

CONTROL BLOCK:

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0	1	A	L	B	R	F	2	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
LICENSEE CODE		LICENSE NUMBER										LICENSE TYPE					CAT 58											

CON'T

0	1	L	6	0	5	0	0	0	2	6	0	7	0	4	2	5	8	1	8	1	2	3	1	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
REPORT SOURCE		DOCKET NUMBER										EVENT DATE					REPORT DATE										

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 While operating at full power steady state, a bypass was installed on MSL high temp-  
03 erature isolation relays to control unit conditions until the ventilation system could  
04 be returned to service or a controlled shutdown initiated and MSIV's closed per T.S.  
05 note 3.2.A.1.B. A reactor operator was stationed at the main steam tunnel temperature  
06 monitor to isolate main steam lines if temperature reached T.S. limits. There was no  
07 danger to the health or safety of the public. Previous similar event: BFRO-50-260/  
08 81017.

0	9	C	D	11	A	12	A	13	Z	Z	Z	Z	Z	Z	14	Z	15	Z	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	
SYSTEM CODE		CAUSE CODE		CAUSE SUBCODE		COMPONENT CODE					COMP. SUBCODE		VALVE SUBCODE		SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.							
LER/RO REPORT NUMBER		EVENT YEAR		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER														
17		18		19		20		21		22		23		24		25		26		27		28		29		30		
ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER												
B		Z		Z		Z		0		Y		N		L		Z		9		9		9		9		26		

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 Personnel error. Individual failed to recognize installing bypass put the unit in an  
11 LCO requiring shutdown within 24 hours. Repairs were initiated, ventilation  
12 restored, and the bypass removed within 48 minutes. Personnel were stationed to  
13 monitor as stated above. MSIV isolation signals from main steam line high flow and  
14 low pressure were operable.

1	5	E	28	1	0	0	29	NA	30	A	31	Operator observed	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
FACILITY STATUS		% POWER		OTHER STATUS		METHOD OF DISCOVERY		DISCOVERY DESCRIPTION																				
1		1		NA		A		Operator observed																				
ACTIVITY CONTENT		RELEASED OF RELEASE		AMOUNT OF ACTIVITY		LOCATION OF RELEASE																						
1		Z		NA		NA																						
PERSONNEL EXPOSURES		NUMBER		TYPE		DESCRIPTION																						
1		0		Z		NA																						
PERSONNEL INJURIES		NUMBER		DESCRIPTION																								
1		0		NA																								
LOSS OF OR DAMAGE TO FACILITY		TYPE		DESCRIPTION																								
1		Z		NA																								
PUBLICITY		ISSUED		DESCRIPTION																								
2		N		NA																								

NAME OF PREPARER Gene Holder

PHONE (205) 729-6134

NRC USE ONLY

LER SUPPLEMENTAL INFORMATION

BFRO-50- 260 /81019 R1 Technical Specification Involved 3.2.A Table 3.2.A

Reported Under Technical Specification 6.7.2.a.5 \* Date Due NRC NA

Date of Occurrence 4/25/81 Time of Occurrence 1030 Unit 2

Identification and Description of Occurrence:

While operating at full power steady state a bypass was installed on main steam line high temperature isolation relays to maintain control of unit conditions until the ventilation system could be returned to service or a controlled shut-down initiated and MSIV's closed per T.S. note 3.2.A.1.B.

Conditions Prior to Occurrence:

Unit 1 at refueling outage.

Unit 2 at 100%.

Unit 3 at 95%.

Action specified in the Technical Specification Surveillance Requirements met due to inoperable equipment. Describe.

A reactor operator was stationed at the main steam tunnel temperature monitor with instructions to isolate the main steam lines if the temperature reached T.S. Limits.

Apparent Cause of Occurrence:

Personnel error.

Analysis of Occurrence:

There was no danger to the health or safety of the public, no release of activity, no damage to the plant or equipment, and no resulting significant chain of events.

Corrective Action:

Repairs were made and the requirements of the applicable LCO were satisfied. The individual involved was reprimanded in writing.

Failure Data:

None

Retention: Period - Lifetime; Responsibility - Document Control Supervisor

\*Revision: John A. [Signature]