

LICENSEE EVENT REPORT

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0	1	S	C	H	B	R	2	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										25	26	LICENSE TYPE					30	57	CAT 58	

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

On July 1, 1981, with the unit at 93% power, the Control Operator observed that Channel I (PI-474) of "A" Steam Generator Steam Line Pressure was indicating high compared to its two redundant channels. Channel I was declared inoperable at 1128 hours. The Channel I bistables were tripped to maintain the minimum degree of redundancy. However the apparent inoperability of Channel I, prior to tripping its bistables, resulted in exceeding the minimum degree of redundancy required by Technical Specification Table 3.5-3 which is reportable pursuant to 6.9.2.b.2.

09		SYSTEM CODE		CAUSE CODE		CAUSE SUBCODE		COMPONENT CODE				COMP. SUBCODE		VALVE SUBCODE	
0	9	C	C	A		A		V	A	L	V	E	X	E	D
7	8	9	10	11		12		13					18	19	20
(17) LER/RO REPORT NUMBER		EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.					
81		81		018		03		L		0					
21		22		23		24		25		26					
ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED					
E		H		Z		Z		0000		Y					
13		14		15		16		17		18					
(18)		(19)		(20)		(21)		(22)		(23)					
21		22		23		24		25		26					
NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER											
N		N		E090											
42		43		44											
(24)		(25)		(26)											
21		22		23											

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The Channel I deviation was caused by a throttled root isolation valve (MSV-14) on
1 1 the instrument sensing line. MSV-14 was opened, and Channel I was declared operable
1 2 at 1440 hours. Operating personnel have been cautioned as to the importance of
1 3 insuring that instrument sensing line root isolation valves are fully open, and all
1 4 employees have been reminded that no valve operation is to be done by unauthorized or
untrained personnel.

FACILITY STATUS								% POWER						OTHER STATUS							METHOD OF DISCOVERY									DISCOVERY DESCRIPTION											
[1][5] [E](28)								[0][9][3](29)						N/A							[A](31)									Operator Observation											
ACTIVITY CONTENT RELEASED								OF RELEASE						AMOUNT OF ACTIVITY							LOCATION OF RELEASE																				
[1][6] [Z](33) [Z](34)								N/A						N/A																											
PERSONNEL EXPOSURES																																									
NUMBER								TYPE						DESCRIPTION																											
[1][7] [0][0][0](37) [Z](38)								N/A																																	
PERSONNEL INJURIES																																									
NUMBER								DESCRIPTION																																	
[1][8] [0][0][0](40)								N/A																																	
LOSS OF OR DAMAGE TO FACILITY																																									
TYPE								DESCRIPTION																																	
[1][9] [Z](42)								N/A																																	
PUBLICITY ISSUED																												NRC USE ONLY													
DESCRPTION								(45)						N/A																											
[2][0] [Z](44)								N/A																																	

NRC USE ONLY

PHONE: (803) 383-4524

SUPPLEMENTAL INFORMATION
FOR
LICENSEE EVENT REPORT 81-018

1. Cause Description and Analysis

At approximately 1100 hours on July 1, 1981, with the unit at 93% power, the Control Operator observed that Channel I (PI-474) of "A" Steam Generator Steam Line Pressure was indicating high compared to its two redundant channels. These Steam Line Pressure Channels supply signals for sensing high differential steam pressure between the steam generator line and the steam header which provide steam line break protection. At 1128 hours, Channel I was declared inoperable and its bistables tripped using Operating Work Permit (OWP) RP-11.

Instrumentation and Control personnel verified that the problem was not in the Channel I electronics. It was suspected the problem was due to sludge blocking the instrument sensing line. When flushing the sensing line failed, an operator proceeded to close the root isolation valve (MSV-14) so the line could be disconnected and back-flushed. The operator discovered MSV-14 to be throttled. This throttled position of MSV-14 caused the steam line pressure signal to be dampened and reduced the ability of Channel I to respond to short duration steam line pressure changes. This created the channel deviation observed by the Control Operator. MSV-14 was opened and Channel I (PI-474) returned within the deviation limits of its two redundant channels. An investigation was conducted to determine how valve MSV-14 could have been misplaced into the throttled position. The most recent valve lineup documentation was reviewed and the operator who made the lineup was questioned as to the last known position of the valve. The operator stated that on June 9, 1981, when the valve was last checked, it was in the fully opened position. A review of past maintenance records indicates that no work has been done on the valve since June 9, 1981. In addition, a review of operating conditions at the valve indicate that local vibrations are not of sufficient magnitude to cause the valve position to change. Therefore, although the operator stated positively that the MSV-14 valve had been fully opened, operator error cannot be ruled out as the most probable cause for this event.

Channel I was checked for proper signal levels and declared operable at 1440 hours in accordance with OWP RP-11. Throughout this event, the other two redundant channels of "A" Steam Generator Steam Line Pressure were operational. This provided the necessary indication and safety signals. There was no threat to the public health and safety. However, the apparent inoperability of Channel I prior to tripping its bistables resulted in exceeding the minimum degree of redundancy required by Technical Specification Table 3.5-3 which is reportable pursuant to 6.9.2.b.2.

2. Corrective Action

The immediate corrective action was to fully open MSV-14. This restored Channel I to within the deviation limits. The instrument sensing was flushed as an added precaution.

3. Corrective Action To Prevent Recurrence

This event appears to be the result of either mis-operation or not assuring the valve was in its fully open position. Therefore, Operating personnel have been cautioned as to the importance of assuring that instrument sensing line root valves, which are required to be open, are fully opened. Also, Operating personnel will review this LER for its lessons to be learned. In addition, all plant personnel will be reminded by August 15, 1981, that no valve operation is to be done by unauthorized or not properly trained personnel.