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: MIDCC1 (2)	LICENSE NUMBER: 00-00000-00 (3)	LICENSE TYPE: 41111 (4) CAT (5)
CON'T 0 1	REPORT SOURCE: L (6)	DOCKET NUMBER: 0500031 5 (7)	EVENT DATE: 020183 (8) REPORT DATE: 021583 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 DURING ROUTINE PLANT TOUR, AN OPERATOR FOUND THE SPRAY ADDITIVE TANK OUTLET VALVE
0 3 SEALED IN THE CLOSED POSITION. WITH THE VALVE CLOSED, THE NAOH WOULD NOT HAVE
0 4 BEEN ADDED TO THE CONTAINMENT SPRAY SYSTEM IN THE EVENT OF AN ACCIDENT. THIS IS
0 5 NON-CONSERVATIVE WITH RESPECT TO T.S. 3.6.2.2. THE PUBLIC HEALTH AND SAFETY
0 6 WERE NOT AFFECTED. A PRELIMINARY SAFETY EVALUATION HAS BEEN PERFORMED AND
0 7 PROVIDED TO THE NRC RESIDENT INSPECTOR.
0 8

0 9	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
	SH (11)	A (12)	AB (13)	ZZZZZZ (14)	Z (15)	Z (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	83	—	009	/	01	T	—	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)	0000	Y (23)	N (24)	Z (25)	Z999 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 THE OPERATORS WERE DISTRACTED DURING THE PERFORMANCE OF THE TEST. APPROPRIATE
1 1 ADMINISTRATIVE ACTIONS HAVE BEEN TAKEN. A REVIEW OF STP SCHEDULING IS BEING
1 2 CONDUCTED.
1 3
1 4

1 5	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
	E (28)	100 (29)	NA	B (31)	OPERATOR OBSERVATION

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

PERSONNEL EXPOSURES

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

PERSONNEL INJURIES

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

LOSS OF OR DAMAGE TO FACILITY (43)

1 9	TYPE	DESCRIPTION
	Z (42)	NA

PUBLICITY

2 0	ISSUED	DESCRIPTION (45)	NRC USE ONLY
	N (44)	NA	

NAME OF PREPARER D. F. KRAUSE PHONE (616) 465-5901 Ext. 1097

10) EVENT DESCRIPTION AND PROBABLE CONSEQUENSES

DURING A ROUTINE PLANT TOUR AT 0915 HOURS ON 2-1-83, AN OPERATOR FOUND THE SPRAY ADDITIVE TANK OUTLET VALVE SEALED IN THE CLOSED POSITION. WITH THE VALVE CLOSED, THE NAOH WOULD NOT HAVE BEEN ADDED TO THE CONTAINMENT SPRAY SYSTEM IN THE EVENT OF AN ACCIDENT. THE VALVE WAS IN THE CLOSED POSITION FOR 7 HOURS. T.S. 3.6.2.2 ALLOWS THE SYSTEM TO BE INOPERABLE FOR 72 HOURS.

27) CAUSE DESCRIPTION

THE SURVEILLANCE TEST PROCEDURE (STP) FOR THIS SYSTEM HAD BEEN COMPLETED AT 0203 ON 2-1-83. DURING THE STP, THE VALVE IS REQUIRED TO BE CLOSED. AFTER THE TEST IS COMPLETED, THE VALVE IS TO BE REOPENED AND SEALED AND THE SEAL NUMBER RECORDED. A VALVE LINEUP IS ALSO COMPLETED AND VERIFIED BY ANOTHER OPERATOR.

THE AUXILIARY EQUIPMENT OPERATOR (AEO) WHO PERFORMED THE TEST AND DID THE INITIAL SIGNOFF HAD STARTED TO OPEN THE VALVE WHEN THE REST OF THE SYSTEMS VALVE SEALS FELL OUT OF HIS POCKET. HE PICKED UP THE SEALS AND PUT ONE ON THE VALVE WITHOUT FURTHER OPENING THE VALVE.

THE REACTOR OPERATOR (RO) WHO VERIFIED THE VALVE LINEUP LOOKED AT THE UNIT TWO VALVE AND SAW IT WAS OPEN BUT THE SEAL NUMBER WASN'T RIGHT (BOTH UNIT'S TANKS ARE IN THE SAME ROOM). HE THEN REALIZED HIS MISTAKE AND CHECKED THE SEAL NUMBER ON THE RIGHT VALVE, SAW THE NUMBERS MATCHED, AND SIGNED IT OFF WITHOUT CHECKING THAT THE VALVE WAS OPEN.

27) CAUSE DESCRIPTION (continued)

EVEN IF THE SUBSEQUENT SHIFT HAD NOT DETERMINED THE VALVE WAS IN AN ABNORMAL POSITION, IT IS DOUBTFUL IF THE EVENT WOULD HAVE WENT UNDETECTED OVER MORE THAN A COUPLE OF SHIFTS AS THE AEO'S ON TOUR, THOUGH NOT REQUIRED, ROUTINELY CHECK SEALED VALVES. A FORMAL CHECK OF THE POSITION OF THESE AND OTHER SEALED VALVES IS MADE WEEKLY. THIS WAS SCHEDULED TO BE COMPLETED ON SUNDAY, FEB. 6. TECHNICAL SPECIFICATIONS REQUIRES THAT VALVE POSITIONS BE VERIFIED EVERY 31 DAYS AND EXEMPTS SEALED VALVES FROM BEING VERIFIED.

THERE WERE THREE FAIRLY DIFFICULT STP'S SCHEDULED DURING THE SHIFT THAT THE EVENT OCCURRED ON. THIS PLACED A VERY HEAVY WORKLOAD ON THE SHIFT.

PREVENTIVE ACTION TAKEN

1. APPROPRIATE ADMINISTRATIVE ACTIONS HAVE BEEN TAKEN WITH THE AEO AND RO INVOLVED IN THE EVENT.

2. AN OPERATING MEMO WAS WRITTEN WHICH EMPHASIZES THE NEED TO CAREFULLY ASSESS AVAILABLE RESOURCES IN SCHEDULING THE WORK LOAD ON THE SHIFTS AND TO CALL IN EXTRA PEOPLE WHEN NEEDED OR RESCHEDULE THE WORK.
3. A REVIEW IS BEING CONDUCTED BY THE OPERATIONS DEPARTMENT PERFORMANCE ENGINEER OF THE PRESENT STP SCHEDULE. IF THE REVIEW DISCLOSES ANY SIGNIFICANT INBALANCE IN SHIFTING WORK LOADS, APPROPRIATE SCHEDULE CHANGES WILL BE MADE.

4. CHANGES HAVE BEEN MADE REGARDING THE TIME OF DAY CERTAIN TESTS ARE CONDUCTED SO THAT MANPOWER CONSIDERATIONS CAN BE OPTIMIZED.