

### LICENSEE EVENT REPORT

CONTROL BLOCK: [ ] [ ] [ ] [ ] [ ] [ ] [ ] (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

[0][1] [N][C][B][E][P] [1] [2] [0][0] [0][0][0][0][0] [0][0] [4][1][1][1] [4] [5]  
7 8 9 LICENSEE CODE 14 15 LICENSE NUMBER 25 26 LICENSE TYPE 30 57 CAT 58

CON'T  
[0][1] REPORT SOURCE [L] (6) [0][5][0] [0][3][2][5] (7) [1][2][2][6][8][1] (8) [0][1][2][5][8][2] (9)  
7 8 60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

[0][2] On January 6, 1982, following a review of Primary Containment Isolation System (PCIS) logic prints, it was determined that the Action Statement 3.3.2b was not entered when required on December 26, 1981, when the B2I-LT-N017D-1 instrument failed upscale.  
[0][3] Failure to enter this action statement could have caused a failure to isolate the out-board isolation valves for groups 2, 6, 7, and 8. The inboard valves would have isolated as required. This event did not affect the health or safety of the public.

Technical Specification 6.9.1.8b

[0][9] SYSTEM CODE [S][D] (11) CAUSE CODE [A] (12) CAUSE SUBCODE [A] (13) COMPONENT CODE [I][N][S][T][R][U] (14) COMP. SUBCODE [T] (15) VALVE SUBCODE [Z] (16)  
7 8 9 10 11 12 13 18 19 20

(17) LER/RO REPORT NUMBER [8][1] (21) EVENT YEAR [8][1] (22) SEQUENTIAL REPORT NO. [ ] (23) OCCURRENCE CODE [0][1] (24) REPORT TYPE [T] (25) REVISION NO. [1]  
21 22 23 24 26 27 28 29 30 31 32

ACTION TAKEN [X] (18) FUTURE ACTION [X] (19) EFFECT ON PLANT [Z] (20) SHUTDOWN METHOD [Z] (21) HOURS [0][0][0][0] (22) ATTACHMENT SUBMITTED [Y] (23) NRPD-4 FORM SUB. [Y] (24) PRIME COMP. SUPPLIER [A] (25) COMPONENT MANUFACTURER [R][3][6][9] (26)  
33 34 35 36 37 40 41 42 43 44 47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

[1][0] This event occurred because Operations personnel failed to recognize and perform the technical specification required action within the specified time frame. The N017D-1 had been repaired prior to this being identified. Involved personnel have been counseled on the importance of prompt and thorough review of identified instrument problems.  
[1][1] Other corrective actions to this event will be provided in a supplemental report.

[1][5] FACILITY STATUS [E] (28) % POWER [0][9][9] (29) OTHER STATUS [NA] (30) METHOD OF DISCOVERY [B] (31) DISCOVERY DESCRIPTION [Routine Maintenance] (32)  
7 8 9 10 12 13 44 45 46 80

[1][6] ACTIVITY RELEASED OF RELEASE [Z] (33) CONTENT [Z] (34) AMOUNT OF ACTIVITY [NA] (35) LOCATION OF RELEASE [NA] (36)  
7 8 9 10 11 44 45 80

[1][7] PERSONNEL EXPOSURES NUMBER [0][0][0] (37) TYPE [Z] (38) DESCRIPTION [NA] (39)  
7 8 9 11 12 13 80

[1][8] PERSONNEL INJURIES NUMBER [0][0][0] (40) DESCRIPTION [NA] (41)  
7 8 9 11 12 80

[1][9] LOSS OF OR DAMAGE TO FACILITY TYPE [Z] (42) DESCRIPTION [NA] (43)  
7 8 9 10 80

[2][0] PUBLICITY ISSUED DESCRIPTION [N] (44) (4) 8202050399 820125 PDR ADCK 05000325 S PDR  
7 8 9 10 68 69 80 NRC USE ONLY

GPO 917-926

LER ATTACHMENT - RO #1-81-92

Facility: BSEP Unit No. 1

Event Date: 12-26-81

This event occurred because Operations personnel failed to recognize an identified instrument problem affecting PCIS instrument, 1-B21-LT-N017D-1, as requiring technical specification corrective action. As a result, the required corrective actions were not performed within the specified time frame.

On December 26, 1981, the on-duty auxiliary operator observed and recorded on the auxiliary operator's Daily Surveillance Report (DSR) a  $> 210''$  reading for the N017D-1 instrument, which was significantly higher than shown by the other redundant level instruments. This person failed to recognize the operability requirement associated with the instrument; consequently, he did not alert the Control Operator to the problem either by word of mouth or submission of a work request authorization to investigate and repair the problem. In addition, the Control Operator and Shift Foreman in reviewing the auxiliary operator's Daily Surveillance Report, also failed to recognize that a possible problem existed. This sequence of these events was duplicated on December 27, 1981.

On December 28, 1981, a different auxiliary operator identified and documented this problem in the auxiliary operator DSR. He also submitted a work authorization to investigate and repair the instrument. In reviewing the work authorization request form, the on-duty Senior Control Operator failed to recognize this was N017D-1, a technical specification related instrument. Therefore, the correct action statement was not entered.

On December 29, 1981, a work authorization was written on B21-LT-N017D-2, a non-technical specification related instrument, which stated that it was failed upscale. While repair work was in progress on N017D-2 on December 31, 1981, a discussion between Maintenance personnel and the on-duty Control Operator alerted him to the questionable operability of N017D-1 which was also pegged high. Following an immediate review of the technical specifications requirements involving the operability of N017D-1, a half scram was manually initiated on channel B. However, the operator failed to note that the N017D-1 instrument was also required in the PCIS section of instrumentation in the technical specifications and, therefore, he did not enter the required Action Statement 3.3.2b. Following a review of PCIS logic on January 6, 1982, it was determined that the appropriate action statement had not been entered on December 26, 1981, or December 31, 1981. When this problem was noted on January 6, 1982, the instrument had already been returned to service.

As a result of this event, the involved personnel were counseled concerning the importance of immediate identification and notification of any abnormal indications relating to technical specification instruments and a more thorough review of technical specification applicability for failed instruments.

In addition, the following actions are under consideration to prevent future events of this type:

1. Review DSRs to provide tolerances and references to technical specifications when required.

2. Provide a cross-reference of technical specification required instrumentation to its referenced technical specifications.
3. Review the concept of specifically identifying (coloring, stamping, tagging, etc.) technical specification related instrumentation in the plant.
4. Review and revise as required technical specifications relating to specific actions required due to instrument inoperability to provide for a better understanding and clarity.
5. Conduct training to help Operations personnel be more alert to changes in instrumentation indication trending relating to instrument operability.
6. Conduct on-shift seminars covering DSR trending, the basis and purpose for instrument checks, the analog modification and how technical specifications are effected.
7. Conduct a thorough review of this event with each shift, emphasizing the events and causes leading up to this problem.

Following a determination of what further corrective actions to this event will be performed, a supplement to this report specifically outlining the corrective actions will be submitted.