

LICENSEE EVENT REPORT

CONTROL BLOCK:

| | | | | | |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |
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 (1)

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

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|---|---|
| 0 | 1 |
|---|---|

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| N | C | B | E | P | 2 |
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 (2)

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| 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | - | 0 | 0 |
|---|---|---|---|---|---|---|---|---|---|---|

 (3)

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| 4 | 1 | 1 | 1 | 1 |
|---|---|---|---|---|

 (4)

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|---|
| 5 |
|---|

 (5)

CONT

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| 0 | 1 |
|---|---|

 REPORT SOURCE (L) (6)

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|---|---|---|---|---|---|---|---|
| 0 | 5 | 0 | - | 0 | 3 | 2 | 4 |
|---|---|---|---|---|---|---|---|

 (7)

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|---|---|---|---|---|---|
| 0 | 7 | 1 | 7 | 7 | 9 |
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 (8)

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| 1 | 0 | 2 | 9 | 7 | 9 |
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 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

(0 2) During normal power operation, safety relief valve F013E lifted and reset approximately
(0 3) five minutes later at 970# for no apparent reason and with no indication of previous
(0 4) leakage. Plans were made to shutdown for F013E repair the next weekend. Two days
(0 5) later, F013E lifted at 980# and reset at 915# after power had been reduced to 53%. A
(0 6) normal reactor shutdown was then commenced to repair the valve and prevent any further
(0 7) chance of inadvertant valve operation.

(0 8) Technical Specification 3.4.2, 6.9.1.9b

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

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| 17 |
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 LER/RO REPORT NUMBER (7) (9) (21) (22) SEQUENTIAL REPORT NO. (0) (5) (7) (24) (26) OCCURRENCE CODE (0) (3) (28) (29) REPORT TYPE (X) (30) (31) REVISION NO. (1) (32) ACTION TAKEN (C) (18) FUTURE ACTION (Z) (19) EFFECT ON PLANT (A) (20) SHUTDOWN METHOD (A) (21) HOURS (0) (0) (4) (0) (37) (40) ATTACHMENT SUBMITTED (Y) (23) (41) (26) NPRI-4 FORM SUB. (Y) (24) (42) PRIME COMP. SUPPLIER (N) (25) (43) COMPONENT MANUFACTURER (T) (0) (2) (0) (44) (47)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

(1 0) An electrical check of the valve operator indicated no electrical fault. The valve
(1 1) solenoid was replaced as a precautionary measure. The valve operator was replaced and
(1 2) the failed operator was sent to Wyle Laboratory for failure evaluation. Wyle Labora-
(1 3) tory reported that the pilot valve assembly was leak tested with nitrogen prior to
(1 4) disassembly. Leakage was beyond measurement capability of the bench test. (CON'T)

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| 1 | 5 |
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 FACILITY STATUS (E) (28) % POWER (0) (9) (4) (29) OTHER STATUS (NA) (30) METHOD OF DISCOVERY (A) (31) DISCOVERY DESCRIPTION (Operator Surveillance) (32)

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

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

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

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

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| 2 | 0 |
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 PUBLICITY ISSUED (N) (44) DESCRIPTION (NA) (45)

NAME OF PREPARER A. C. Tollison, Jr.

PHONE: 919-457-9521

1281 011

7911010 411

NRC USE ONLY

LER CONTINUATION -- RO# 2-79-057

Facility: BSEP Unit No. 2

Event Date: 7-17-79

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS:

Moderate steam cutting the seat and disk were verified during disassembly. Target Rock's opinion is that the steam cutting of the seat and disk was the cause of the inadvertant operation of the valve. Target Rock recommends installing model 7567F main steam relief valve , which are insensitive to pilot leakage. We are awaiting field evaluation of these valves before consideration is made for us to use them.

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