

LICENSEE EVENT REPORT

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

01 PATMI 11 290-000000-000 341111 45
7 8 9 14 15 25 26 30 37 CAT 58

CON'T
01 REPORT SOURCE L 605000289 70 90282 8091782 9
7 8 60 61 68 69 74 75 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 While in long term cold shutdown, after performing a routine surveillance for
03 station liquid effluent monitor (RML-7) it was discovered that the alarm setpoint
04 hadnot been calculated properly since the implementation of License Amendment #72
05 (Nov. 1981). Calculations for alarm setpoint had incorrectly accounted for dilution
06 flow. All releases have been controlled up-stream of RML-7 with appropriate
07 monitors and lower "alert" setpoint was never reached, so health and safety
08 of the public was unaffected.
7 8 9

09 SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE CUMP. SUBCODE VALVE SUBCODE
M C 11 A 12 D 13 Z Z Z Z Z Z 14 Z 15 Z 16
7 8 9 10 11 12 13 18 19 20

17 LER/RO REPORT NUMBER EVENT YEAR SEQUENTIAL REPORT NO. OCCURRENCE CODE REPORT TYPE REVISION NO.
82 012 01 T 0
21 22 23 24 26 27 28 29 30 31 32

ACTION TAKEN FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED NPD-4 FORM SUB. PRIME COMP. SUPPLIER COMPONENT MANUFACTURER
H 13 G 19 Z 20 Z 21 0000 Y 23 N 24 Z 25 Z 9999 26
33 34 35 36 37 40 41 42 43 44 47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 Cause was personnel error in incorrectly accounting for dilution at RML-7 when
11 License Amendment #72 was implemented. Alarm setpoints were recalculated per ODCM,
12 High alarm setpoint changed to 1,000 CPM, but alert setpoint remains at 800 CPM.
13 Radiation monitoring system setpoint procedure has been changed.
7 8 9

14 FACILITY STATUS % POWER OTHER STATUS (30) METHOD OF DISCOVERY DISCOVERY DESCRIPTION (32)
15 X 28 000 29 NRC Order B 31 Investigation of Routine Surveillance
7 8 9 10 11 12 13 44 45 46 80

16 ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36)
17 Z 33 Z 34 N/A N/A
7 8 9 10 11 44 45 80

17 PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION (39)
18 000 37 Z 38 N/A
7 8 9 10 11 12 13 80

19 PERSONNEL INJURIES NUMBER DESCRIPTION (41)
20 000 40 N/A
7 8 9 10 11 12 80

21 LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION (43)
22 Z 42 N/A
7 8 9 10 80

23 PUBLICITY ISSUED DESCRIPTION (45)
24 N 44 N/A
7 8 9 10 80

8209300179 820917
PDR ADOCK 05000289
S PDR

NRC USE ONLY

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I. Current Activities at the Time of Occurrence

TMI Unit I was in a long term cold shutdown condition.

II. Circumstances Leading to the Occurrence

At 1200 hours, on 08/29/82, while performing a routine surveillance for RML-7, (RML-7 is the station liquid effluent discharge monitor) the scaler calibration was found to be outside the tolerances specified in the procedure. Subsequent investigation revealed that the alarm set-points for RML-7 had not been correctly set since implementation of Tech. Spec. Section 3.21.1 in November 1981 (The alert setpoint has been and continues to be set at 800 cpm).

III. Description

Tech. Spec. Section 3.21.1 requires that RML-7 be operable at all times with its alarm/trip setpoints set in accordance with the Offsite Dose Calculation Manual (ODCM) to ensure that the limits of 10 CFR 20, Appendix B, Table II, Column 2, and the Limits of Specification 3.22.1.1 are not exceeded. At the time of implementation of the Radiological Environmental Technical Specifications (R.E.T.S.) the calculation for the new setpoint incorrectly accounted for dilution flow.

At 1430 hours on September 2, 1982, it was determined that the Tech. Spec. 3.21.1 Limiting Condition for Operation (LCO) was not being met for the station effluent line monitor, RML-7, since the high alarm set-point on RML-7 was not set in accordance with the ODCM and that the action statement of the LCO was not performed. Therefore, this LCO was considered to be violated and this event prompt reportable per Tech. Spec. 6.9.2.A(2).

However, all releases of radioactive effluents from TMI-1 have been controlled upstream of RML-7 with appropriate radiation monitors and sampling techniques in accordance with TMI-1 Tech. Specs. to ensure that all TMI-1 releases were less than the limits of Tech. Spec. 3.21.1. Additionally, there were no valid alert alarms on RML-7 during the period 11/04/81 to present.

IV. Resultant Events

No known significant occurrence has taken place as a result of this finding.

V. Previous Events of a Similar Nature

No previous reportable events of a similar nature have occurred since the implementation of the R.E.T.S. on November 4, 1981.

VI. Root Cause

Incorrectly accounting for dilution at RML-7 when the Tech. Spec. change including the R.E.T.S. was implemented.

VII. Immediate Corrective Action

The correct alarm setpoints have been calculated in accordance with the ODCM. The high alarm setpoint has been changed (09/08/82) from 400,000 cpm to 1000 cpm, and the alert setpoint will remain at 800 cpm. The high alarm setpoint has been changed in the Radiation Monitoring System Setpoint procedure. Past records of all liquid effluents from TMI-1 were below 10 CFR 20 limits.

VIII. Long Term Corrective Action

The new setpoints for RML-7 were based on the present plant status. Prior to startup these setpoints will be reevaluated. Also, setpoint calculations for other effluent monitors will be checked and verified.

IX. Component Failure Data

NA