

LICENSEE EVENT REPORT

CONTROL BLOCK: 1 (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 F I L S L S 1 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
LICENSEE CODE LICENSE NUMBER LICENSE TYPE CAT 58

CON'T
0 1 REPORT SOURCE L 0 5 0 0 0 3 3 5 0 5 2 2 8 1 0 6 2 2 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
DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)
0 2 During 100% power operation, 1 of 2 chlorine detectors in the north control
0 3 room air intake failed. Action was taken per T.S. 3.3.3.6a. The detector
0 4 was returned to service in approximately 18 hours. The health and safety
0 5 of the public was not affected. This is the third LER involving a failure
0 6 of a chlorine detectors See LER's 335-76-36 and 81-12
0 7
0 8
0 9

SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP TUB CODE VALVE SUR CODE
S G E X I N S T R U E Z
11 12 13 14 15 16

17 LER/RO REPORT NUMBER 8 1 1 0 1 2 8 0 3 1 0
21 22 23 24 25 26 27 28 29 30 31 32
EVENT YEAR SEQUENTIAL REPORT NO. OCCURRENCE CODE REPORT TYPE REVISION NO.

ACTION TAKEN FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED NRC-4 FORM 508 PRIME COMP SUPPLIER COMPONENT MANUFACTURER
A Z Z Z 0 0 0 0 N N A W O 2 1 5
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
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

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)
1 0 The failure was due to clogging of the wick. The wick was replaced in
1 1 kind.
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4 0
4 1
4 2
4 3
4 4
4 5
4 6
4 7
4 8
4 9
5 0
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5 9
6 0

FACILITY STATUS % POWER OTHER STATUS METHOD OF DISCOVERY DISCOVERY DESCRIPTION
E 1 0 0 NA A OPERATOR OBSERVATION
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

ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY LOCATION OF RELEASE
Z Z NA NA
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

PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION
0 0 0 Z NA
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

PERSONNEL INJURIES NUMBER DESCRIPTION
0 0 0 NA
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

LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION
Z NA
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

PUBLICITY ISSUED DESCRIPTION
N NA
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

NRC USE ONLY
2 0 N
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

NAME OF PREPARER P. L. Pace PHONE: (305) 552-3801

Supplemental Information

for

Licensee Event Report 81-014

1. Cause Description and Analysis

On May 23, 1981, at approximately 0130 hours with the plant at cold shutdown, a routine instrument calibration identified that the Hagan Summator (PM-446B) in the first stage turbine pressure channels which develops the high steam line flow setpoint for reactor protection safeguards had shifted nonconservatively approximately 3%. This shift would have delayed but not prevented the fulfillment of the protection functions of this channel. The redundant channel was operational so there was no threat to the health and safety of the public. This event, which is contrary to Technical Specification 3.5.1, is reportable under Technical Specification 6.9.2.b.1.

2. Corrective Action

The cause of this event was found to be the failure of a filter capacitor. This failure is attributed to normal wear resulting in the end-of-life of the component. The faulty capacitor was replaced and the module recalibrated on May 23, 1981.

3. Corrective Action to Prevent Further Occurrence

Since the failure is attributed to normal wear, no further action is required. The module is tested and recalibrated yearly.