

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CONTROL BLOCK:

						(1)
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0	1	W	I	P	B	H	Z	2	0	0	-	0	0	0	0	0	-	0	0	3	4	1	1	1	1	4		5																					
7	8	9						14						15						25						26						30						57						58					
Z		B		LICENSEE CODE						LICENSE NUMBER						LICENSE TYPE						CAT																											

REPORT

REPORT SOURCE: 0 1 7 8 L 6 0 5 0 0 0 3 0 1 7 1 0 0 6 8 2 8 1 1 0 5 8 2 9
60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

On 10/06/82, during normal operation, periodic testing per ICP 2.1 found the low steam line pressure setting for pressure instrument 2PT-478 lower than allowed by Technical Specification Table 15.3.5-1. 2PT-478 is one of three pressure instruments for the "B" steam generator which make up a two out of three logic for initiating a SI signal on low steam line pressure. The other two instruments were found to be operable. This event is reportable IAW Technical Specification 15.6.9.2.B.1.

SYSTEM CODE I B (11)		CAUSE CODE X (12)		CAUSE SUBCODE Z (13)		COMPONENT CODE I N S T R U (14)			COMP. SUBCODE X (15)		VALVE SUBCODE Z (16)						
EVENT YEAR 8 2 (21 22)		SEQUENTIAL REPORT NO. 0 0 8 (24 25 26)		OCCURRENCE CODE 0 3 (28 29)		REPORT TYPE L (30)		REVISION NO. 0 (32)									
ACTION TAKEN E (18)		FUTURE ACTION Z (19)		EFFECT ON PLANT Z (20)		SHUTDOWN METHOD Z (21)		HOURS 0 0 0 0 (22 23 24 25)		ATTACHMENT SUBMITTED Y (23)		NPRD-4 FORM SUB. N (24)		PRIME COMP. SUPPLIER N (25)		COMPONENT MANUFACTURER F 1 8 0 (26 27 28 29)	

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The cause of the out-of-specification setpoint is attributed to bumping
11 of the setpoint adjustment knob during installation of a thumbscrew
12 securing the module to the instrument rack. The pressure instrument was
13 tested satisfactorily, realigned and returned to service on October 6,
14 1982.

7 8 9
FACILITY STATUS
1 5 E 28
% POWER 0 9 8 29 NA
OTHER STATUS 30
METHOD OF DISCOVERY B 31 Technician observation 32
DISCOVERY DESCRIPTION 32

ACTIVITY CONTENT
RELEASED OR RELEASE

1 6 Z (33) Z (34) NA

AMOUNT OF ACTIVITY (35)

NA

LOCATION OF RELEASE (36)

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

7		8		9		10		11		12		13	
PERSONNEL INJURIES													
NUMBER						DESCRIPTION							
1	8	0	0	0	40	NA							

		R 9		11 12		
		LOSS OF OR DAMAGE TO FACILITY		(43)		
		TYPE		DESCRIPTION		
1	9	Z	(42)	NA		

7 8 9 10 80
PUBLICATION
ISSUED DESCRIPTION (45) 8211160295 821105
2 0 N (44) NA PDR ADOCK 05000301
S PDR
NRC USE ONLY
68 69 80

PHONE:

414/277-2811

ATTACHMENT TO LICENSEE EVENT REPORT NO. 82-008/03L-0

Wisconsin Electric Power Company
Point Beach Nuclear Plant Unit 2
Docket No. 50-301

During normal operation on October 6, 1982, periodic testing (per the requirements of Technical Specification 15.4.5, plant procedure ICP 2.1) of the Unit 2 reactor protection and safeguards analog systems revealed the low steam line pressure setpoint for pressure instrument 2PT-478 lower than allowed by Technical Specification Table 15.3.5-1. The setpoint was found at 416.5 psig, approximately 85 psig lower than the setpoint requirement of ≥ 500 psig. 2PT-478 was one of three pressure instruments for the "B" steam generator which make up a two-of-three logic for initiating a safety injection signal on low steam line pressure.

The event had no effect on the public health and safety as the two other channels were fully operational. 2PT-478 would still have initiated the required signal, but at a lower pressure than specified.

After the previous ICP 2.1 testing (September 8, 1982) the pressure instrument module was secured to the instrument rack with a thumb screw. It is believed that during this installation, the setpoint adjustment knob was bumped causing the setpoint misalignment.

The pressure instrument was tested satisfactorily, realigned, and returned to service on October 6, 1982.

This event has been discussed with the instrument technicians to emphasize the importance of using extreme care while working around sensitive equipment. Increased technician awareness should prevent occurrences of this type in the future.

The event is being reported as required by Technical Specification 15.6.9.2.B.1.