NRC FORM 366
(7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

Update Report.
Previous Report Date: 1-25-82

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

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

CON'T
0 1 | REPORT SOURCE L ⑥ | 0 5 0 - 0 3 2 5 ⑦ DOCKET NUMBER | 1 2 2 6 8 1 ⑧ EVENT DATE | 0 6 2 1 8 2 ⑨ REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES ⑩

0 2 On January 6, 1982, following a review of Primary Containment Isolation System (PCIS)
0 3 logic prints, it was determined that the Action Statement 3.3.2b was not entered when
0 4 required on December 26, 1981, when the B21-LT-N017D-1 instrument failed upscale.
0 5 Failure to enter this action statement could have caused a failure to isolate the out-
0 6 board isolation valves for groups 2, 6, 7, and 8. The inboard valves would have iso-
0 7 lated as required. This event did not affect the health or safety of the public.
0 8 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

⑰ LER/RO REPORT NUMBER | EVENT YEAR 8 1 | — | SEQUENTIAL REPORT NO. 0 9 2 | / | OCCURRENCE CODE 0 1 | REPORT TYPE T | — | REVISION NO. 2

ACTION TAKEN X ⑱ | FUTURE ACTION X ⑲ | EFFECT ON PLANT Z ⑳ | SHUTDOWN METHOD Z ㉑ | HOURS ㉒ 0 0 0 0 | ATTACHMENT SUBMITTED Y ㉓ | NPRD-4 FORM SUB. Y ㉔ | PRIME COMP. SUPPLIER A ㉕ | COMPONENT MANUFACTURER R 3 6 9 ㉖

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS ㉗

1 0 This event occurred because Operations personnel failed to recognize and perform the
1 1 technical specification required action within the specified time frame. The N017D-1
1 2 had been repaired prior to this being identified. Involved personnel have been coun-
1 3 seled on the importance of prompt and thorough review of identified instrument problems.
1 4 All Operations personnel have reviewed this event.

1 5 FACILITY STATUS E ㉘ | % POWER 0 9 9 ㉙ | OTHER STATUS ㉚ NA | METHOD OF DISCOVERY B ㉛ | DISCOVERY DESCRIPTION ㉜ Routine Maintenance

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

1 7 PERSONNEL EXPOSURES NUMBER 0 0 0 ㊲ | TYPE Z ㊳ | DESCRIPTION ㊴ NA

1 8 PERSONNEL INJURIES NUMBER 0 0 0 ㊵ | DESCRIPTION ㊶ NA

1 9 LOSS OF OR DAMAGE TO FACILITY ㊸ TYPE Z ㊷ | DESCRIPTION NA

2 0 PUBLICITY ISSUED N (44) | DESCRIPTION NA | NRC USE ONLY

8206300109 820621
PDR ADOCK 05000325
S PDR

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

LER ATTACHMENT - RO #1-81-92

Facility: BSEP Unit No. 1 Event Date: December 26, 1981

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 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 corrective actions have been accomplished or are in progress in an effort to prevent future events of this type:

1. The Control Operator and auxiliary operator DSRs have been thoroughly reviewed and extensively revised. Where practical, the responsibility for technical specifications related surveillance responsibility has been assigned to the Control Operator. In both DSRs, applicable technical specification tolerances have been identified. In addition, all monthly required surveillances are identified in separate PTs and do not appear in either DSR. Also, where applicable, all instrument channel checks are now performed by comparison with similar required instrument indications.

2. A new procedure has been developed, with expected implementation by July 31, 1982, to provide a cross reference of technical specifications related plant instrumentation. This procedure will define which instruments comprise a particular reactor instrumentation trip channel in order to provide the Control Operator with a more concise understanding of each required technical specifications action statements in a uniform and timely manner. All licensed personnel will receive instruction on the use of this procedure.

3. Each operating shift has conducted a thorough review of this event with emphasis on the need to be alert to changes in plant instrumentation trending. In addition, an on-shift seminar with each operating shift was conducted which covered DSR readings and trending, the basis and purpose of instrumentation checks, and the operability concerns of recently installed analog type instrumentation.