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 1 (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 5 (7) | EVENT DATE: 0 3 1 8 8 3 (8) | REPORT DATE: 0 4 0 1 8 3 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 Performance of the weekly surveillance of Fire Suppression Sprinkler and Deluge
0 3 Systems, PT-35.7, revealed the well water isolation valve to both SBGTS trains' deluge
0 4 systems, 1-WW-V207, was closed, thereby rendering both deluge systems to each SBGTS
0 5 train inoperable. It was then consequently determined that a required continuous
0 6 fire watch with backup fire suppression equipment to each SBGTS train had not been
0 7 established when V207 was closed. This event did not affect the health and safety
0 8 of the public. Technical Specifications 3.0.3, 3.7.7.2a, 6.9.1.8b

0 9 | SYSTEM CODE: A B (11) | CAUSE CODE: A (12) | CAUSE SUBCODE: A (13) | COMPONENT CODE: V A L V E X (14) | COMP. SUBCODE: Z (15) | VALVE SUBCODE: Z (16)

(17) LER/RO REPORT NUMBER | EVENT YEAR: 8 3 | — | SEQUENTIAL REPORT NO.: 0 1 5 | / | OCCURRENCE CODE: 0 1 | REPORT TYPE: T | — | REVISION NO.: 0

ACTION TAKEN: X (18) | FUTURE ACTION: X (19) | EFFECT ON PLANT: Z (20) | SHUTDOWN METHOD: Z (21) | HOURS (22): 0 0 0 0 | ATTACHMENT SUBMITTED: Y (23) | NPRD-4 FORM SUB.: N (24) | PRIME COMP. SUPPLIER: Z (25) | COMPONENT MANUFACTURER: Z 9 9 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 Affected deluge systems were unknowingly isolated by the intentional closing of V207
1 1 while attempting to isolate Service Water System vital header inleakage. Upon event
1 2 determination, an appropriate LCO and fire watch were established and V207 reopened
1 3 on 3/15/83. Disciplinary actions are in process for involved personnel. Additional
1 4 corrective actions have been made or are in progress to preclude future similar occurrences.

1 5 | FACILITY STATUS: H (28) | % POWER: 0 0 0 (29) | OTHER STATUS (30): NA | METHOD OF DISCOVERY: B (31) | DISCOVERY DESCRIPTION (32): Periodic Test

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

PERSONNEL EXPOSURES
1 7 | NUMBER: 0 0 0 (37) | TYPE: Z (38) | DESCRIPTION (39): NA

PERSONNEL INJURIES
1 8 | NUMBER: 0 0 0 (40) | DESCRIPTION (41): NA

LOSS OF OR DAMAGE TO FACILITY (43)
1 9 | TYPE: Z (42) | DESCRIPTION: NA

PUBLICITY
2 0 | ISSUED: N (44) | DESCRIPTION (45): NA | NRC USE ONLY

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PDR ADOCK 05000325
S PDR

NAME OF PREPARER M. J. Pastva, Jr. PHONE: (919) 457-9521

LER ATTACHMENT - RO # 1-83-15

Facility: BSEP Unit No. 1 Event Date: March 18, 1983

During an ongoing refueling outage while performing the weekly performance of Fire Suppression Sprinkler and Deluge Systems, PT-35.7, it was discovered that the Well Water System isolation valve to both of the Standby Gas Treatment Systems' (SBGTS) deluge systems, 1-WW-V207, was closed, thereby rendering deluge systems to each of the SBGTS trains inoperable. Upon notification of closure of 1-WW-V207 to Operations personnel, an appropriate LCO and continuous fire watch on the subject deluge systems were established in accordance with technical specifications. An investigation of this event revealed that on February 11, 1983, 1-WW-V207 was placed under clearance in the closed position. This was done while attempting to isolate an unknown source of inleakage to the Service Water System vital header in order to permit draining of the vital header for installation of a plant modification. V207 was placed under clearance by adding it to an existing equipment clearance established to allow draining of the vital header. It was not recognized by the involved Operations personnel, however, that closing V207 isolated the SBGTS deluge systems. Therefore, the event went undetected and the issuance of the required LCO and fire watch were missed.

This event went undetected until March 13, 1983. In the interim period of time, four documented satisfactory performances of PT-35.7 (on February 12, 20, 28, and March 7, 1983) failed to detect the closed V207. The circumstances surrounding the failure by plant Fire Protection personnel to detect the closed V207 are still under investigation. In addition, following the event discovery on March 13, 1983, responsible Operations personnel failed to identify the event as immediately reportable to appropriate plant management, and the event continued to go undetected until March 18, 1983, during a subsequent LCO reportability review by plant Regulatory Compliance personnel.

The investigation of the event concluded the following as contributory factors:

1. The plant Shift Operating Supervisor did not provide appropriate independent review and oversight and was too involved in the details of the actions being taken in association with generating the clearance and later when assessing the reportability of the event, once discovered.

2. The plant drawing aperture cards, utilized when attempting to isolate the Service Water System vital header inleakage, were not easily interpreted.

3. PT-35.7 did not require a hands-on verification of actual valve position.

4. Plant equipment clearance procedures presently do not provide for an overall plant systems impact consideration when additional clearance tags are placed on already existing equipment clearance.

5. Qualifications of Fire Protection group personnel to perform valve position verifications appear to be deficient.

6. Failure of plant management controls to provide for proper identification of a reportable event with respect to LCO applicability.

7. Lack of initiative on the part of the responsible plant Shift Operating Supervisor and Shift Foreman to actively evaluate the consequences of the closed valve when notified.

As a result of this event, the following corrective actions have been performed:

1. A complete audit of existing plant equipment clearances was conducted to ensure compliance with applicable LCOs. This audit verified no LCOs were being violated.

2. A qualified plant auxiliary operator has been assigned to each Fire Protection group operating back shift (16-24 and 00-08) in order to provide expertise in the proper isolation of fire protection equipment and the verification of Fire Protection System equipment lineups. Two qualified plant auxiliary operators will be assigned to the Fire Protection group day shift (08-16).

3. The involved Shift Operating Supervisor has been extensively counseled concerning this event including disciplinary action.

4. Assessment of appropriate disciplinary action for Fire Protection personnel is in progress. These personnel have been suspended pending this determination.

5. PT-35.7 was reviewed and results determined to be satisfactory.

6. Informal on-shift counseling was conducted by the Manager - Plant Operations for shift supervisory personnel concerning this event. This informal counseling was begun immediately following the determination of this event.

7. Formal, documented "live time" training was begun on March 29, 1983, for all shifts covering details of this event, including event description, investigation results, corrective actions, safety considerations, and reportability evaluations. This training will continue until all licensed shift personnel have received this training.

As a result of this event, the following corrective actions are under development in order to prevent future similar occurrences:

1. Upgrade the Fire Protection group personnel training program with respect to the basic discipline of verification of equipment lineups.

2. Update plant drawing aperture cards requiring clarification to provide for easier interpretation of actual system layouts.

3. Provide plant administrative controls which ensure the overall plant systems impact is assessed prior to adding clearance tags to an already existing plant equipment clearance.

4. PT-35.7 is being revised to require a "hands-on" verification of actual valve position.