

## 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 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 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 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

CON'T

0 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 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

## EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 On February 10, 1983, at 1500 hours, while performing Functional Test QIS 35-2,

0 3 the Fuel Pool Radiation Monitor, 1-1705-16A, failed to trip upscale. Fuel Pool

0 4 Monitor 1-1705-16B was subsequently tested and found to be functioning properly;

0 5 therefore, by complying with Technical Specification 3.2.F.2. The Fuel Pool

0 6 Radiation Monitors are set up with a one-out-of-two-twice logic, thus, the ability

0 7 of the system to isolate the Reactor Building Ventilation System and initiate

0 8 Standby Gas Treatment was not hindered as a result of this occurrence.

0 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 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

17 LER/RO REPORT NUMBER 8 3

18 ACTION TAKEN E 19 FUTURE ACTION Z 20 EFFECT ON PLANT Z 21 SHUTDOWN METHOD Z 22 HOURS 0 0 0 0

23 SEQUENTIAL REPORT NO. 0 0 8

24 OCCURRENCE CODE 0 3

25 REPORT TYPE L

26 REVISION NO. 0

27 ATTACHMENT SUBMITTED N 28 NPRD-4 FORM SUB. N 29 PRIME COMP. SUPPLIER N 30 COMPONENT MANUFACTURER G 0 8 0

## CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of this failure was due to instrument calibration drift. Radiation

1 1 Monitor 1-1705-16A was recalibrated and successfully function tested within the

1 2 24 hour limit as specified in Technical Specification 3.2.F.2.

1 3 1 4 1 5 1 6 1 7 1 8 1 9 2 0 2 1 2 2 2 3 2 4 2 5 2 6 2 7 2 8 2 9 3 0 3 1 3 2 3 3 3 4 3 5 3 6 3 7 3 8 3 9 4 0 4 1 4 2 4 3 4 4 4 5 4 6 4 7 4 8 4 9 5 0 5 1 5 2 5 3 5 4 5 5 5 6 5 7 5 8 5 9 6 0 6 1 6 2 6 3 6 4 6 5 6 6 6 7 6 8 6 9 7 0 7 1 7 2 7 3 7 4 7 5 7 6 7 7 7 8 7 9 8 0 8 1 8 2 8 3 8 4 8 5 8 6 8 7 8 8 8 9 9 0 9 1 9 2 9 3 9 4 9 5 9 6 9 7 9 8 9 9 100

1 5 FACILITY STATUS E 16 % POWER 0 9 9 17 OTHER STATUS NA 18 METHOD OF DISCOVERY B 19 DISCOVERY DESCRIPTION Quarterly Calibration Surveillance

1 6 ACTIVITY CONTENT Z 17 RELEASED OF RELEASE Z 18 AMOUNT OF ACTIVITY NA 19 LOCATION OF RELEASE NA

1 7 PERSONNEL EXPOSURES NUMBER 0 0 0 18 TYPE Z 19 DESCRIPTION NA

1 8 PERSONNEL INJURIES NUMBER 0 0 0 19 DESCRIPTION NA

1 9 LOSS OF OR DAMAGE TO FACILITY TYPE Z 20 DESCRIPTION NA

2 0 PUBLICITY N 21 ISSUED DESCRIPTION NA

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PDR ADOCK 05000254  
S PDR

NRC USE ONLY

NAME OF PREPARER

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