NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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 1 6 8 2 (8)
	REPORT DATE	0 3 1 7 8 2 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 During plant operation, while performing the channel calibration of Reactor Building
0 3 exhaust ventilation radiation instrumentation, PT 4.1.1PC, exhaust ventilation radiation
0 4 high instrument, 2-D12-RM-N010A, was inadvertently actuated. This resulted in a Group 6
0 5 PCIS signal which closes CAC System drywell vent/purge, inerting, and containment
0 6 monitoring instrumentation isolation valves. On 2/17/82, a similar event, involving
0 7 redundant instrument, 2-D12-RM-N010B, occurred. Also on 2/17/82 N010A was found
0 8 indicating downscale. These events did not affect the health and safety of the public.

Technical Specifications 6.9.1.9b

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
0 9	S D (11)	A (12)	C (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 4	/	0 3	L	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
X (18)	X (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	Y (24)	N (25)	G 0 8 0 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 Accidental jumpering of terminals in distribution panel P606 by involved technicians
1 1 caused the N010A and B actuations. Mislabeled detectors to the N010A and B resulted
1 2 in the N010A detector being unknowingly taken out of service. The PCIS signal was
1 3 reset and the PT was satisfactorily completed. Involved technicians have been
1 4 counseled and proper labeling of N010A and B detectors was performed.

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1 5	E (28)	0 8 0 (29)	NA	B (31)	Periodic Test

	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

8204020398 820317
PDR ADOCK 05000329
S PDR

2 0 NA

NRC USE ONLY

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

GPO 917-920

LER ATTACHMENT - RO #2-82-34

Facility: BSEP Unit No. 2 Event Date: February 16, 1982

During plant operation, while performing the channel calibration of Reactor Building exhaust ventilation radiation instrumentation per PT-4.1.1PC, the involved plant technicians inadvertently actuated exhaust ventilation radiation high instrument, 2-D12-RM-N010A. On February 17, 1982, during the same PT, the redundant instrument, 2-D12-RM-N010B, was also inadvertently actuated due to the action of the involved plant technicians.

A direct result of each event was the receipt of a Group 6 PCIS signal. This resulted in the closing of postaccident monitoring and remote shutdown panel instruments, 2-CAC-AT-1259 and 1263, containment radiation detection instruments, 2-CAC-AQH-1260, 1261 and 1262, in addition to CAC System drywell vent/purge, and inerting isolation valves.

The Technical Specifications applicable to these systems are 3.3.2, 3.3.5.2, 3.3.5.3, 3.4.3.1, 3.6.6.2, and 3.6.6.4. In addition, this report is submitted in accordance with Technical Specification 6.9.1.9b.

N010A was inadvertently actuated when plant technicians accidentally jumpered terminal Nos. 27 and 28, located in Control Room distribution panel P606. These terminals are located directly behind terminal Nos. 19 and 20, which are required to be jumpered during performance of the PT.

N010B was inadvertently actuated because plant technicians incorrectly identified the terminals required to be jumpered for purposes of the PT. This occurred when terminal identification Nos. 18 and 19 inside distribution panel P606 were incorrectly associated as identifying terminals located above them. As a result, a test jumper was installed from terminal No. 18 to No. 19, whereas it should have been installed from No. 19 to No. 20. This caused the instrument panel supply fuse No. 5 in terminal board TB3A of distribution panel P606 to blow on overcurrent.

On February 17, 1982, N010A was unintentionally removed from service when its detector, which is located alongside the detector to N010B, was removed. This occurred due to mislabeling of the detectors where each was incorrectly labeled as being the other.

Following the inadvertent actuation of the N010A instrument, General Electric Model No. 129B2802G11, it was returned to service and the incurred PCIS Group 6 signal was reset. The PT section pertaining to N010A was then satisfactorily completed. After the second event, the N010B power supply fuse was replaced and the PCIS signal was again reset and the PT section pertaining to N010B was satisfactorily completed. A review of the maintenance history files on the N010A and B detectors did not reveal an explanation for the detector mislabeling. The detectors were then properly labeled and the PT was satisfactorily completed.

As a result of these events, the following steps have been taken:

1. The involved technicians have been counseled to exercise caution whenever installing test jumpering clips.

2. Smaller type jumpering clips will be utilized in the performance of the PT to minimize the possibility of inadvertent contact with undesired adjacent wire terminals. In addition, the PT will be revised to require the use of such clips.

3. Involved technicians were counseled on how to properly identify terminals in distribution panels.

4. PT-4.1.1PC will be revised such that it will be performed during unit shutdown in order to eliminate the technical specifications' requirements of the instrumentation under test.

5. The corresponding Unit No. 1 instrument detectors were verified as properly labeled.