

LICENSEE EVENT REPORT

CONTROL BLOCK: 1 2 3 4 5 6 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

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 N Y N M P 1 2 0 0 - 0 0 0 0 0 0 - 0 0 3 4 1 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

CON'T
0 1 REPORT SOURCE L 6 0 5 0 0 0 2 2 0 7 0 2 0 9 8 1 8 0 2 2 3 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

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES 10

0 2 During normal operation, the #111 Main Steam Radiation Monitor input to the #11 RPS
0 3 Trip System was inoperable for approximately 90 minutes while the #11 Trip System was
0 4 left in the untripped condition. This is contrary to the RPS Instrument Channel oper-
0 5 ability requirements as given in the Technical Specifications. The Technical Specifi-
0 6 cations require that the Trip System be placed in the tripped condition when either of
0 7 the Instrument Channels associated with that Trip System is inoperable. During this
0 8 time the redundant monitor input to #11 Trip System, and the two (2) (SEE OVER)
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

0 9 SYSTEM CAUSE CAUSE COMPONENT COMP. VALVE
CODE CODE SUBCODE CODE SUBCODE SUBCODE
S H 11 A 12 A 13 R E L A Y X 14 X 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 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

17 LER/RO REPORT NUMBER 8 1 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

ACTION TAKEN FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED NPED-4 FORM SUB. PRIME COMP. SUPPLIER COMPONENT MANUFACTURER
X 18 H 19 Z 20 Z 21 0 0 0 0 22 Y 23 N 24 N 25 G 0 8 0 26
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

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27

1 0 The subject radiation monitor signal had been fluctuating sufficiently to cause multi-
1 1 ple spurious half scram actuations. Consequently, the SSS granted permission to in-
1 2 stall a block in the RPS actuation relay of the subject monitor, to prevent further
1 3 spurious half scrams, while the Instrument technician was to proceed with trouble
1 4 shooting by withdrawing the detector from the holder. Upon removal (SEE OVER).
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

1 5 FACILITY STATUS E 28 0 8 7 29 OTHER STATUS 30 N/A METHOD OF DISCOVERY B 31 DISCOVERY DESCRIPTION 32 SUPERVISION REVIEW
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

1 6 ACTIVITY CONTENT RELEASED OF RELEASE Z 33 Z 34 AMOUNT OF ACTIVITY 35 N/A LOCATION OF RELEASE 36 N/A
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

1 7 PERSONNEL EXPOSURES NUMBER 0 0 0 37 TYPE Z 38 DESCRIPTION 39 N/A
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

1 8 PERSONNEL INJURIES NUMBER 0 0 0 40 DESCRIPTION 41 N/A
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

1 9 LOSS OF OR DAMAGE TO FACILITY TYPE Z 42 DESCRIPTION 43 N/A
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

2 0 PUBLICITY ISSUED DESCRIPTION 45 N/A
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

NRC USE ONLY

010,303 0757

NAME OF PREPARER Paul Harrison

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EVENT DESCRIPTION AND PROBABLE CONSEQUENCES

monitor inputs to #12 Trip System were operable, thus there was no significant safety concern.

CAUSE DESCRIPTION AND CORRECTION ACTIONS

of the detector, it was discovered that the detector-to-cable connector was loose, which was causing the fluctuating output signal. The connector was tightened, the detector reinstalled, and the monitor returned to normal indication. The RPS relay block was then removed. At this time the #111 Main Steam Line Radiation Monitor was fully operable.

In order to prevent occurrences of this nature in the future, several corrective actions have been taken. First, a review of the circumstances was made with the shift personnel involved. Second, an instruction has been issued to all operations personnel regarding this matter. Third, procedures changes have been made to ensure specific Technical Specification reviews are made and documented when equipment important to safety is removed from service. Fourth, this incident and aforementioned procedure changes will be incorporated into regularly scheduled training sessions for Operations personnel. Fifth, training sessions will be conducted within the Instrument and Control Department, regarding instrumentation important to safety and the Technical Specifications requirements in general.

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