

LICENSEE EVENT REPORT

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

0 1 S I C V I C S 1 1 2 0 0 - 0 0 0 0 0 0 - 0 0 2 4 1 1 1 0 4 3
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
LICENSEE CODE DOCKET NUMBER LICENSE NUMBER LICENSE TYPE DAY YEAR

CON'T
0 1 L 5 0 5 0 0 0 3 9 5 7 0 8 2 0 8 2 8 0 9 1 6 8 2 9
30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50
REPORT SOURCE DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 An isolation valve in the fire service system was found closed which
0 3 rendered the fire suppression system inoperable for the Control Building
0 4 cable spreading rooms and chases. No adverse consequences since the
0 5 plant had recently finished initial fuel loading with no fission product
0 6 inventory or decay heat available.

0 9 A B 11 A 12 A 13 V A L V E X 14 E 15 D 16
9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32
SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP SUBCODE VALVE SUBCODE
17 8 2 0 0 3 0 3 L 0
33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50
LER/RO REPORT NUMBER EVENT YEAR SEQUENTIAL REPORT NO. OCCURRENCE CODE REPORT TYPE REVISION NO.
E H Z 0 0 0 Y N A A 6 10 5 16
51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70
ACTION FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED NRC-1 FORM SUB PRIME COMP SUPPLIER COMPONENT MANUFACTURER

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 5 Header valve was tagged out prior to the plant initially entering Mode 6.
1 6 The system was declared operable with existing discrepancy. Valve tag
1 7 was cleared and valve was opened. The system alignment was verified
1 8 correct. The incident was reviewed with appropriate Operations personnel.

1 5 B 0 0 0 N/A A Line Up Verification
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
FACILITY STATUS % POWER OTHER STATUS METHOD OF DISCOVERY DISCOVERY DESCRIPTION
1 6 Z Z N/A N/A N/A
33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50
ACTIVITY CONTENT RELEASED OR RELEASE AMOUNT OF ACTIVITY LOCATION OF RELEASE
1 7 0 0 0 Z N/A
51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70
PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION
1 8 0 0 0 N/A
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
PERSONNEL INJURIES NUMBER DESCRIPTION
1 9 Z N/A
33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50
LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION
2 0 N N/A
51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70
PUBLICITY ISSUED DESCRIPTION

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DESCRIPTION OF EVENT

On August 20, 1982, with the plant in Mode 5, a routine insurance fire inspection revealed that valve 4064-FS in the Fire Service System was tagged closed. At that time, it was discovered that the valve had previously been tagged out to the vendor prior to entering Mode 6. This situation rendered the preaction sprinkler system for Control Building cable spreading rooms and cable chases inoperable.

PROBABLE CONSEQUENCES

There were no potential adverse consequences because the Station was in Mode 5 with the initial reactor core in place. There was no decay heat or fission product inventory onsite.

CAUSE(S) OF THE OCCURRENCE

The preaction sprinkler system was tagged out of service prior to the issuance of Station Administrative Procedure 205, "System Status and Equipment Removal and Restoration to Service," and prior to the Station initially entering Mode 6 after License issuance. The tag-out condition was detected during a surveillance performed on the system prior to Mode 6, but the information was not properly interfaced into the SAP-205 tracking system when implemented.

IMMEDIATE CORRECTIVE ACTION

The system was declared inoperable at 1455 hours on August 20, 1982. At that time the Station entered the Action Statement (a) of Technical Specifications 3.7.9.2(e). The valve tag was cleared, and the valve was opened at 1510 hours. A system lineup verification was performed, and the system was declared operable.

ACTION TAKEN TO PREVENT RECURRENCE

The incident was reviewed with all Shift Supervisors and Control Room Foremen. A review of the tag out log was initiated to detect any other similar potential problems with no resulting deficiencies. Also, the Administrative Program for removal and restoration of equipment has been functionally implemented which should prevent future recurrence of these types of problems.