NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Calvert Cliffs, Unit 1	0 5 0 0 0 3 1 7	1 OF 0 3

TITLE (4)
Failure to Implement Administrative Controls

EVENT DATE (5)			LER NUMBER (6)					REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR		SEQUENTIAL NUMBER		REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
											NA	0 5 0 0 0
0 1	1 3	8 4	8 4	–	0 0 1	–	0 0	0 2	1 0	8 4		0 5 0 0 0

OPERATING MODE (9)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
1	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10) 1 0 0	20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
	20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
	20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
	20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
	20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
	AREA CODE
John Lohr, Operations Technical Advisor	3 0 1 2 6 9 – 4 7 7 6

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)

		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

At 1315 it was discovered that the post accident sampling system return to the reactor coolant drain tank isolation valve was open. This valve is a key operated solenoid valve which is permitted, by T.S. 3.6.4.1 containment isolation valves, to be open during power operation if administratively controlled. Since this valve was open without administrative controls, in effect this violates T.S. 3.6.4.1. It could not be determined why this key operated valve was in the open position. To prevent a recurrence of this incident, the key switches for this and similar valves will be modified. Additionally, key control will be improved and personnel will be reinstructed on the administrative requirements for operation of such valves.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

At 1315 on 1-13-84 a radiation control technician in the area of the post accident sampling system (IP) control panel, located in the auxiliary building (NF), noted an irregularity in the valve position indication lights for one valve. The irregularity noted was that the red (open) and green (shut) indication lights for one valve were in different relative positions than all other similar indicators on that panel. The valve on which the irregularity was noted was 1-SV-6529 (FSV), post accident sampling system return to reactor coolant drain tank isolation valve. This valve is operated from the post accident sampling control panel by use of a key operated switch with key removal permitted in the open or shut position of the switch.

The radiation control technician who discovered the irregularity in the position indication lights called a plant operator to the scene. The operator noted the key switch for 1-SV-6529 was in the open position and the key was removed. He also noted the red and green lens caps for open and shut position indication were in the wrong place. That is the green lens was on the open indication lamp and the red lens was on the shut lamp. The operator realized the valve was really in the open position and notified the control room accordingly. The operator then shut 1-SV-6529 and changed the red and green position indication lens caps to their correct positions. 1-SV-6529 was then verified to be shut locally. The fact that 1-SV-6529 was open without administrative controls in effect was a violation of T.S. 3.6.4.1.

Review of the plant records indicated the last time the valve was documented to be shut was on 1-3-84, during a routine monthly surveillance procedure.

The chemistry group, electrical maintenance group and operations group maintain keys under their control which would allow 1-SV-6529 to be opened. The records on key usage maintained by these groups was reviewed. Personnel using this key during the time period from 1-3-84 to 1-13-84 were interviewed, but no reason was found for 1-SV-6529 being left in the open position or for the lens caps for the open and shut position indication lights being reversed. It is suspected the lens caps for 1-SV-6529 may have been inadvertently switched when checking the light bulbs in the position indication lamps.

To prevent recurrence of this incident, keys that could operate 1-SV-6529 and other similar containment isolation valves have been removed from the control of the chemistry and electrical maintenance groups. All such keys will be maintained only by the operations group.

The following additional corrective action will be taken:

1. A facility design change will be made such that key operated containment isolation valve key switches will be keyed uniquely from all other plant equipment.

2. A facility design change will be made such that for key operated containment isolation valves key withdrawal will not be permitted when the key switch is in the open position.

3. The administrative requirements for operation of 1-SV-6529 and similar valves will be reviewed with plant chemistry personnel, operations personnel, and personnel of the electrical and controls group.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

Having 1-SV-6529 in the open position did not result in the loss of containment integrity. 1-SV-6529 is allowed to be open during operation if administratively controlled. 1-SV-6529 allows the return of sample water from the post accident sampling system to the reactor coolant drain tank (TK) of the reactor coolant waste system (WD) which is located in the reactor containment building (NH). The reactor coolant drain tank is a closed system and is not open to the containment atmosphere.

There was no other equipment inoperable which contributed to the event. This event would not have been more severe under other reasonable and credible alternative conditions.

A similar event was reported under LER 82-51/3L in which a manual isolation valve required to be under administrative control was inadvertently left open. The corrective action for LER 82-51/3L was to issue a standing instruction to require recording in the control room operator's log the position of all containment isolation valves opened under administrative control pursuant to T.S. 3.6.4.1. This corrective action did not prevent this event, 84-01, as the control room operator was not aware 1-SV-6529 had been opened.

BALTIMORE GAS AND ELECTRIC COMPANY

P.O. BOX 1475

BALTIMORE, MARYLAND 21203

NUCLEAR POWER DEPARTMENT
CALVERT CLIFFS NUCLEAR POWER PLANT
LUSBY, MARYLAND 20657

February 10, 1984

Dr. Thomas E. Murley
Regional Administrator
U. S. Nuclear Regulatory Commission
Region 1
631 Park Avenue
King of Prussia, PA 19406

Docket No. 50-317
License No. DPR 53

Dear Dr. Murley:

The attached LER 84-01 is being sent to you as required by 10 CFR 50.73.

Should you have any questions regarding this report, we would be pleased to discuss them with you.

Very truly yours,

LB Russell

L. B. Russell
Plant Superintendent

LBR:JFL:bsb

cc: Director, Office of Management Information and Program Control
Messrs: A. E. Lundvall, Jr.
J. A. Tiernan

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