

CONTROL BLOCK: 

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(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0	1	M	I	D	C	C	1	2	0	0	-	0	0	0	0	0	0	0	3	4	1	1	1	1	4			5		
7	8	9	LICENSEE CODE					14	15	LICENSE NUMBER										25	26	LICENSE TYPE					30	57	CAT	58

CON'T

0	1
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REPORT SOURCE

60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	
	6	0	5	0	0	0	3	1	5	7	1	1	0	9	8	2	8	0	5	1	6
DOCKET NUMBER											EVENT DATE					REPORT DATE					

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 DURING NORMAL OPERATION, THE UNIT 2 AUXILIARY CABLE VAULT (ZONE 11) EXPERIENCED  
03 AN INADVERTANT CO<sub>2</sub> DISCHARGE (REF: 50-316/82-092). AFTER DETERMINING THAT THE CO<sub>2</sub>  
04 ACTUATION WAS SPURIOUS, THE CO<sub>2</sub> TANK WAS ISOLATED AT 1512 HOURS TO TERMINATE THE  
05 DISCHARGE. THE MAIN ISOLATION VALVE WAS USED WHICH ALSO ISOLATED UNIT 1. THIS  
06 EVENT WAS NON-CONSERVATIVE WITH RESPECT TO TECHNICAL SPECIFICATION 3.7.9.3. PUBLIC  
07 HEALTH AND SAFETY WERE NOT AFFECTED. A SIMILAR EVENT OCCURRED ON 1/18/83 LER  
08 NO. 83-001.

SYSTEM CODE [0][9]		CAUSE CODE [A][B]		CAUSE SUBCODE [A]		COMPONENT CODE [I][N][S][T][R][U]								COMP. SUBCODE [E]		VALVE SUBCODE [Z]	
7	8	9	10	11	12	13	14	15	16	17	18	19	20				
LER/RO REPORT NUMBER [17]		EVENT YEAR [8][2]		SEQUENTIAL REPORT NO. [1][1][1]		OCCURRENCE CODE [0][3]		REPORT TYPE [X]		REVISION NO. [1]							
21	22	23	24	25	26	27	28	29	30	31	32						
ACTION TAKEN [H]		FUTURE ACTION [Z]		EFFECT ON PLANT [Z]		SHUTDOWN METHOD [Z]		HOURS [0][0][0][0]		ATTACHMENT SUBMITTED [Y]		NPRD-4 FORM SUB. [N]		PRIME COMP. SUPPLIER [A]		COMPONENT MANUFACTURER [P][4][3][5]	
33	34	35	36	37	38	39	40	41	42	43	44	45	46	47			

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 THE CO2 TANK MAIN ISOLATION WAS ISOLATED WHICH AFFECTS BOTH UNIT 1 AND 2.

1 1 APPROXIMATELY 18 MINUTES LATER, THE VALVE ISOLATING THE SPECIFIC AREA OF CONCERN

1 2 WAS CLOSED AND THE MAIN ISOLATION RE-OPENED. (SEE SUPPLEMENT)

1 3

1 4

FACILITY STATUS (28) 1 5 8 9 E 10 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27  
 % POWER (29) 1 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27  
 OTHER STATUS (30) NA 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27  
 METHOD OF DISCOVERY (31) B 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60  
 DISCOVERY DESCRIPTION (32) QA SURVEILLANCE 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80  
 ACTIVITY CONTENT (33) 1 5 8 9 7 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27  
 RELEASED OF RELEASE (34) 1 5 8 9 7 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27  
 AMOUNT OF ACTIVITY (35) NA 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27  
 LOCATION OF RELEASE (36) NA 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

PERSONNEL EXPOSURES									
NUMBER		TYPE		DESCRIPTION					
1	7			37	38	NA			

PERSONNEL INJURIES  
NUMBER DESCRIPTION (41)  
1 2 3 4 5 6 7 8 9 10 11 12 NA 8305240374 830516

LOSS OF OR DAMAGE TO FACILITY (43)  
TYPE DESCRIPTION  
1 9 Z (42) NA  
8 9 10

PUBLICITY DESCRIPTION (45)

ISSUED (44) NA

NRC USE ONLY

NAME OF PREPARER D. F. KRAUSE

PHONE: (616) 465-5901

SUPPLEMENT TO LER

LER 82-111/03L-1

27. THE CO<sub>2</sub> TANK MAIN ISOLATION WAS ISOLATED WHICH AFFECTS BOTH UNIT 1 AND 2. APPROXIMATELY 18 MINUTES LATER, THE VALVE ISOLATING THE SPECIFIC AREA OF CONCERN WAS CLOSED AND THE MAIN ISOLATION RE-OPENED.

THE ORIGINAL EVENT OCCURRED ON NOVEMBER 9, 1982 AND WAS REPORTED VIA LER 50-316/82-092. THAT LER DID NOT ADDRESS THE FACT THAT THE CO<sub>2</sub> WAS ISOLATED TO BOTH UNITS. THIS WAS DISCOVERED DURING A PLANT QUALITY ASSURANCE SURVEILLANCE (12-83-040) WHICH WAS PERFORMED ON FEBRUARY 8, 1983. IT WAS UNCLEAR IF THE EFFECT OF ISOLATION DUE TO A PROBLEM ON ONE UNIT SHOULD ALSO BE REPORTED ON THE OPPOSITE UNIT. AS PART OF THE RESPONSE TO THE QA SURVEILLANCE REPORT, LER 82-111 WAS INITIATED ON MARCH 2, 1983.

THE PURPOSE OF THIS UPDATE IS TO EXPLAIN WHY THE ORIGINAL REVISION OF THIS LER WAS DATED FOUR MONTHS AFTER THE EVENT, TO CHANGE THE TECHNICAL SPECIFICATION NUMBER WHICH WAS WRONG ON THE ORIGINAL LER, AND TO FURTHER DESCRIBE THE CORRECTIVE ACTIONS TAKEN AT THE TIME THIS LER WAS ORIGINALLY SUBMITTED.

AN OPERATING MEMO (83-15) WAS ISSUED WHICH DESCRIBED THE PREFERRED METHOD OF ISOLATION. IT INCLUDED DISCUSSIONS ON THE FOLLOWING:

1. PLACING LOCAL CO<sub>2</sub> ISOLATION SWITCH IN ISOLATE, WHICH PREVENTS CO<sub>2</sub> FROM BEING INJECTED INTO THE ROOM. THIS ISOLATES ONLY THE AREA AFFECTED AND NOT THE ENTIRE SYSTEM.
2. TWO PEOPLE, WEARING BREATHING APPARATUS, INSPECT THE AREA FOR FIRES AND FAULTY DETECTORS.
3. IF DURING THE INSPECTION, A FIRE STILL REMAINS, THE TWO PEOPLE ARE TO EXIT IMMEDIATELY AND PLACE THE ISOLATED SWITCH BACK TO THE NORMAL POSITION AND PRESS THE MANUAL BUTTON FOR THAT AREA. THIS

SUPPLEMENT TO LER (page 2)

LER 82-111/03L-1

GIVES ANOTHER TIMED DISCHARGE OF CO<sub>2</sub> INTO THE AREA.

THE MEMO WENT ON TO EXPLAIN HOW TO RESET SYSTEM AND VERIFY THAT THE MAIN CO<sub>2</sub> TANK WAS STILL ABOVE THE TECHNICAL SPECIFICATION LIMITS.

WE REGRET ANY INCONVENIENCE AND ADDITIONAL WORK THIS HAS CAUSED YOU.