NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

0 1	LICENSEE CODE: N C B E P 2 (2)	LICENSE NUMBER: 0 0 - 0 0 0 0 0 - 0 0 (3)	LICENSE TYPE: 4 1 1 1 1 (4)	CAT (5)

CON'T

0 1	REPORT SOURCE: L (6)	DOCKET NUMBER: 0 5 0 - 0 3 2 4 (7)	EVENT DATE: 0 7 1 9 8 2 (8)	REPORT DATE: 0 8 0 2 8 2 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 While observing ongoing ILRT and LLRT valve lineups the resident inspector noted that
0 3 the one and one-quarter inch bypass line around the core spray discharge testable check
0 4 valves, E21-F006A and B, did not appear to be in compliance with seismic design cri-
0 5 teria. An analysis of this line by the architect engineer (UE&C) was then performed
0 6 which determined the line configuracion, as installed, would not maintain structural
0 7 integrity during a seismic event. This event did not affect the health and safety of
0 8 the public. Technical Specifications 3.5.3.1, 6.9.1.8i

0 9	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
	S F (11)	A (12)	X (13)	P I P E X X (14)	A (15)	Z (16)

(17) LER/RO REPORT NUMBER

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
8 2	—	0 8 5	/	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)	Z (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	Y (24)	A (25)	R 3 4 1 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 During plant construction a field change to the line configuration was made to resolve
1 1 a pipe interference problem; however, the field change dimensions were omitted from
1 2 the A/E drawings. The subject lines have been eliminated in accordance with an
1 3 approved modification. These respective lines on the RHR/Core Spray Systems on both
1 4 units were checked and found to be seismically qualified.

1 5	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
	H (28)	0 0 0 (29)	NA	C (31)	Resident Inspector Observation

1 6	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
	Z (33)	Z (34)	NA	NA

PERSONNEL EXPOSURES

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

PERSONNEL INJURIES

1 8	NUMBER	DESCRIPTION (41)
	0 0 0 (40)	NA

LOSS OF OR DAMAGE TO FACILITY (43)

1 9	TYPE	DESCRIPTION
	Z (42)	NA

PUBLICITY

2 0	ISSUED	DESCRIPTION (45)	NRC USE ONLY
	N (44)		

NAME OF PREPARER M. J. PASTVA, JR. PHONE 919-457-9521

LER ATTACHMENT - RO #2-82-85

Facility: BSEP Unit No. 2 Event Date: July 19, 1982

While observing ongoing ILRT and LLRT valve lineups in the drywell, the resident inspector noted that the one and one-quarter inch bypass line around the core spray discharge testable check valves, E21-F006A and B, did not appear to be in compliance with seismic design criteria. As a result of this discovery, the plant architect-engineer (United Engineers and Constructors) was contacted to perform an analysis of the subject line. The analysis determined that, as installed, the vendor-supplied line configuration would not maintain proper structural integrity during a seismic event.

The investigation of this event determined the as found line configuration occurred as a result of a 1974 field change performed to alleviate a pipe interference problem. Documentation of the field change was made via written memorandums; however, the detail dimensions of the change were omitted from the isometric and A/E drawings. Consequently, seismic analysis of the subject lines was not performed. The reason for this omission could not be determined.

To alleviate this condition, the subject lines were removed in accordance with an approved plant modification.

As a result of this discovery, a field check of the respective bypass piping of the discharge testable check valves on the RHR and Core Spray Systems on both units was performed, which revealed no additional problems with seismic qualifications of the respective bypass lines.

While this is considered an isolated case, a review of the presently employed methods for analyzing vendor-supplied components is in progress. This review will determine if any changes to plant procedures are required to help prevent future similar occurrences.