

Attachment to LER 81-021/01X-0

Event Description and Probable Consequences

This report is to notify you of two similar events which occurred at PNPS.

Event #1: On 6/1/81 two manually operated 1" valves on the containment nitrogen purge system were closed to allow work to be performed on the Post Accident Nitrogen Purge System. The ORC determined that closing these valves rendered the primary containment isolation valves on the nitrogen purge system inoperable. Since the nitrogen purge isolation valves are listed in table 3.7.1 of the Tech. Specs. by rendering them inoperable and closing the 1" manually operated valve we placed ourselves in a limiting condition for operation as stated in section 3.7.D.2 of the Tech. Specs.

Event #2: The same event described above occurred on 7/21/80 however we did not recognize that we were operating in a limiting condition for operation at that time and therefore did not submit an LER.

Cause Description and Corrective Action

The work performed on the Post Accident Nitrogen Supply System on 6/1/81 resulted from an inspection performed on 5/27/81 which revealed that two one inch lines on the Post Accident Sample System had been cut and capped. An investigation made to determine when and why the lines had been cut revealed that on 7/21/80 two check valves were removed from the system for use in another system.

It was determined that when the check valves were removed the system isolation caused PNPS to be operating in a limiting condition for operation as described in Event #1.

Regarding event #2, operation in a limiting condition during the 7/21/80 event was not obvious, due to a failure in administrative control which did not allow for a proper review of the situation prior to the work being performed.

The cause of the administrative breakdown and the effects of removing the Post Accident Nitrogen Purge Supply System are under investigation and will be addressed in a followup report to LER 81-021/01X-0.

POOR ORIGINAL