

LICENSEE EVENT REPORT

CONTROL BLOCK:

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(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

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

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

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 | At 0815 during power increase, a Rad Con Technician reported the CNTINT

613 | gaseous and particulate radioactivity sample pump had failed (T.S. 3.4. |

6.1). The standby pump was immediately started. However, at 0930 on

4-20-81 it was discovered that the operating sample pump's discharge

06 | valve was shut. The valve was opened to place the system in service.

07 | Routine containment samples were obtained on 4-17-81 and 4-19-81. The

018 | CNTMNT sump alarm was operable. Similar events: none.

0 9

SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP. SUBCODE VALVE SUBCODE

B B 11 E 12 F 13 P U M P X X 14 G 15 Z 16

9 10 11 12 13 14 15 16

(17) LER/PO REPORT NUMBER 81 EVENT YEAR — SERIAL REPORT NO. 022 CODE TYPE 03 TYPE L NO. 0

ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER					
A	18		19	Z	20	Z	21	0	0	0	0	Y	23	N	24	A	25	C	5	2	1
33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 | The RMS sample pump failed due to a broken motor coupling. The coupling

111 failed as a result of excessive wear. It was replaced and the pump was

1 2 | returned to service. Compounding the pump failure was a faulty RMS low

flow indicating light socket, which had a burned contact. The socket

114 | was replaced with a spare.

1 5 C 28 0 0 7 29 NA A 31 Technician Discovery 32

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

1 6 7 33 34 NA NA

PERSONNEL EXPOSURES

NUMBER		TYPE	DESCRIPTION
1	7	000	37 Z 38 NA 39

80

PERSONNEL INJURIES		NUMBER		DESCRIPTION	
1	2	3	4	5	6
		0	0	0	NA

1 9 8 9 10 60

LOSS OF OR DAMAGE TO FACILITY (43)
TYPE DESCRIPTION NA

PUBLICITY										NRC USE ONLY									
ISSUED		DESCRIPTION																	
2	0	44	NA																
8	9	10																	
				68						69									
				000						174044000									
										80									

8210270241 810515
PDR ADOCK 05000318
S PDR

C. M. Doyle / J. L. Osburn

NRC USE ONLY

68 69 80

(301) 269-4742/4803

011-826

LER NO. 81-22/3L
DOCKET NO. 50-318
LICENSE NO. DPR-69
EVENT DATE 04-19-81
REPORT DATE 05-15-81
ATTACHMENT

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (CONT'D)

At 0815 during a power increase after a shutdown, a Radiation Control Technician informed the Control Room Operator that the Containment Gaseous and Particulate Radioactivity Monitoring System sample pump motor coupling was broken rendering the system inoperable (T.S. 3.4.6.1). The standby pump was immediately placed in service. However, at 0930 on 4-20-81 it was discovered that the discharge valve on the operating sample pump was shut, again placing the Containment Gaseous and Particulate Monitors in an inoperable state. The system was immediately placed in service per Operating Instruction 35. Apparently, when the standby pump was placed in service the operator failed to open its discharge valve as required by the operating instructions. In both instances, the sample low flow alarm indicating light on the Radiation Monitoring System cabinet in the control room failed to indicate the lack of air sample flow. However, the Control Room Annunciating System had actuated. Radiation control technicians had obtained containment atmosphere grab samples at 0110 on 4-17-81 and again at 1015 on 4-19-81. In addition, the containment sump level alarm system was operable during the event. Therefore, adequate reactor coolant leakage detection was assured.

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (CONT'D)

The Control Room Radiation Monitoring System (RMS) low flow indicating light socket was found to have a burned contact, preventing light bulb indication on the RMS panel (2-RI-5280). The presence of the Control Room Annunciation System alarm without the instrument specific alarm light caused some confusion on the part of operations personnel as to the condition that existed.

The socket (Master Specialties Series 80E) was replaced with a spare. All licensed operators have been cautioned to investigate either source of malfunction indication. All operations personnel will be informed of the details of this event.