

**CENSEE EVENT REPORT**

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CON'T

0	1
7	8

REPORT SOURCE

L	6	0	5	0	0	0	3	1	5	7	0	3	1	1	8	0	8	0	4	3	0	8	0	9
60	61									68	69					74	75							80
DOCKET NUMBER											EVENT DATE					REPORT DATE								

### EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

SYSTEM CODE I D (11)		CAUSE CODE E (12)		CAUSE SUBCODE B (13)		COMPONENT CODE I N S T R U (14)		COMP. SUBCODE E (15)		VALVE SUBCODE Z (16)	
LER/RO REPORT NUMBER 8 0 (17)		EVENT YEAR 8 0 (21)		SEQUENTIAL REPORT NO. 0 0 4 (24)		OCCURRENCE CODE 0 3 (28)		REPORT TYPE X (30)		REVISION NO. 1 (32)	
ACTION TAKEN A (18)		FUTURE ACTION Z (19)		EFFECT ON PLANT B (20)		SHUTDOWN METHOD Z (21)		HOURS 0 0 7 (22)		ATTACHMENT SUBMITTED Y (23)	
NPRD-4 FORM SUB. Y (24)		PRIME COMP. SUPPLIER N (25)		COMPONENT MANUFACTURER W T 2 0 (26)							

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 A REEVALUATION OF THIS EVENT HAS REVEALED THAT THE INITIATING CAUSE WAS THE FAILURE  
1 1 OF ONE OF THE TWO DETECTORS IN USE FOR THE APDMS SYSTEM. THE FAILURE WAS DUE TO  
1 2 THE DETECTOR DEVELOPING A STRETCHED HELEX AND SUBSEQUENTLY A DAMAGED DRIVE WHEEL.  
1 3 AT THE TIME OF THIS EVENT ALL OTHER DETECTORS IN THE FLUX MAPPING SYSTEM WERE  
1 4 UNAVAILABLE THUS MAKING THE APDMS (SEE ATTACHED SUPPLEMENT)

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

FACILITY STATUS (28) E 1 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

% POWER 1 0 0 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

OTHER STATUS NA 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

METHOD OF DISCOVERY A 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

DISCOVERY DESCRIPTION 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

OPERATOR OBSERVATION 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

ACTIVITY CONTENT 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

RELEASED OF RELEASE 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

AMOUNT OF ACTIVITY 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

NA 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

LOCATION OF RELEASE 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

NA 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

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

PERSONNEL INJURIES		NUMBER		DESCRIPTION	
1	8	0	0	0	NA

7		8		9		10		11	
1		2		3		4		5	
TYPE		DESCRIPTION		TYPE		DESCRIPTION		TYPE	
1	9	Z	(42)	NA	(43)	8005050272			

PUBLICATION								NRC USE ONLY															
ISSUED		DESCRIPTION																					
2	0	N	(44)	NA																			
7	8	9	10	68 69 70 71 72 73 74 75 76 77 78 79 80																			

PHONE: 616-465-5901



ATTACHMENT TO LER #80-004/03X-1

SUPPLEMENT TO CAUSE DESCRIPTION

AND ALTERNATE P250 COMPUTER SYSTEMS UNAVAILABLE FOR USE.

WHEN IT WAS DETERMINED THAT THE REQUIRED SCANS COULD NOT BE COMPLETED REACTOR POWER WAS REDUCED TO 83 PER CENT IN COMPLIANCE WITH THE ACTION REQUIREMENTS OF T.S. 3.2.6.

THE DAMAGED DETECTOR AND DRIVE WHEEL WERE REPLACED AND RETURNED TO SERVICE. NO FURTHER ACTION IS PLANNED AT THIS TIME.

INCORE FLUX PROBE WAS A WESTINGHOUSE MODEL NO. WL-23630.

THE DRIVE WHEEL WAS A TELEFLEX PART NO. 25495.

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