

CONTROL BLOCK: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ (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 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

CON'T

01 REPORT SOURCE L 6 0 5 0 0 0 3 1 7 7 1 2 3 0 8 2 8 1 1 0 8 8 5 9
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

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 During normal power operation at 1015 while performing surveillance

03 testing, the ESFAS AL sequencer was found to be inoperable (T. S. 3.8.1.1).

04 Consequently, the handswitch for #11 CMT Spray Pump (CSP) was placed

05 in pull-to-lock (T.S. 3.6.2.1). The operability of the sequencer and

06 the CSP was restored at 1130. The redundant ESFAS instrumentation and

07 the redundant CSP and CMT coolers remained operable during this

08 event. Similar events: None

09 SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP SUBCODE VALVE SUBCODE
I B 11 E 12 G 13 I N S T R U 14 X 15 Z 16

17 LEN/RO REPORT NUMBER 8 2 18 0 8 5 19 0 3 20 X 21 1 22 1 23 0 3 24 X 25 1 26 1 27 1 28 1 29 1 30 1 31 1 32 1 33 1 34 1 35 1 36 1 37 1 38 1 39 1 40 1 41 1 42 1 43 1 44 1 45 1 46 1 47 1 48 1 49 1 50 1 51 1 52 1 53 1 54 1 55 1 56 1 57 1 58 1 59 1 60 1 61 1 62 1 63 1 64 1 65 1 66 1 67 1 68 1 69 1 70 1 71 1 72 1 73 1 74 1 75 1 76 1 77 1 78 1 79 1 80 1 81 1 82 1 83 1 84 1 85 1 86 1 87 1 88 1 89 1 90 1 91 1 92 1 93 1 94 1 95 1 96 1 97 1 98 1 99 1 100

18 ACTION TAKEN 19 FUTURE ACTION 20 EFFECT ON PLANT 21 SHUTDOWN METHOD 22 HOURS 23 ATTACHMENT SUBMITTED 24 NPD-4 FORM SUB. 25 PRIME COMP. SUPPLIER 26 COMPONENT MANUFACTURER

18 C 19 Z 20 Z 21 Z 22 0 0 0 0 23 N 24 Y 25 N 26 V 1 3 2

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 Investigation found no cause for failure of the sequential blocking module

11 (Vitro Eng. Div.). The module was replaced with a spare. The failed module

12 was returned to the vendor for repair and testing. Vendor failure analysis

13 revealed no further corrective action required.

14

15 FACILITY STATUS 16 % POWER 17 OTHER STATUS 18 METHOD OF DISCOVERY 19 DISCOVERY DESCRIPTION 20

15 E 16 0 0 0 17 NA 18 B 19 Surveillance Testing 20

21 ACTIVITY CONTENT RELEASED OF RELEASE 22 AMOUNT OF ACTIVITY 23 LOCATION OF RELEASE 24

21 Z 22 Z 23 NA 24 NA 25

26 PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION 27

26 0 0 0 27 38 28 NA 29

30 PERSONNEL INJURIES NUMBER DESCRIPTION 31

30 0 0 0 31 40 32 NA 33

34 LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION 35

34 Z 35 NA 36

37 PUBLICATION ISSUED DESCRIPTION 38

37 N 38 NA 39

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

November 8, 1985

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

Docket No. 50-317
License No. DPR 53

Dear Sirs:

The attached LER 82-085/3X, Revision 1, is being sent to you as required by 10 CFR 50.73.

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

Very truly yours,

LBR

L. B. Russell
Plant Superintendent

MS
LBR:RBS:fld

cc: Dr. Thomas E. Murley
Director, Office of Management Information
and Program Control

Messrs: A. E. Lundvall
J. A. Tiernan
W. J. Lippold

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