

# LICENSEE EVENT REPORT

CONTROL BLOCK:  (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 N C B E P 2 0 0 - 0 0 0 0 0 - 0 0 3 4 1 1 1 1 4 5  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

CON'T  
0 1 REPORT SOURCE L 0 5 0 - 0 3 2 4 7 0 6 2 9 8 1 8 0 7 0 9 8 1 9  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 While performing a normal reactor startup, it was determined that the valve lineup  
0 3 for the A loop of RHR in standby readiness was incorrect. The F020A valve, torus  
0 4 suction for the A loop, was reported to be in the shut position with the mode switch  
0 5 in Startup and seven rods withdrawn. This condition makes the A loop of LPCI inoper-  
0 6 able. This event did not affect the health or safety of the public.

0 7

0 3 Technical Specification 6.9.1.8b

0 9 SYSTEM CODE C F 11 CAUSE CODE A 12 CAUSE SUBCODE A 13 COMPONENT CODE V A L V E X 14 COMP. SUBCODE E 15 VALVE SUBCODE D 16  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause for this event was the Control Operator commencing a plant startup  
1 1 without knowing that the F020A valve was open. The seven withdrawn rods were immedi-  
1 2 ately inserted and the mode switch placed in Refuel. The F020A valve was opened, the  
1 3 system lineup verified correct and a normal reactor startup was performed.

1 4

1 5 FACILITY STATUS C 28 % POWER 0 0 0 29 OTHER STATUS NA 30 METHOD OF DISCOVERY A 31 DISCOVERY DESCRIPTION Operator Notification 32  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

1 6 ACTIVITY CONTENT Z 33 RELEASED OF RELEASE Z 34 AMOUNT OF ACTIVITY NA 35 LOCATION OF RELEASE 36  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

1 7 PERSONNEL EXPOSURES NUMBER 0 0 0 37 TYPE Z 38 DESCRIPTION NA 39  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

1 8 PERSONNEL INJURIES NUMBER 0 0 0 40 DESCRIPTION NA 41  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

1 9 LOSS OF OR DAMAGE TO FACILITY TYPE Z 42 DESCRIPTION NA 43  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

2 0 PUBLICITY ISSUED N 44 DESCRIPTION 8108030393 810709 PDR ADDCK 05000324 PDR  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

NAME OF PREPARER R. M. Poulk, Jr.

PHONE: 919-457-9521

LER 2-81-59 ATTACHMENT

Facility: BSEP Unit No. 2

Event Date: 6/29/81

At approximately 0430 while establishing a standby readiness lineup for A loop of RHR in preparation for a reactor startup, the breaker for the torus suction valve, F020A tripped. Two Auxiliary Operators were sent to manually open the valve. The Auxiliary Operators were not able to break the valve disk off of its seat, so another Auxiliary Operator was sent to assist with a manual valve operator. At 0528, prior to receiving word on the status of the F020A valve, a normal reactor startup was commenced. Shortly after the commencement of the startup, the Shift Operating Supervisor questioned the position of the F020A valve during a review of the control panel. The startup was secured with seven rods withdrawn and the Auxiliary Operators' assigned to open the valve were contacted to determine the actual valve position. At 0554, word was received in the Control Room that the F020A valve was still shut and still could not be broken off its seat. The seven withdrawn control rods were immediately inserted and the mode switch was taken to the Refuel position.

An investigation of this event has determined that the main cause was personnel error with slow communications being a minor cause. The Control Operator assumed that sufficient time had elapsed to open the F020A valve and thus initiated a reactor startup. He also initialed the step on the startup procedure requiring the valve to be open as complete. To correct these problems the following actions have been or will be taken:

1. A meeting was held with senior plant management and those personnel involved to discuss the series of events that led to this violation of technical specifications and the seriousness of that violation.
2. Appropriate disciplinary action was taken with the individuals involved in this event. The Shift Foreman and the Control Operator involved with this event were removed from duties requiring a license until the investigation was completed. Following the investigation and the meeting described in 1. above, the personnel were returned to normal duty.
3. Each Shift Operating Supervisor will review this event with their respective shifts with emphasis on ensuring that items are verified complete prior to signing them off, and that all blocks are completed or an explanation documented and an approval signature obtained prior to initiation of any event requiring the documentation.
4. The Shift Foreman will discuss with all Auxiliary Operators and Control Operators the need to maintain effective communications and to report problems to the Control Room in an expedited manner.
5. GP-1 (plant startup procedure) will be reviewed and revised as required to better define startup prerequisites.