

* CONTROL BLOCK:

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 (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CON'T

0	1
7	8

REPORT SOURCE

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

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | During normal operation, while performing periodic spray system valve
0 3 | lock check, valve 1-831A (spray additive isolation valve) was found
0 4 | shut. This condition would have prevented automatic NaOH injection in
0 5 | the event of containment spray operation. This is a violation of
0 6 | Technical Specification 15.3.3.B.1.d. Both trains of containment spray
0 7 | were operable at all times. This event only affected the spray additive.
0 8 |

7 8 9 80

09		SYSTEM CODE		CAUSE CODE		CAUSE SUBCODE		COMPONENT CODE				COMP. SUBCODE		VALVE SUBCODE			
7	8	S	C	A	A	V	A	L	V	E	X	F	D				
LER/RO REPORT NUMBER		EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.							
17	8	1	—	0	0	6	/	0	1	T	—	0					
ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER	
H	H	Z	Z	0	0	0	0	Y	N	N	E	0	9	5			
33	34	35	36	37	38	39	40	41	42	43	44	45	46	47			

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 Subject valve was immediately repositioned and locked open. Investi-
1 1 gation revealed that the valve had been shut for four days since
1 2 completion of Technical Specification surveillance testing of NaOH
1 3 addition valves. The operator signing for the work failed to position
1 4 the valve correctly. Increased operator awareness will prevent
7 8 9 recurrence of problems of this type.

FACILITY STATUS				% POWER			OTHER STATUS		METHOD OF DISCOVERY		DISCOVERY DESCRIPTION	
1	5	E	28	0	8	0	29	N/A	B	31	Periodic valve position check	

ACTIVITY CONTENT
RELEASED OF RELEASE AMOUNT OF ACTIVITY (35)

1 6 Z (33) Z (34) N/A

7 8 9 10 11 44

LOCATION OF RELEASE (36)

N/A

45 80

PERSONNEL EXPOSURES									
NUMBER			TYPE	DESCRIPTION					
1	7	0	0	0	(37)	Z	(38)	N/A	

PERSONNEL INJURIES		NUMBER		DESCRIPTION	
1	8	0	0	0	N/A

7		8		9		11		12		80			
LOSS OF OR DAMAGE TO FACILITY (43)													
TYPE				DESCRIPTION									
1		9		Z		(42)		N/A					

	7	8	9	10											80	
	PUBLICITY															
	ISSUED		(44)	DESCRIPTION (45)											NRC USE ONLY	
	2	0	N	(44)	N/A											

ATTACHMENT TO LICENSEE EVENT REPORT NO. 81-006/01T-0

Wisconsin Electric Power Company
Point Beach Nuclear Plant Unit 1
Docket No. 50-266

At 0245 hours on June 21, 1981, during normal operation and while conducting PC-9 Part II, "Spray System Valve and Lock Checklist," valve 1-831A (spray additive isolation valve) was found locked shut. The valve was immediately repositioned and locked open.

Valve 1-831A is the spray tank additive isolation valve, and operation with it shut would have prevented automatic sodium hydroxide injection into the containment spray system in the event that spray system operation was initiated. Operation in this mode is prohibited by Technical Specification 15.3.3.B.1.d.

Investigation revealed that the last operation of valve 831A had occurred on June 17, 1981, during TS-29, "Technical Specification Surveillance Testing of Sodium Hydroxide Addition Valves." The procedure clearly states the importance of valve 831A to the operation of the system, and the system restoration portion of TS-29 requires that it be locked open. The operator inadvertently locked the valve shut.

All operators are being reinstructed in the importance of maintaining proper valve lineups, with special emphasis on safety-related systems and where valve position indication is not available to control room personnel. It has also been restressed that the precautions and notes written in procedures have been placed there for the benefit of operators, and that they should be read by all affected personnel prior to execution of the procedure.

Both trains of containment spray were operable at all times during the period that 831A was shut. If spray additive flow had been initiated, the control board indications of zero additive flow rate and unchanging additive tank level would have shown operators that a problem existed which could easily have been narrowed to one of two manual isolation valves. The Emergency Operating Procedures require that operators verify correct operation of the spray system and specifically that the NaOH addition has been made.

This event is being reported in accordance with Technical Specification 15.6.9.2.A.2. The event was reported on the Emergency Notification System at 0304 hours on June 21, 1981. The Resident Inspector was notified at a later time.