

LICENSEE EVENT REPORT

CONTROL BLOCK:

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 (1)

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

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|---|---|---------------|---|---|---|---|---|----|----|----------------|---|---|---|---|---|---|---|---|---|----|----|--------------|---|---|---|---|----|----|-----|--|----|
| 0 | 1 | N | C | B | E | P | 2 | 2 | 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | - | 0 | 0 | 3 | 4 | 1 | 1 | 1 | 1 | 4 | | | 5 | | |
| 7 | 8 | LICENSEE CODE | | | | | | 14 | 15 | LICENSE NUMBER | | | | | | | | | | 25 | 26 | LICENSE TYPE | | | | | 30 | 57 | CAT | | 58 |

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REPORT SOURCE 6 0 5 0 - 0 3 2 4 7 0 3 3 0 8 2 8 0 4 2 8 8 2 9
60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 During plant operation, while performing the RCIC System isolation channel functional
0 3 and operability test, PT-02.1.9P, to determine the cause of a spurious RCIC steam
0 4 leak detection isolation signal, the HPCI System automatically isolated due to the
0 5 receipt of an "A" channel steam leak detection high temperature isolation signal.
0 6 In accordance with technical specifications, the HPCI System was declared inoperable.
0 7 This event did not affect the health and safety of the public. The spurious RCIC
0 8 isolation signal is being reported in LER 2-82-35. Technical Specifications 3.3.2,
7 8 9 3.5.1, 6.9.1.9b

| | | | | | | | | | | | | | | | | | | | | | | | | |
|-------------------|----|----------------------|----|----------------------|-----------------|----|----|--------------------------------|----|----|-----------------------------------|----------------------|----|----|---------------------------|----|--------------------|-----------------------|-------------------|--------------------|---------------------------|----|----|----|
| 09 | | SYSTEM CODE S D | | 11 | CAUSE CODE A | | 12 | CAUSE SUBCODE C | | 13 | COMPONENT CODE E L E C T R O N | | | | | 14 | COMP. SUBCODE Z | | 15 | VALVE SUBCODE Z | | 16 | | |
| 7 | 8 | 9 | 10 | | 11 | | | 12 | | | 13 | | | | 14 | | | 15 | | | 16 | | | |
| 17 | | LER/RO REPORT NUMBER | | EVENT YEAR 8 2 | | 21 | 22 | SEQUENTIAL REPORT NO. 0 6 5 | | 24 | 26 | OCCURRENCE CODE / | | 27 | REPORT TYPE 0 3 | | 28 | 29 | REVISION NO. L | | 30 | 31 | 32 | |
| ACTION TAKEN X | | FUTURE ACTION X | | EFFECT ON PLANT Z | | 18 | 19 | SHUTDOWN METHOD Z | | 20 | 21 | HOURS 0 0 0 0 | | 22 | ATTACHMENT SUBMITTED Y | | 23 | NPRD-4 FORM SUB. Y | | 24 | PRIME COMP. SUPPLIER A | | 25 | 26 |
| 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 |

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 While performing the PT, the involved technician utilized a blurry copy of the PT
1 1 procedure. As a result, he mistakenly lifted the wire at terminal CC-19 in
1 2 electrical distribution panel P614 causing the HPCI isolation. The subject wire was
1 3 reterminated and the HPCI isolation signal was reset within one minute of its receipt.
1 4 The involved person has been counseled to utilize legible photostatic copies of PT
7 8 9 procedures.

| | | | | | | | | | | | | | | |
|---------------------|---|---|---------------------|----|---|-------------------------------|----|----|---------------------|---------------|--|-----------------------|--|--|
| FACILITY STATUS | | | % POWER | | | OTHER STATUS | | | METHOD OF DISCOVERY | | | DISCOVERY DESCRIPTION | | |
| 1 | 5 | E | 0 | 7 | 4 | NA | | | B | Periodic Test | | | | |
| ACTIVITY CONTENT | | | RELEASED OF RELEASE | | | AMOUNT OF ACTIVITY | | | LOCATION OF RELEASE | | | | | |
| 1 | 6 | Z | Z | NA | | | NA | | | | | | | |
| PERSONNEL EXPOSURES | | | PERSONNEL INJURIES | | | LOSS OF OR DAMAGE TO FACILITY | | | PUBLICITY | | | | | |
| 1 | 7 | 0 | 0 | 0 | Z | | | NA | | | | | | |
| 1 | 8 | 0 | 0 | 0 | Z | | | NA | | | | | | |
| 1 | 9 | Z | NA | | | NA | | | | | | NRC USE ONLY | | |
| 2 | 0 | N | NA | | | NA | | | | | | | | |

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M. J. PASTVA, JR.

PHONE: 919-457-9521

LER ATTACHMENT - RO #2-82-65

Facility: BSEP Unit No. 2

Event Date: March 30, 1982

During plant operation, while investigating the cause of a spurious RCIC System steam leak detection isolation, the channel functional and operability test of the RCIC System isolation channel, PT-02.1.9P, was performed. While performing the PT, one of the involved technicians misread the PT procedure and caused an unplanned isolation of the HPCI System due to an "A" channel steam leak detection high temperature isolation signal.

This event occurred as a result of the involved technician using a photostatic copy of the PT procedure which had a section which was not completely legible. The procedure requires the wire at terminal GG-19 in electrical distribution panel P614 to be lifted; however, the involved technician mistakenly interpreted the "GG" in GG-19 as "CC." As a result, when he lifted the wire at terminal CC-19, the HPCI isolation occurred.

After the cause of the unplanned HPCI isolation was determined, the subject wire was reterminated and the HPCI isolation signal was reset. The HPCI System was returned to normal standby readiness within one minute of the unplanned isolation.

The technicians who performed the PT have been instructed to utilize legible written procedures while performing any PT. In addition, all plant Maintenance and Operations personnel will review this report to ensure their familiarity of this concern.