

LICENSEE EVENT REPORT

Attachment to AECM-82/530

Page 1 of 4

CONTROL BLOCK:

| | | | | | | |
|--|--|--|--|--|--|-----|
| | | | | | | (1) |
|--|--|--|--|--|--|-----|

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 M S G G S 1 2 0 0 - 0 0 0 0 0 0 - 0 0 3 4 1 1 1 1 1 4 57 CAT 58

7 8 9 14 15 25 26 30 57 58

LICENSEE CODE LICENSE NUMBER LICENSE TYPE

CON'T

| | |
|---|---|
| 0 | 1 |
| 7 | 8 |

REPORT SOURCE

| | | | | | | | | | | | | | | | | | | | | | | | | |
|----|----|---|---|---|---|---|---|---|----|----|---|---|---|---|---|----|----|---|---|---|---|---|---|----|
| L | 6 | 0 | 5 | 0 | 0 | 0 | 4 | 1 | 6 | 7 | 1 | 0 | 0 | 8 | 8 | 2 | 8 | 1 | 1 | 0 | 5 | 3 | 2 | 9 |
| 60 | 61 | | | | | | | | 68 | 69 | | | | | | 74 | 75 | | | | | | | 80 |

DOCKET NUMBER

EVENT DATE

REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 With the plant in Cold Shutdown, the HPCS Pump was declared inoperable due to an
03 engineering review of an incident which occurred on October 2, 1982. This incident
04 involved an incorrect valve lineup during the performance of a routine surveillance
05 on the HPCS System. This left only one ECCS pump, LPCS, operable. T.S.3.5.2 requires
06 two ECCS Systems to be operable. This had no effect on the health and safety of the
07 public and did not constitute a threat to plant safety. This event is reported as
08 required by T.S.6.9.1.13.b.

| | | | | | | | | | | | | | | | | | |
|----------------------------|--|-----------------------|--|--------------------------------------|--|------------------------------|--|----------------------------------|--|------------------------------|--|--------------------------|--|------------------------------|--|--|--|
| 0 9 | | SYSTEM CODE F 11 | | CAUSE CODE A 12 | | CAUSE SUBCODE B 13 | | COMPONENT CODE V A L V E X 14 | | | | COMP. SUBCODE B 15 | | VALVE SUBCODE D 16 | | | |
| 7 8 | | 9 10 | | 11 | | 12 | | 13 18 | | | | 19 | | 20 | | | |
| LER/RO REPORT NUMBER 17 | | EVE 4T YEAR 8 2 22 | | SEQUENTIAL REPORT NO. 0 9 7 24 26 | | OCCURRENCE CODE 0 3 28 29 | | REPORT TYPE L 30 | | REVISION NO. 0 32 | | | | | | | |
| ACTION TAKEN G 18 | | FUTURE ACTION H 19 | | EFFECT ON PLANT Z 20 | | SHUTDOWN METHOD Z 21 | | HOURS 0 0 0 0 22 40 | | ATTACHMENT SUBMITTED Y 23 | | NPRD-4 FORM SUB. N 24 | | PRIME COMP. SUPPLIER A 25 | | COMPONENT MANUFACTURER P 3 4 0 26 44 47 | |
| 33 34 | | 35 36 | | 37 | | 41 | | 42 | | 43 | | 44 47 | | | | | |

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 Incorrect valve lineup in the incident on October 2, 1982 was caused by insufficient

1 1 retesting following valve position indicators modification and failure to remove an

1 2 information tag on the valve which told the operator to not rely on the position

1 3 Indicator. The information tag was removed and the Retest Control Procedure was

1 4 revised. The system was tested and returned to service.

8 9 FACILITY STATUS (28) % POWER (29) OTHER STATUS (30) METHOD OF DISCOVERY (31) DISCOVERY DESCRIPTION (32)

1 5 G 0 0 0 NA B Operator Observation/Routine Surveillance

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 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

ACTIVITY CONTENT
RELEASED OF RELEASE AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36)

1 6 7 8 9 Z (33) 10 Z (34) 11 NA 44 45 NA 80

| PERSONNEL EXPOSURES | | | | | | | | | |
|---------------------|---|---|------|-------------|----------------|--|--|--|--|
| NUMBER | | | TYPE | DESCRIPTION | | | | | |
| 1 | 7 | 0 | 0 | 0 | (37) Z (38) NA | | | | |

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

| 1 | | 2 | | 3 | | 4 | | 5 | | 6 | | 7 | | 8 | | 9 | | 10 | | 11 | | 12 | |
|-------------------------------|---|-------------|------|----|--|---|--|---|--|------|--|---|--|---|--|---|--|----|--|----|--|----|--|
| LOSS OF OR DAMAGE TO FACILITY | | | | | | | | | | (43) | | | | | | | | | | | | | |
| TYPE | | DESCRIPTION | | | | | | | | | | | | | | | | | | | | | |
| 1 | 9 | Z | (42) | NA | | | | | | | | | | | | | | | | | | | |
| 7 | 8 | 9 | 10 | | | | | | | | | | | | | | | | | | | | |

