

## LICENSEE EVENT REPORT

CONTROL BLOCK: \_\_\_\_\_

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

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	9	LICENSEE CODE					14	15	LICENSEE NUMBER										25	26	LICENSE TYPE					30	57	CAT		58

CON'T

0	1	I	6	0	5	0	-	0	3	2	4	7	0	2	2	3	8	3	8	0	3	2	5	8	3	9				
7	8	REPORT SOURCE		60	61	DOCKET NUMBER										68	69	EVENT DATE					74	75	REPORT DATE					80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0	2	While performing the High Steam Line Radiation Channel Calibration and Functional																																																																													
0	3	Test PTOI 1.12PC, during normal plant operation, main steam line instrument channels																																																																													
0	4	A & D were found to be out of calibration. The allowable setpoints were 364 mr and																																																																													
0	5	152 mr respectively and the as-found valves were 369 mr and 172 mr. This event did																																																																													
0	6	not affect the health or safety of the public.																																																																													
0	7	Technical Specification 3.3.1, 3.3.2, 6.9.1.2b																																																																													
0	8																																																																														

0	9	I	A	11	D	12	Z	13	I	N	S	T	R	U	14	E	15	Z	16				
7	8	SYSTEM CODE		9	10	CAUSE CODE		11	CAUSE SUBCODE		12	COMPONENT CODE					13	COMP. SUBCODE		19	VALVE SUBCODE		20
17		LE/RO REPORT NUMBER		EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.											
8		3		0		3		0		3		0											
X		X		Z		Z		0		0		0											
33		34		35		36		37		40		41											
Y		Y		Y		Y		Y		Y		Y											
33		34		35		36		37		40		41											

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1	0	The out of calibration readings were attributed to instrument drift. The drawers																																																																													
1	1	were recalibrated and returned to service. Also, a review of the procedure indicated																																																																													
1	2	that the section for drawer "D" was not the correct revision. Administrative steps																																																																													
1	3	are being taken to ensure that the correct revision to plant procedures are used when																																																																													
1	4	required.																																																																													

1	5	E	28	0	9	9	29	NA	30	A	31	Surveillance Testing	32
7	8	FACILITY STATUS		9	10	% POWER		12	13	OTHER STATUS		44	45
1		6		Z		Z		NA		NA		36	
7		8		9		10		11		12		13	
1		7		0		0		0		Z		39	
7		8		9		10		11		12		13	
1		8		0		0		0		NA		41	
7		8		9		10		11		12		13	
1		9		Z		NA		NA		NA		43	
7		8		9		10		11		12		13	
2		0		N		44		8304010451 830325		PDR ADOCK 05000324		PDR	
7		8		9		10		11		12		13	

NAME OF PREPARER R. M. Poulk, Jr.

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ATTACHMENT TO LER 2-83-33

Facility: BSEP Unit No. 2

Event Date: February 23, 1983

While performing the High Steam Line Radiation Channel Calibration and Functional Test, PT-01.1.12PC, it was determined that drawers A and D were out of calibration. The drawers were recalibrated and returned to service.

While researching several concerns expressed by the Resident Inspector, it was determined that the procedure used to perform weekly functional tests on the D instrument had not been revised as required on December 14, 1982, to reflect new calibration data derived from the December 14 calibration on the D drawer. This failure to revise the functional test allowed operation of the D drawer from December 12, 1982, to February 23, 1983. The sequence of events for this procedural error was as follows:

December 14, 1982: While performing the weekly functional test, it was determined that the D drawer needed to be recalibrated. A calibration was performed and new baseline data was established for the D drawer only.

December 16, 1982: The weekly functional test was performed on all drawers, with a temporary revision reflecting the new baseline data from the calibration on the D drawer.

Administrative controls were not adequate to assure that a permanent revision was made to the weekly functional test; therefore, subsequent tests reflected pre-December 14 baseline data.

December 23, 1982-  
February 16, 1983: Functional tests were performed on a weekly basis using pre-December 14 data. A past review of these tests indicates that they were in specifications for the pre-December 14 baseline data, but exceeded the required baseline data on each performance.

February 23, 1983: The periodically required calibration was performed on all drawers and the A and D drawers were found out of calibration and were recalibrated. After this event, all required procedures were properly revised to reflect the new baseline data and have been satisfactorily performed since.

To correct the problem of plant procedures not being revised as required, a task force was established to review the incident and make recommendations to plant management by April 1, 1983. Based on these recommendations, appropriate controls will be established to prevent future occurrences by April 30, 1983. Until those controls are finalized, the General Manager has directed that the Plant Nuclear Safety Committee (PNSC) not approve temporary revisions requiring a permanent revision unless the permanent revision accompanies the temporary change. If an exception is required, it will be tracked on management's daily Immediate Attention List, until completion, to assure it receives adequate attention.