14 associated personnel reviewed the circumstances of the procedural inconsistency. All

(cont'd.)

15 FACILITY STATUS E28 % POWER 10029 OTHER STATUS NA30 METHOD OF DISCOVERY B31 DISCOVERY DESCRIPTION Performance of scheduled leak test32

16 ACTIVITY CONTENT RELEASED OF RELEASE Z33 Z34 AMOUNT OF ACTIVITY NA35 LOCATION OF RELEASE NA36

17 PERSONNEL EXPOSURES NUMBER 00037 TYPE Z38 DESCRIPTION NA39

18 PERSONNEL INJURIES NUMBER 00040 DESCRIPTION NA41

19 LOSS OF OR DAMAGE TO FACILITY TYPE Z42 DESCRIPTION NA43

20 PUBLICITY Z44 DESCRIPTION NA45

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PDR ADDOCK 05000244  
S PDR

J. Bodine

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LER 83-012/01T

Event Description and Probable Consequences (cont'd.)

possible uncertainty factors, it is believed that the outer door leakage was less than Tech. Specs. limits. The inner door leakage may have been greater than the limits. The method of testing this hatch makes it impossible to measure individual door leakage. Based on conditions explained under cause investigation, this is reportable under 6.9.2a(6) of our Tech. Specs.

Cause Description and Corrective Actions (cont'd.)

maintenance procedures are being reviewed and revised as necessary to control proper follow-up testing requirements. Test personnel have been cautioned about the necessity to determine "as-found" conditions before discontinuing tests when performing local leakage testing to satisfy Tech. Spec. requirements.