8211100436 821105

| PUBLICATION | | ISSUED | | DESCRIPTION | | PDR | | NRC USE ONLY | |
|-------------|---|--------|------|-------------|--|-----|--|--------------|--|
| 2 | 0 | N | (44) | NA | | PDR | | | |
| 7 | 8 | 9 | 10 | 68 | | 69 | | 80 | |

NAME OF PREPARER Original signed by W. H. Chenault

PHONE: _____

5, p. 917-926

SUPPLEMENTAL INFORMATION TO
LER 82-097/03 L-0

Mississippi Power & Light Company
Grand Gulf Nuclear Station - Unit 1
Docket No. 50-416

Technical Specification Involved: 3.5.2
Reported Under Technical Specification: 6.9.1.13.b

Event Narrative:

On October 2, 1982, with the plant in Cold Shutdown, Operations attempted to perform the HPCS Pump monthly surveillance test to prove operability of the system. The HPCS Pump was aligned to take suction from the Condensate Storage Tank (CST) and pump thru the HPCS test return line back to the CST (See Figure 1). When the pump was started, the operator at the HPCS Pump noticed a waterleak from check valve F216. He immediately informed the control room operator of the leak and requested that the HPCS Pump be stopped. The control room operator, who had opened the F010 and F011 valves and established a flow of 5000 gpm, stopped the HPCS pump and closed the F010 and F011 valves.

A walkdown of the system piping was initiated to determine the cause for the leakage at valve F216. The walkdown revealed the top gasket of valve F216 leaking, possibly due to high pressure. Further inspection revealed valve F070 (at the CST) had a stem seal leak. The local position indicator for valve F070 indicated the valve was closed. The operator, who had verified the valve in the OPEN position prior to starting the HPCS Pump, was questioned about the discrepancy. He stated that when he went to valve F070 to verify the valve was open, he found the valve locked and the indicator showing closed. He notified the control room that the valve was indicating closed but there was an Information Tag (#821063) on the valve handle stating that the "Indicator May Indicate Incorrectly, Do Not Rely On Indicator Pointer". He unlocked the valve and attempted to OPEN the valve. The valve opened about 1/4 turn and stopped. He backed the valve off 1/4 turn and tried to open the valve again. The valve stopped at the same position. With the information tag stating not to rely on the position indicator and his inability to open the valve any further, the operator informed the control room operator that the valve was OPEN but indicated CLOSED.

After the HPCS Pump was shutdown and valve F070 discovered leaking, two operators using a lever arm opened valve F070. The valve had been closed as indicated by the position indicator when the HPCS pump was started.

Previous Similar Events:

Further investigation revealed a Design Change (DCP 82/486) had been incorporated on valve F070 under a Maintenance Work Order (MWO M28924) on August 24, 1982 to correct the indicator problem. However, the information tag which was hung on July 28, 1982 stating "Do Not Rely on Indicator Pointer", was not removed following the indicator modification per the design change. The information tag was verified removed on October 5, 1982. In addition to valve F070, an additional 60 valves with the Pratt Type MDT-5 Manual Valve Operators supplied with Pratt Butterfly Valves, were modified by the same

design change. Each of the 60 valves had information tags hung on July 28, 1982, stating "Do Not Rely on Indicator Pointer". All the tags were verified removed on October 5, 1982. Administrative Procedure Protective Tagging System (01-S-06-1) states that any operations personnel may request that an information tag be removed when conditions no longer warrant the need for the information tag, however, the retest requirements should have specified tag removal.

After valves F070 and F216 were found to be leaking, Maintenance Work Orders (MWO M2A695 and M2A696) were issued to correct the leaks. The F070 valve was replaced and the gaskets on F216 were replaced. In addition to the work orders issued, Operations initiated an Incident Report (82-10-07) documenting "An event happening out of the ordinary which is not a violation of plant operating procedures or Technical Specifications but is important for its historical significance or to prevent future incidents" (Section 5.1.1 and 5.2.4 of Administrative Procedure 01-S-06-5 "Incident Reports/Reportable Events"). This incident was not considered reportable because the section of piping involved was the HPCS Test Line and therefore the HPCS system was still operable.

When the incident report was evaluated by the Engineering Department, Engineering recommended that the HPCS System be declared inoperable until certain additional checks could be completed.

The HPCS system was declared inoperable at 1720 on October 8, 1982 pending the results of the inspection previously described. Declaring the HPCS system inoperable required placing the plant in a Limiting Condition for Operation. T.S.3.5.2 requires two operable ECCS systems during shutdown. LPCS remained the only operable ECCS System. LPCI "A" was considered inoperable due to being in the shutdown cooling mode. LPCI "B" and "C" were inoperable due to the associated Diesel Generator being out of service. This LCO (82-0128) resulted in incident report 82-10-14 which required this LER per T.S.6.9.1.13.b.

