

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

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REPORT SOURCE

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DOCKET NUMBER

EVENT DATE

REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

SYSTEM CODE 0 9		CAUSE CODE S A		CAUSE SUBCODE X		COMPONENT CODE Z Z Z Z Z Z						COMP SUBCODE Z		VALVE SUBCODE Z	
7	8	9	10	11	12	12	13	13	14	15	16	17	18	19	20
LE/RO REPORT NUMBER 17		EVENT YEAR 8 3		SEQUENTIAL REPORT NO. —		OCCURRENCE CODE 0 1 7		REPORT TYPE /		REPORT TYPE 0 3		REVISION NO. L		REVISION NO. —	
21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
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 Z	
37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52
CAUSE DESCRIPTION Z		CAUSE DESCRIPTION 9		CAUSE DESCRIPTION 9		CAUSE DESCRIPTION 9		CAUSE DESCRIPTION Z		CAUSE DESCRIPTION Y		CAUSE DESCRIPTION N		CAUSE DESCRIPTION Z	

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 Internal pressure increased due to normal air leakage into containment without
1 1 venting. Ventilation package was sent to the Chemistry Lab for proper authorization
1 2 to vent containment. The package was not returned until pressure had exceeded
1 3 limits. At 1623 hours, pressure was back within limits by venting. Operations
1 4 personnel were instructed to remind lab personnel of the need to vent containment and
1 5 6 9 identify time limitations as needed.

FACILITY STATUS: 1 5 E 28 1 0 0 29 NA 30
 ACTIVITY CONTENT: 1 6 Z 33 Z 34 NA 35
 PERSONNEL EXPOSURES: 1 7 0 0 0 37 Z 38 NA 39
 PERSONNEL INJURIES: 1 8 0 0 0 40 NA 41
 LOSS OF OR DAMAGE TO FACILITY: 1 9 Z 42 NA 43
 PUBLICITY: 2 0 N 44 NA 45
 DISCOVERY DESCRIPTION: B 31 Operator observation 32
 LOCATION OF RELEASE: NA 36
 METHOD OF DISCOVERY: 30
 NRC USE ONLY

8303210327 830302
 PDR ADOCK 05000328
 S PDR

Name of Preparer: A. M. Carver /M. R. Harding

Phone: (615) 751-0349

LER SUPPLEMENTAL INFORMATION

SQRO-50-328/83017

Technical Specification Involved: 3.6.1.4

Reported Under Technical Specification: 6.9.1.13.b

Date of Occurrence: 02/01/83 Time of Occurrence: 1600 CST

Identification and Description of Occurrence:

At 1600 hours during normal operation, the containment pressure relative to the annulus was discovered to be greater than +0.3 psi.

Conditions Prior to Occurrence:

Unit 2 in mode 1 at 100% power with RCS temperature and pressure at 579 degrees F and 2235 psig.

Apparent Cause of Occurrence:

Internal pressure increased due to normal air leakage into containment without venting.

Analysis of Occurrence:

A surveillance instruction (SI-410) ventilation package was sent to the Chemistry Lab in order for a sample analysis to be performed and a proper release (ventilation) authorization to be given to Operations. This is accomplished at least once per day. The package was not returned until the containment pressure exceeded +0.3 psi. The operator did not remind the lab personnel of the need to vent containment, and lab personnel did not return the vent package in the normal time of two to four hours.

Corrective Action:

At 1623 hours, pressure was back within limits by venting. Operations personnel were instructed to remind lab personnel of the need to vent containment before exceeding technical specifications limits. This is considered an isolated incident. Two to four hours turnaround time is sufficient and this surveillance instruction is performed at least daily. No further corrective action is necessary.

Failure Data:

None.