U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

APPROVED BY OMB 3150-0011

CONTROL BLOCK: [| | | | |] (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

Line	Field	Value
0 1	LICENSEE CODE (2)	P A S E S 1
	LICENSE NUMBER (3)	0 0 - 0 0 0 0 0 - 0 0
	LICENSE TYPE (4)	4 1 1 1 1
	CAT (5)	
CON'T 0 1	REPORT SOURCE (6)	L
	DOCKET NUMBER (7)	0 5 0 0 0 3 8 7
	EVENT DATE (8)	0 2 2 2 8 3
	REPORT DATE (9)	0 3 2 3 8 3

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 Three Division I radiation monitors were found to have their intended isolation/
0 3 actuation function disabled. The monitors would indicate radiation levels and
0 4 alarm accordingly , but they would not initiate Reactor Building Zone III ventil -
0 5 ation isolation and would not start the Standby Gas Treatment System. The plant
0 6 was in an outage , Operating Condition 4 , at the time of this discovery . The
0 7 redundant Division II radiation monitors were operable .
0 8

0 9	SYSTEM CODE (11)	CAUSE CODE (12)	CAUSE SUBCODE (13)	COMPONENT CODE (14)	COMP. SUBCODE (15)	VALVE SUBCODE (16)
	B A	A	C	Z Z Z Z Z Z	Z	Z

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 3	—	0 4 1	/	0 3	L	—	0

ACTION TAKEN (18)	FUTURE ACTION (19)	EFFECT ON PLANT (20)	SHUTDOWN METHOD (21)	HOURS (22)	ATTACHMENT SUBMITTED (23)	NPRD-4 FORM SUB. (24)	PRIME COMP. SUPPLIER (25)	COMPONENT MANUFACTURER (26)
X	Z	Z	Z	0 0 0 0	Y	N	Z	Z 9 9 9

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 Accomplishment of a Unit 1/Unit 2 electrical separation work item resulted in a
1 1 wire used in Unit 1 circuitry to be lifted with a corresponding wire of the same
1 2 designation used in Unit 2 circuitry . Work pracτise rather than electrical
1 3 separation program inadequacies were at fault .
1 4

1 5	FACILITY STATUS (28)	% POWER (29)	OTHER STATUS (30)	METHOD OF DISCOVERY (31)	DISCOVERY DESCRIPTION (32)
	G	0 0 0	n/a	A	operator observation

1 6	ACTIVITY RELEASED (33)	CONTENT OF RELEASE (34)	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
	Z	Z	n/a	n/a

1 7	PERSONNEL EXPOSURES NUMBER (37)	TYPE (38)	DESCRIPTION (39)
	0 0 C	Z	n/a

1 8	PERSONNEL INJURIES NUMBER (40)	DESCRIPTION (41)
	0 0 0	n/a

1 9	LOSS OF OR DAMAGE TO FACILITY TYPE (42)	DESCRIPTION (43)
	Z	n/a

8304110440 830323
PDR ADOCK 05000387
S PDR

2 0	PUBLICITY ISSUED (44)	DESCRIPTION (45)	NRC USE ONLY
	N	n/a	

NAME OF PREPARER Jon T. Todd PHONE (717) 542-2181 X3524

Attachment

LICENSEE EVENT REPORT 83-041/03L-0

While in Operating Condition 4, cold shutdown, during an investigation of the Standby Gas Treatment System (SGTS), "A" Railroad Bay radiation monitor alarm came in without subsequent ventilation isolation and SGTS initiation. A further investigation into the "A" Refuel Floor Wall Exhaust Radiation monitor and the "A" Refuel Floor High Exhaust radiation monitor resulted in similar circumstances. The problem was traced to a common panel where two leads were found lifted and tagged as Unit 1/Unit 2 separation. Unit separation was a program instituted prior to Unit 1 fuel load to eliminate interactions with Unit 2 systems in the construction phase. It was determined that both of the leads should not have been lifted. One lead was the power supply to Unit 2 circuitry however, the other lead was the power supply to the lockout relay for isolating Unit 1 Zone III Reactor Building ventilation on high radiation and SGTS initiation. The Unit 1 lead was reterminated. A failed GM tube in the "A" Railroad Bay radiation monitor (the reason for the alarm) brought in a ventilation isolation signal and started SGTS. The isolation signal was reset and the radiation monitor was reworked.

This event affected only the safety function of the radiation monitors in Division I. The radiation indication and alarm functions of the radiation monitors remained operable. The redundant Division II radiation monitors were operable. All LOCA signals to the ventilation isolation circuitry and SGTS initiation were also operable. There were no consequential effects to the public health and safety. No spent fuel had been moved through the railbay or on the refuel floor. Initial criticality was performed with the reactor vessel head tensioned and the head has not been removed.

An investigation into the incident indicates that poor work practice is the only reason for the Division I radiation monitors to have had their safety function defeated. The unit separation documents request leads to be lifted at specific terminal points for Unit 2 devices. However, a lead was lifted at one of the terminal points that also affected Unit 1 devices. In this event, there was a terminal point referenced which had two wires terminated. One wire went to a Unit 2 device that was to be lifted. The other wire was a common jumper that connected 120VAC to the lockout relay circuit for Zone III ventilation.

The remainder of the Unit 1/Unit 2 separation for this equipment was performed satisfactorly and the Division II radiation monitors were separated properly. This is considered to be an isolated incident in that poor work practices were at fault rather than the separation program. However, a review of the separation program is currently in progress.