At 1430 on October 10, 1982, the HPCS system was declared operable following the satisfactory completion of the required tests and inspections.

This event had no effect on the health or safety of the public and did not constitute a threat to plant safety.

The root causes of this event are attributed to the lack of adequate retest requirements by the Maintenance Work Order following the work on the F070 valve and improper valve position verification by the operator.

Since the performance of the Maintenance Work Order on August 24, 1982, Technical Section Procedure "Control of Retest Requirements" (09-S-07-6) has been revised to give better guidance to Maintenance Planners on what type of activities require retests and what type of retest are required.

Pratt valves with this type of position indication problem have all been modified and the information tags removed. This is a final report.

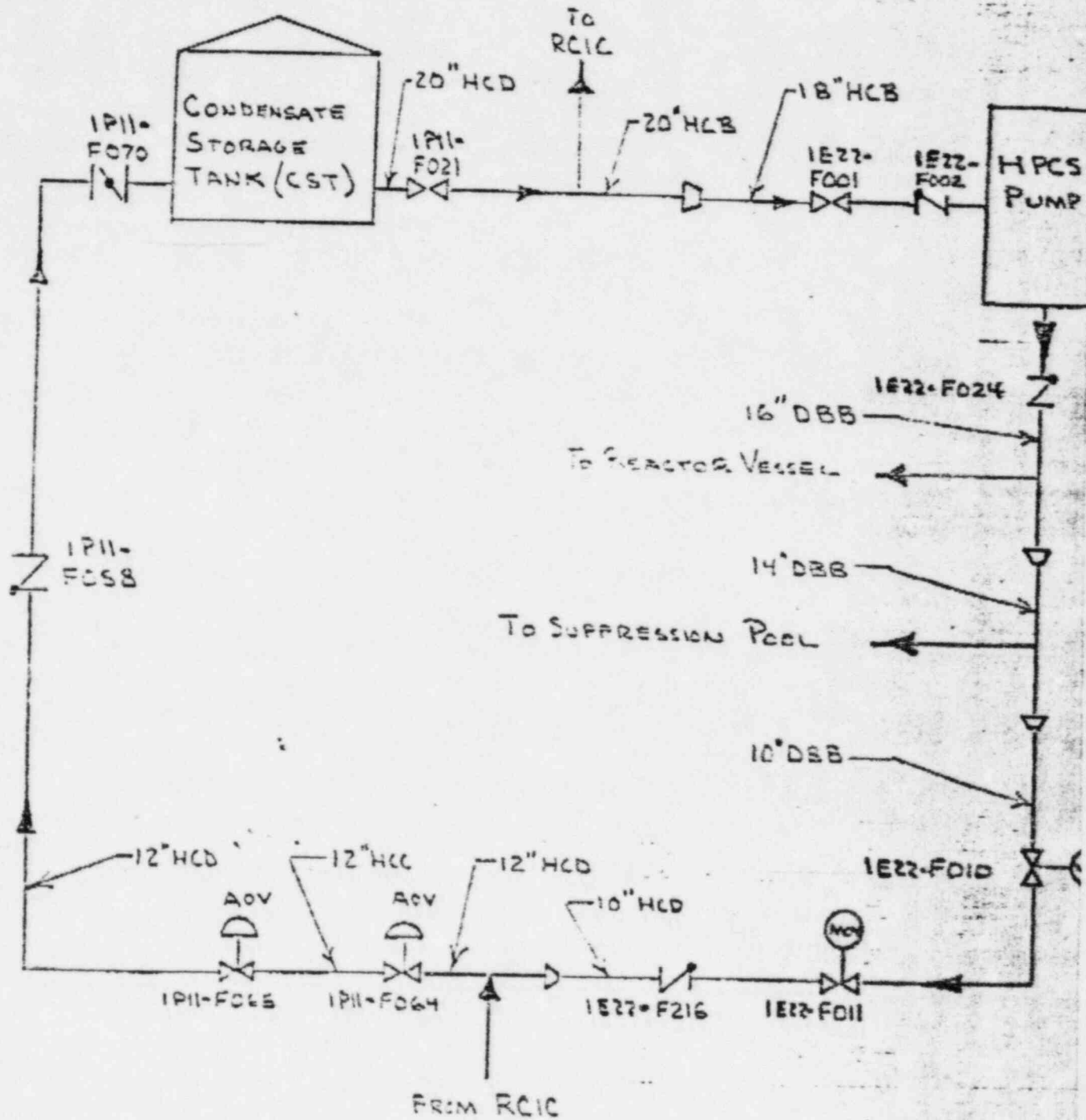


FIGURE 1