

0 1 A L J M F 1 2 0 0 - 0 0 0 0 0 - 0 0 3 4 1 1 1 1 4 5
7 8 9 14 15 25 26 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

REPORT SOURCE L 6 0 5 0 0 0 3 4 8 7 0 5 1 0 8 2 8 0 5 2 4 8 2 9
7 8 9 14 15 25 26 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

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 At 0705 on 5/10/82, while conducting a shift turnover and main control board walkdown,
0 3 it was determined that both containment spray suction valves from the RWST were closed.
0 4 Tech. Spec. 3.6.2.1, in part, requires these valves to be open. Tech. Spec. 3.6.2.1
0 5 action statement requirements were met. Health/safety of the public was not affected.
0 6
0 7
0 8

0 9
7 8 9 14 15 25 26 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

SYSTEM CODE S A (11)
CAUSE CODE A (12)
CAUSE SUBCODE A (13)
COMPONENT CODE V A L V E X (14)
COMP SUBCODE D (15)
VALVE SUBCODE D (16)

17 LER NO REPORT NUMBER 8 2
EVENT YEAR 8 2
SEQUENTIAL REPORT NO. 0 2 1
OCCURRENCE CODE 0 1
REPORT TYPE T
REVISION NO. 0

ACTION TAKEN H (18) Z (19)
FUTURE ACTION Z (20)
EFFECT ON PLANT Z (21)
SHUTDOWN METHOD Z (22)
HOURS 0 0 0 0
ATTACHMENT SUBMITTED Y (23)
NPRD-4 FORM SUB N (24)
PRIME COMP SUPPLIER A (25)
COMPONENT MANUFACTURER G 2 5 5

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 Immediately upon discovery, the valves were opened and position verification of the
1 1 accessible containment spray system valves was conducted with no discrepancies noted.
1 2 An extensive investigation revealed that during the performance of FNP-1-STP-20.0
1 3 (Penetration Room Exhaust and Air Filtration System Train (A)B Operability and Valve
1 4 Inservice Test), the plant operator mistakenly closed the containment spray suction
7 8 9 14 15 25 26 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

1 5 FACILITY STATUS E (28) 1 0 0 (29) OTHER STATUS NA (30) METHOD OF DISCOVERY A (31) DISCOVERY DESCRIPTION Operator Observation (32)
7 8 9 14 15 25 26 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

1 6 ACTIVITY CONTENT Z (33) Z (34) AMOUNT OF ACTIVITY NA (35) LOCATION OF RELEASE NA (36)
7 8 9 14 15 25 26 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

1 7 PERSONNEL EXPOSURES NUMBER 0 0 0 (37) TYPE Z (38) DESCRIPTION NA (39)
7 8 9 14 15 25 26 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

1 8 PERSONNEL INJURIES NUMBER 0 0 0 (40) DESCRIPTION NA (41)
7 8 9 14 15 25 26 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

1 9 LOSS OF OR DAMAGE TO FACILITY TYPE Z (42) DESCRIPTION NA (43)
7 8 9 14 15 25 26 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

2 0 PUBLICITY ISSUED N (44) DESCRIPTION NA (45)
7 8 9 14 15 25 26 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

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CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (Continued)

valves instead of turning off the penetration room filtration recirculation and exhaust fans. When the valves were closed, a main control board annunciator sounded. This annunciator was not properly acknowledged by the plant operators which resulted in the cause of the annunciator not being investigated properly. If the annunciator had been properly investigated using the Annunciator Response Procedure, the mispositioned valves would have been discovered at this time. The valves were closed for a period of six hours and fifty-five minutes.

It has been emphasized to the operators that they should ensure that the action they initiate gives the desired result. Operations personnel were also instructed in the proper acknowledgement of Main Control Board Annunciators and the need for investigation into their cause was emphasized.