

LICENSEE EVENT REPORT

CONTROL BLOCK:

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 (1)

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0	1	N	C	B	E	P	1	2	0	0	-	0	0	0	0	0	-	0	0	3	4	1	1	1	1	4			5			
7	8	LICENSEE CODE							14	LICENSE NUMBER										25	LICENSE TYPE					30	CAT					58

CON'T

REPORT SOURCE L 0 5 0 - 0 3 2 5 7 0 3 2 7 8 1 8 0 4 1 0 8 1 9

60 63 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | While removing a clearance from the C TIP machine, the Senior Operator expressed a
0 3 | concern as to the operability of the isolation ball valve with the TIP machine de-ener-
0 4 | gized. An investigation determined that the isolation ball valve was operable; however,
0 5 | power to retract the TIP probe was lost. While the clearance was hung, the probe and
0 6 | associated cable were not retracted, thus making the primary containment ball isolation
0 7 | valve inoperable.

Technical Specifications 6.9.1.8b,f and 3.6.1

SYSTEM CODE S D 11		CAUSE CODE B 12		CAUSE SUBCODE A 13		COMPONENT CODE V A L V E X 14		COMP. SUBCODE A 15		VALVE SUBCODE D 16	
EVENT YEAR 8 1 21 22		SEQUENTIAL REPORT NO. 0 4 2 24 25 26		OCCURRENCE CODE 0 1 28 29		REPORT TYPE T 30		REVISION NO. 0 32			
ACTION TAKEN X 18		FUTURE ACTION F 19		EFFECT ON PLANT Z 20		SHUTDOWN METHOD Z 21		HOURS 0 0 0 0 22		ATTACHMENT SUBMITTED Y 23	
NPRD-4 FORM SUB. N 24		PRIME COMP. SUPPLIER N 25		COMPONENT MANUFACTURER G 0 8 0 26							

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | This event was caused by a design deficiency which allowed the removal of power to the

1 1 | TIP probe drive motor when the electronics to the TIP were de-energized. An Engineering

1 2 | Work Request has been written to correct the probe drive design so that the probe

1 3 | will drive in on an isolation signal so that the ball valve can close.

1	4																	80			
7	8	9																			
FACILITY STATUS			% POWER			OTHER STATUS (30)			METHOD OF DISCOVERY			DISCOVERY DESCRIPTION (32)						80			
1	5	E	(28)	0	9	5	(29)	NA			A	(31)	Operational Event						80		
7	8	9	ACTIVITY CONTENT			AMOUNT OF ACTIVITY (35)									LOCATION OF RELEASE (36)						80
RELEASED OF RELEASE																					
1	6	Z	(33)	Z	(34)	NA			NA									80			
7	8	9																			

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

PERSONNEL INJURIES		NUMBER		DESCRIPTION	
1	H	0	0	0	NA

7		8		9		10		11		12	
1		2		3		4		5		6	
TYPE		DESCRIPTION		43							
1	9	Z	42	NA							

ISSUED (2) (0) (44) (45) NA

NAME OF PREPARER M. J. Pastva, Jr.

PHONE: (919) 457-9521

8104170455

LER 1-81-42 ATTACHMENT

Facility: BSEP Unit No. 1

Event Date: 32781

At 0710 on March 25, 1981, the Unit No. 1 C TIP machine was placed under clearance to troubleshoot and repair problems caused by excessive moisture from steam leaks in the TIP room. This clearance required de-energizing the TIP machine in the Control Room, which removes power from the probe drive mechanism. When the clearance was placed on the TIP machine, the probe was tagged at position 0001, which was believed to be the "in shield" position. This position actually placed the probe in the indexer mechanism.

While removing the clearance from the tip machine, the Senior Reactor Operator expressed a concern as to the operability of the ball valve. I&C was instructed to investigate and determine the status of this valve with the machine de-energized. The results of this investigation determined that a design deficiency exists in that while the ball valve would still isolate on an isolation actuation signal, power would be lost to the drive mechanism. With the probe located in the indexer, the ball valve would not be able to isolate under an isolation condition due to the probe cable not being capable of withdrawing to its shield, and primary containment integrity could not be maintained.

A contributing factor to this event is the low level of knowledge on the TIP System by the operators. These machines are operated by the nuclear Engineers with very little operator influence. Also, the operating procedure for the TIP machine does not contain sufficient information or precaution to inform the operator that he could get into a situation where the automatic isolation function would be negated.

