NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

CONTROL BLOCK: (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 W I P B H 2 (2) LICENSEE CODE — 0 0 - 0 0 0 0 0 - 0 0 (3) LICENSE NUMBER — 4 1 1 1 1 (4) LICENSE TYPE — CAT (5)

CON'T 01 REPORT SOURCE L (6) — 0 5 0 0 0 3 0 1 (7) DOCKET NUMBER — 1 0 2 2 8 1 (8) EVENT DATE — 1 1 0 3 8 1 (9) REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 During routine operations on 10-22-81 at 2227 the NRC Resident Inspector
03 noted valve 2SI-866A, high head "A" SI pump discharge valve, was indi-
04 cated in the shut position. This motor-operated gate valve serves as an
05 isolation valve for the "A" train. No effect to the public health or
06 safety was caused by this event. This event is reportable in accordance
07 with Technical Specification 15.6.9.2.A.6.
08

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
09	S F (11)	A (12)	A (13)	V A L V E X (14)	E (15)	D (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 1	—	0 0 8	/	0 1	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)	0 0 0 0	Y (23)	N (24)	N (25)	D 0 2 0 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 After immediate investigation revealed no reason for the valve closure,
11 the valve was opened. Subsequent investigation indicated that potential
12 operator inattentiveness during a replacement of a ready status light
13 may have been the primary cause. Operators will be cautioned to avoid
14 this sequence of events in the future.

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
15	E (28)	1 0 0 (29)	NA	D (31)	NRC Resident Inspector Surveillance

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

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION (39)
17	0 0 0 (37)	Z (38)	NA

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
18	0 0 0 (40)	NA

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
19	Z (42)	NA

PUBLICITY

	ISSUED	DESCRIPTION (45)
20	N (44)	NA

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PDR ADOCK 05000301
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NRC USE ONLY

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GPO 917-926

ATTACHMENT TO LICENSEE EVENT REPORT NO. 81-008/01T-0

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

During routine operations at 2227 hours on 10/22/81, an inspection by the NRC Senior Resident Inspector revealed valve 2SI-866A, high head "A" safety injection pump discharge valve, was indicated in the shut position on the control board for Unit 2. This valve is a motor-operated gate valve which serves as an isolation valve for the "A" train. The valve was then reopened.

Investigations conducted during and following this event failed to disclose any maintenance, repair or testing which could have involved the direct manipulation of this valve. Further investigation revealed that during the beginning of the shift, one of the ready status indicating light bulbs required replacement. These ready status indicating lights are located above the apron section of the control board, above the switch which operates the valve in question. The event is postulated to have transpired in the following manner: The operator, noting the failed ready status light, brought a step ladder to the area and using the control board for support changed the light; however, he unwittingly jostled the momentary contact switch which controlled valve 2SI-866A. Since the cycle time of the valve is two minutes, the operator had completed his bulb replacement and left the immediate area before the ready status light or valve position lights would have reflected the change in valve status. Thus, the change in status went unnoticed until the Resident Inspector noted a discrepancy in the valve position lights and caused the investigation.

In view of the above-postulated sequence, the Technical Specification reporting criteria is changed from 15.6.9.2.A.2 (Operating in a less conservative aspect than permitted by a limiting condition for operation) to 15.6.9.2.A.6 "Personnel error or procedural inadequacy which prevents, or could prevent by itself, the fulfillment of the functional requirements of systems required to cope with accidents analyzed in the FFDSAR." It should be noted that although Technical Specification 15.6.9.2.A.6 deals with personnel errors, this event was caused not so much as by error as by inattentiveness.

Corrective actions to preclude further events of this type include operator review of this Licensee Event Report and a separate memo to be issued to operating personnel from the Superintendent - Operations. Further positive corrective action has

included procurement of six protective cap devices to protect, in addition to the valve noted in this Licensee Event Report, both the high head safety injection pumps suction and discharge valves as well as the refueling water storage tank suction to containment spray pump suction valves. As none of these valves receive an automatic open signal upon safety injection, these devices will provide protection from inadvertent operation.

The Resident Inspector was present at the time of discovery and the NRC Operations Center was notified promptly via the emergency notification system.