NRC FORM 366 (7-77)

U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

Update Report
Previous Report Date 3-4-82

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

0 1	LICENSEE CODE: N C B E P 2 (2)	LICENSE NUMBER: 0 0 - 0 0 0 0 0 - 0 0 (3)	LICENSE TYPE: 4 1 1 1 1 (4)	CAT (5)

CON'T

0 1	REPORT SOURCE: L (6)	DOCKET NUMBER: 0 5 0 - 0 3 2 4 (7)	EVENT DATE: 0 2 0 9 8 2 (8)	REPORT DATE: 0 3 1 2 8 2 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 During plant operation, a water leak dripping on the equipment cabinet of Primary
0 3 Containment Atmospheric Monitor, 2-CAC-ATM-1259 came in contact with the monitor
0 4 power supply transformer and resulted in a loss of power to the monitor. Following
0 5 initial discovery of this event, the plant fire brigade was dispatched to the scene
0 6 in case of fire; however, deenergizing the cabinet prevented a fire. This event did
0 7 not affect the health and safety of the public.
0 8 Technical Specifications 3.3.5.3, 3.6.6.4, 6.9.1.9b

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
0 9	S E (11)	E (12)	A (13)	I N S T R U (14)	Y (15)	Z (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 2	—	0 3 1	/	0 3	L	—	1

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
C (18)	Z (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	Y (24)	A (25)	N 3 0 5 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 Well water from a small gasket leak on the upstream valve body flange of RHRSW header
1 1 flushing valve, 2-SW-V140, dripped onto the monitor transformer causing the monitor
1 2 power failure. The transformer was replaced and the monitor, Model No. F3M3-1AX,
1 3 was returned to service. The leaking V140 gasket was replaced with one of greater
1 4 durability and the valve was returned to service. No further action to this event is required.

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1 5	E (28)	0 7 8 (29)	NA	A (31)	Plant Technician Surveillance

	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
1 6	Z (33)	Z (34)	NA	NA

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION (39)
1 7	0 0 0 (37)	Z (38)	NA

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
1 8	0 0 0 (40)	NA

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
1 9	Z (42)	NA

PUBLICITY

ISSUED	DESCRIPTION (45)	NRC USE ONLY
	NA	

NAME OF PREPARER M. J. Pastva, Jr. PHONE 919-457-9521

LER ATTACHMENT - RO #2-82-31

Facility: BSEP Unit No. 2 Event Date: 2-9-82

During plant operation, while performing their routine duties, two plant technicians in the vicinity of primary containment atmospheric monitor, 2-CAC-ATH-1259, detected an unusual odor emanating from the monitor cabinet. This monitor is located on the 20-foot elevation of the Reactor Building. Further investigation revealed water was dripping down on the top of the cabinet from the 50-foot elevation. This water had entered the cabinet and made contact with the monitor main power transformer causing it to electrically short, which resulted in the detected odor.

Immediate notification of the 1259 monitor problem was then made to the Control Room. Power supplying the affected monitor transformer was secured. In addition, a temporary water deflector was installed above the monitor cabinet to prevent further intrusion of water into the monitor components.

A search for the source of the leak revealed the dripping water had originated from a small valve body flange gasket leak on the RHR service water header flushing valve 2-SW-V140 located on the 50-foot elevation of the Reactor Building. This valve serves to isolate well water used to flush either RHR service water subsystem. As the leak occurred on the upstream side of the valve body, the water involved was well water.

Following isolation of the leak, the affected 1259 monitor transformer was replaced and the monitor was returned to normal service. The defective valve flange gasket was then replaced with one of greater strength and durability than the original and the valve was returned to normal service. It is felt that the performed corrective actions in response to this event are appropriate and need no further follow-up.