

NRC FORM 366
(12-81)U.S. NUCLEAR REGULATORY COMMISSION
LICENSEE EVENT REPORTAPPROVED BY OMB
3150-0011
EXPIRES 4-30-82

CONTROL BLOCK: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>										(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)									
01 M D C C N 1 2 0 0 - 0 0 0 0 0 0 - 0 0 3 4 1 1 1 1 4 5										7 8 9 14 15 25 26 30 37 CAT 38									
CON'T																			
01 REPORT SOURCE L 6 0 5 0 0 0 3 1 7 7 0 2 1 0 8 3 8 0 7 3 0 8 4 9										7 8 9 14 15 25 26 30 37 CAT 38									
EVENT DESCRIPTION AND PROBABLE CONSEQUENCES 10																			
02 During normal operation at 1000, while conducting a review of the Unit 1 and																			
03 2 snubber surveillance test procedures (STPs), the following discrepancies																			
04 were discovered: (1) Snubber 2-15-10 was not included in both the Unit 2																			
05 Technical Specification (T.S.) and STPs and (2) a missed surveillance had																			
06 occurred on snubber 1-15-8. This is considered reportable IAW T.S. 4.7.8.1.																			
07 Similar events: none																			
08																			
09																			
SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP. SUBCODE VALVE SUBCODE																			
Z Z 11 X 12 Z 13 S U P P O R T 14 D 15 Z 16																			
EVENT YEAR																			
8 3																			
SEQUENTIAL REPORT NO.																			
0 0 9																			
OCCURRENCE CODE																			
0 3																			
REPORT TYPE																			
X																			
REVISION NO.																			
3																			
ACTION TAKEN FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED NPRO-4 FORM SUB. PRIME COMP. SUPPLIER COMPONENT MANUFACTURER																			
G 18 X 19 Z 20 Z 21 0 0 0 0 0 Y 23 N 24 A 25 I 2 0 7																			
CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27																			
10 Snubber 2-15-10 was incorrectly tagged 1-15-8. This resulted in missed																			
11 surveillance on the actual snubber 1-15-8. Both snubbers were examined																			
12 and passed the visual inspection criteria. Snubber 2-15-10 has been																			
13 correctly tagged and added to the Unit 2 T.S. and STPs. No further																			
14 corrective action is necessary.																			
FACILITY STATUS % POWER OTHER STATUS 30 METHOD OF DISCOVERY DISCOVERY DESCRIPTION 32																			
15 F 28 1 0 0 29 N/A Z 31 N/A																			
ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY 35 LOCATION OF RELEASE 36																			
16 Z 33 Z 34 N/A N/A																			
PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION 39																			
17 0 0 0 37 Z 38 N/A																			
PERSONNEL INJURIES NUMBER DESCRIPTION 41																			
18 0 0 0 40 N/A																			
LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION 43																			
19 Z 42 N/A																			
PUBLICITY ISSUED DESCRIPTION 45																			
20 N 44 N/A																			
NAME OF PREPARER E. V. Farrell										PHONE: (301) 269-4504									

LER NO. 83-09/3X, Rev. 3
DOCKET NO. 50-317
LICENSE NO. DPR 53
EVENT DATE 02-10-83
REPORT DATE 07/30/84
ATTACHMENT

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (CONT'D)

While conducting a review of the Unit 1 and 2 snubber Surveillance Test Procedures (STPs), it was discovered that snubber 2-15-10 had not been incorporated into the Technical Specifications, and therefore was not in the appropriate Surveillance Test Procedure (STP). A visual inspection of the snubber revealed that it was incorrectly tagged 1-15-8. Hence, two snubbers had been surveilled as snubber 1-15-8. These actions resulted in missed surveillance of the actual snubber 1-15-8.

CAUSE/DESCRIPTION AND CORRECTIVE ACTIONS (CONT'D)

Snubber 2-15-10 was incorrectly tagged 1-15-8. This resulted in missed surveillance on actual snubber 1-15-8. Both snubbers were examined and passed the visual inspection criteria. They were also removed for functional testing (per NRC request) and replaced with rebuilt snubbers. Snubber 1-15-8 failed functional testing because the bleed adjustment screw had been incorrectly set. This resulted in a bleed (release) rate of zero. A visual inspection was performed on the line in which snubber 1-15-8 was installed. This inspection revealed that the components supported by the snubber were not adversely affected by the inoperability of the snubber. Snubber 2-15-10 passed functional testing, has been correctly tagged, and incorporated into the appropriate snubber Surveillance Test Procedure and Unit 2 Technical Specifications. All Unit 1 and Unit 2 snubbers have been inspected and correct tags have been installed where necessary. A review of the snubber maintenance procedures verified that adequate controls exist to prevent the installation of a snubber with the wrong identification tag. No further corrective action is necessary.

BALTIMORE GAS AND ELECTRIC COMPANY

P.O. BOX 1475

BALTIMORE, MARYLAND 21203

NUCLEAR POWER DEPARTMENT
CALVERT CLIFFS NUCLEAR POWER PLANT
LUSBY, MARYLAND 20657

August 3, 1984

U. S. Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

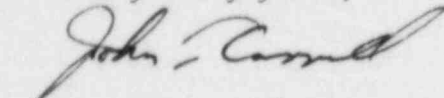
Docket No. 50-317
License No. DPR 53

Dear Sirs:

The attached revision to LER 83-09, Revision 3 is being forwarded to you for your information.

Should you have any questions regarding this report, we would be pleased to discuss them with you.

Very truly yours,


Fu L. B. Russell

Plant Superintendent


LBR:EVF:srm

Attachment

cc: Dr. Thomas E. Murley
Director, Office of Management Information
and Program Control
Messrs: A. E. Lundvall, Jr.
J. A. Tiernan

IE 22

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