

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] (3) [4][1][1][1][1] (4) (5)  
7 8 9 LICENSEE CODE 14 15 LICENSE NUMBER 29 30 LICENSE TYPE 57 CAT 58

CON'T [0][1] REPORT SOURCE [L] (6) [0][5][0]-[0][3][2][5] (7) [0][7][0][8][8][2] (8) [0][8][0][6][8][2] (9)  
7 8 9 REPORT SOURCE 60 61 DOCKET NUMBER 62 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

[0][2] While performing a visual inspection of HPCI System CST suction low water level  
[0][3] instrument, 1-E41-LSL-N003, it was discovered that the instrument reference sensing  
[0][4] leg root isolation valve, 1-E41-V150, was closed thereby rendering the instrument  
[0][5] inoperable. At the time of this discovery redundant instrument, 1-E41-LSL-N002, was  
[0][6] operable. Each instrument functions to shift the HPCI System suction lineup from  
[0][7] the CST to the suppression pool upon a CST low level condition. This event did not  
[0][8] affect the health and safety of the public. T. S. 3.3.3, 6.9.1.9b 80

[0][9] SYSTEM CODE [S][F] (11) CAUSE CODE [X] (12) CAUSE SUBCODE [Z] (13) COMPONENT CODE [V][A][L][V][E][X] (14) COMP. SUBCODE [E] (15) VALVE SUBCODE [D] (16)  
7 8 9 9 10 11 12 13 18 19 20

(17) LER RO REPORT NUMBER [8][2] (18) [ ] (19) [ ] (20) [ ] (21) [ ] (22) [0][7][1] (23) [ ] (24) [0][3] (25) [L] (26) [ ] (27) [0] (28)  
21 22 23 24 25 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) NPRD-4 FORM SUBG. [Y] (24) PRIME COMP. SUPPLIER [A] (25) COMPONENT MANUFACTURER [V][0][8][5] (26)  
33 34 35 36 37 40 41 42 43 44 47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

[1][0] An extensive investigation of this event, which included interviews with known  
[1][1] possibly-involved personnel plus a review of applicable documentation involving cali-  
[1][2] brations and maintenance performed on the instrument, failed to conclusively determine  
[1][3] the reason for or by whom the subject valve was closed. The N003 was returned to  
[1][4] service. A memorandum concerning this event will be reviewed by 8-20-82. 80

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

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

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

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

LOSS OR DAMAGE TO FACILITY TYPE [Z] (42) DESCRIPTION [NA] (43) 8208130286 820806 PDR ADOCK 05000325 S PDR ...  
7 8 9 10 11 80

PUBLICITY ISSUED [N] (44) DESCRIPTION [NA] (45) NRC USE ONLY  
7 8 9 10 80

LER ATTACHMENT - RO #1-82-71

Facility: BSEP Unit No. 1

Event Date: July 8, 1982

While performing a visual inspection of HPCI System CST suction low water level instrument, 1-E41-LSL-N003, it was discovered that the instrument reference sensing leg root isolation valve was closed. The closure of this valve, 1-E41-LSL-V150, thereby rendered the N003 instrument inoperable. At the time, redundant instrument, 1-E41-LSL-N002, was verified as being properly aligned for operation. Both instruments individually function to shift the HPCI System normal preferred suction lineup from the CST to the suppression pool upon a CST low level condition.

The visual inspection of the N003 instrument, in progress at the time of this event discovery, resulted from two previous events involving this instrumentation as reported in LERs 1-82-60 and 2-82-76. Those LERs reported the discovery of an organic type deposit in these type instruments. As a result of those events, a commitment was then made to visually inspect the remaining redundant instruments on both units for possible organic deposits.

Following this event discovery, an investigation to determine the reason for the closed N003 root valve was conducted. Prior to the discovery, the last previous maintenance performed on the instrument was the channel functional test, PT-03.1.2P, on June 17, 1982. The PT procedure incorporates a double verification signoff for restoring the instrument to service. A review of the June 17, 1982, performance documentation showed a double verification for returning the instrument to service had been performed. Interviews conducted with the involved I&C technicians verify that the subject valve was restored to the required open position following testing.

Prior to this event, CST chemistry analysis samples were normally drawn from the Control Rod Drive System (CRD) suction piping from the CST. Due to work involved with a plant modification to the CRD suction filter inlet piping, plant chemistry was unable to obtain their routine CST samples. Permission was then obtained from plant Operations to obtain the CST samples by opening the N003 instrument drain valve, 1-E41-V151. There is no evidence which suggests that other N003 instrument root isolation valves, particularly the V150 reference leg root isolation, were manipulated at any time by plant Chemistry personnel.

A plant memorandum outlining the concerns involving this event will be reviewed by all plant management personnel by August 20, 1982. A copy of the subject memorandum is enclosed with this report.