An Engineering Work Request has been written requesting that Engineering evaluate the system and correct this deficiency. Also, the following actions have been or are being taken to correct this problem:

1. All plant licensed personnel will review this event.
2. The operating procedure will be revised to provide sufficient instructions and precautions to prevent a recurrence.
3. Caution tags have been placed on all TIP machines (both units) to warn personnel of the possibilities of an isolation override.
4. Upgrading the operator training documents and procedures to include TIP machine influence on the isolation ball valve.
5. Increase operator training on the TIP System.

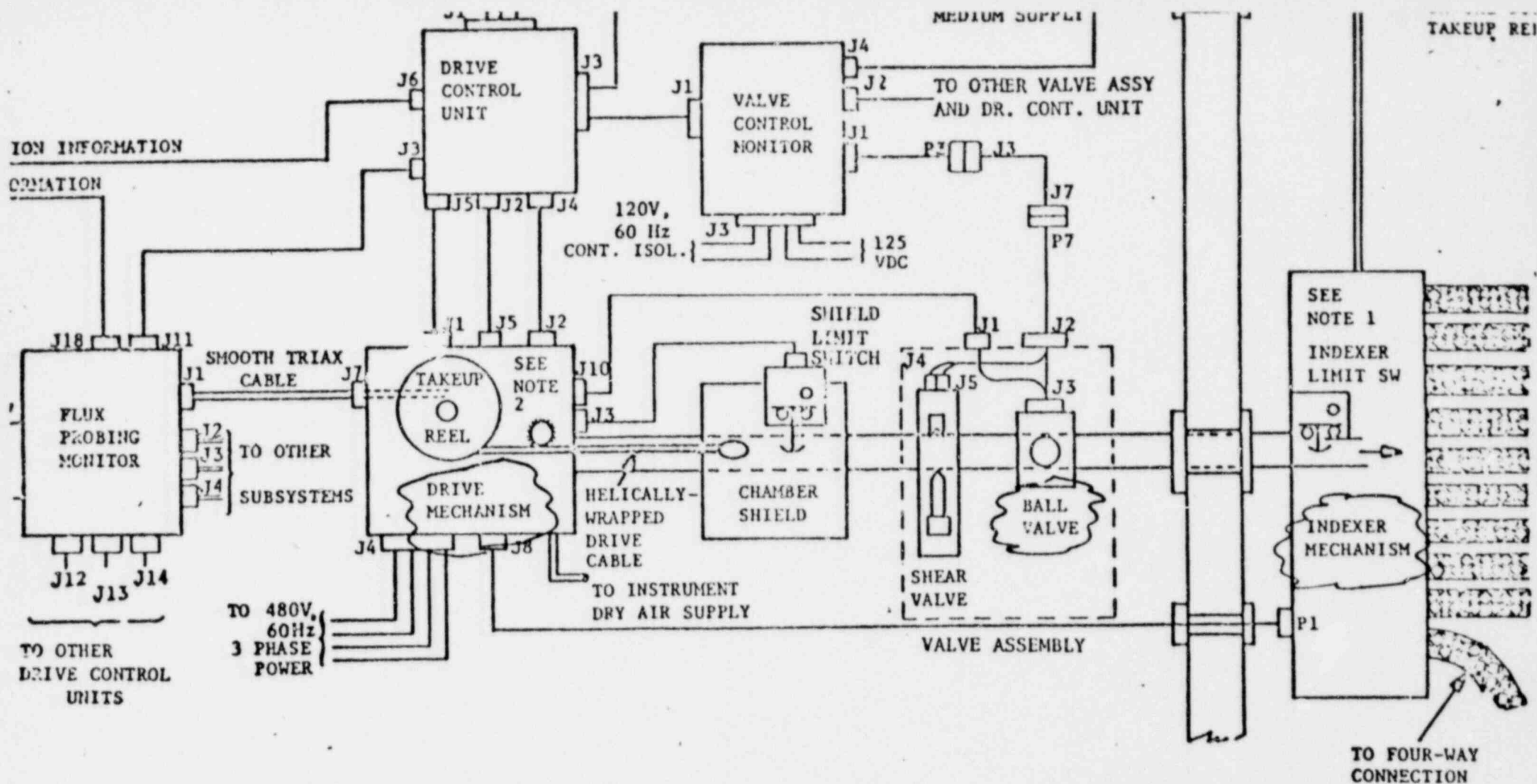


Figure 9-2-1 Tra
Pro
Sys

SD-9.