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TELEPHONE
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June 21, 1973

Mr. John F. O'Leary, Director
Directorate of Licensing
U. S. Atomic Energy Commission
Washington, D. C. 20545

Subject: R. E. Ginna Nuclear Power Plant, Unit No. 1
Malfunction of Blend System Valve FCV-110B
Docket No. 50-244



Dear Mr. O'Leary:

In accordance with Ginna Station Technical Specifications, Change No. 8, Section 6.6.2, Item b-2 which requires that "discovery of any substantial variance from performance specifications contained in the Technical Specifications or in the Safety Analysis Report" shall be submitted in the form of a written report within 30 days to the Director of Licensing and to the Director of Regional Regulatory Operations office, the following is presented:

The reactor was operating normally at 1266 MW_t with the Control Bank D rods at 226 steps when the incident occurred. The boric acid transfer pumps were started at approximately 1015 hours on May 23, 1973, to recirculate the tanks prior to sampling.

Approximately thirty minutes after the boric acid transfer pumps were started, the operator noted the control rods were stepping out (from 226 steps to 229 steps).

In accordance with Emergency Procedure E-11, Continuous Rod Withdrawal, the rod control selector switch was placed in manual mode.

The operator noted that Reactor Coolant System Tavg had dropped approximately 2°F. The boric acid makeup flow recorder revealed a slight flow during the time the boric acid storage tanks recirculation was in progress. The boric acid makeup integrated 10.6 gallons of boric acid. Preliminary observation pointed to valves FCV-110B or FCV-110C leaking through. The operator then diluted the Reactor Coolant System 179 gallons. Subsequently, Tavg returned to normal (568.5°F), and the control rods were returned to automatic on the rod control mode selector switch.

Further investigation revealed that the blend system valve FCV-110B was leaking through.

The Plant Operations Review Committee convened at 1625 hours to discuss

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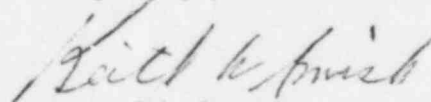
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TO Mr. John F. O'Leary

the occurrence. A procedure EM-73, Repair of Blend System Valve FCV-110B, was presented and approved.

Repair was instituted and completed on May 24, 1973 at approximately 1230 hours.

The operator displayed proper action by placing the rod control switch in manual mode. The maintenance repair revealed the diaphragm of FCV-110B was in need of replacement. To prevent recurrence of this incident the Plant Operations Review Committee recommended and the Plant Superintendent approved that the diaphragms of both valves FCV-110B and FCV-110C, which are on the downstream lines of the blender, be replaced and tested at each refueling shutdown.

Very truly yours,


Keith W. Amish

xc: Mr. James P. O'Reilly