

LICENSEE EVENT REPORT

CONTROL BLOCK:

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(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0	1	N Y N M P												2	0	0	-	0	0	0	0	0	0	0	3	4						4						5				
8		9												14		15												25		26		30					57		58			
		LICENSEE CODE														LICENSE NUMBER																LICENSE TYPE							CAT			

CON'T

0 1 8
REPORT SOURCE L 6 0 5 0 0 0 2 2 0 7 0 17 2 9 8 1 8 0 8 0 8 1 2 8 1 9
60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | SEE ATTACHED

0 9 10 11 12 13 14 15 16

LER/RO REPORT NUMBER		EVENT YEAR		SEQUENTIAL REPORT NO.			OCCURRENCE CODE		REPORT TYPE		REVISION NO.	
17		18	19	20	21	22	23	24	25	26	27	28
ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB
29	30	31	32	33	34	35	36	37	38	39	40	41
PRIME COMP SUPPLIER		COMPONENT MANUFACTURER										
42	43	44	45	46	47	48	49	50	51	52	53	54

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 SEE ATTACHED

FACILITY STATUS (28) 098 (29) NA OTHER STATUS (30) METHOD OF DISCOVERY (31) D RESIDENT INSPECTOR OBSERVATION (32)

ACTIVITY RELEASED (33) CONTENT OF RELEASE (34) AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36)

1 5 Z 10 11 NA 44 45 NA 50

PERSONNEL EXPOSURES									
NUMBER			TYPE		DESCRIPTION				
1	2	0	0	0	17	Z	38	NA	

PERSONNEL INJURIES										
NUMBER				DESCRIPTION						
1	2	3	4	5	6	7	8	9	10	
0	0	0	0	40	NA					41

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	
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PUBLICATION		ISSUED		DESCRIPTION		NRC USE ONLY	
2	0	44	NA				

NRC USE ONLY

8108200359 810812
PDR ADCK 05000220
S PDR

Richard Neild

(315) 343-2110, X1528

PHONE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES

On 6/30/81 during a routine calibration of the Emergency Condenser Vent Monitors, all four monitors exceeded the upscale trip set point. This incident was previously reported as LER 81-30. On 7/29/81, while performing a followup investigation of this incident, the technician requested permission from the Shift Supervisor to work on Emergency Condenser Vent Monitor #122. In order to prevent an inadvertent system isolation during the trouble shooting effort, the #12 System high radiation isolation function was bypassed using a keylock switch. In addition, as a precaution against a possible personnel error, the #11 system high radiation isolation function was bypassed in the same manner. These switches also bypass the Emergency Condenser High Steam flow system isolation function. The isolation functions were bypassed for approximately 30 minutes, at which time #11 Emergency Condenser was returned to normal. The isolation functions of #12 Emergency Condenser remained in bypass for an additional 15 minutes. These actions were in violation of Technical Specification Table 3.6.2c which specifies the minimum number of tripped or operable systems and the minimum number of operable instrument channels per operable trip system required for Emergency Cooling System Operability.

The heat removing capability of the Emergency Condenser remained operable throughout the incident. However, the protective system isolation signals of high steam flow and high radiation were inoperable. There was no release of radioactivity, and no effect on the health and safety of the public or plant personnel.

CAUSE, DESCRIPTION AND CORRECTIVE ACTIONS

Violation of Technical Specifications during this event was caused by failure to follow station Administrative Procedures. Present procedures call for maintaining records in the control room of all equipment status changes which may render the equipment or system not capable of performing its intended function in its required manner. The procedures further require that these status changes or the placement of jumpers or blocks shall include reference to the applicable Technical Specifications. All operating, technical, and maintenance personnel are instructed on these procedures as they apply to their duties.

As discussed at the Management meeting in the Region I office, that during primary and requalification instruction sessions an increased emphasis will be placed on the importance of the rationale in Technical Specifications. Also during the meeting, we discussed the fact that the investigation of this event and the two previous occurrences, Inspection 80-13 and LER 81-04, was still continuing. This investigation revealed, from operator feedback, that previous training has failed to emphasize that both the LCO's for a given system, and the LCO's for instrumentation, which may initiate or isolate a given system, must be referred to whenever component failures occur or when maintenance or testing is to take place on that system. Failure to check both sections of the Technical Specifications may be the cause of inadvertent Technical Specification violations. Training will place increased emphasis on this matter. Also a component oriented cross-

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reference system will be developed as an aid to readily access all portions of Technical Specifications which may directly or indirectly pertain to the operability or non-operability of all safety-related components or systems.