

LICENSEE EVENT REPORT

CONTROL BLOCK: | | | | | | |

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0	1	M	I	D	C	C	2	2	0	0	-	0	0	0	0	0	-	0	0	3	4	1	1	1	1	4			5	
7	8	LICENSEE CODE						14	15	LICENSE NUMBER										25	26	LICENSE TYPE					30	37	41	58

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REPORT SOURCE: 01 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80  
DOCKET NUMBER: 01 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80  
EVENT DATE: 01 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80  
REPORT DATE: 01 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

012 DURING A ROUTINE SAMPLING OF THE BORON INJECTION TANK (BIT), SAMPLING VALVES AT THE OUT-  
013 LET OF THE TANK WERE INADVERTENTLY LEFT PARTIALLY OPEN. THE AFTER SAMPLING VALVING  
014 CONFIGURATION CREATED A 1.25 GPM LEAK TO WASTE. THE BIT REMAINED FULL DURING THIS IN-  
015 CIDENT AS IT WAS ON RECIRCULATION WITH THE BORIC ACID STORAGE SYS. THE BORIC ACID "LOST"  
016 WAS NOTED AS A DROP IN A BORIC ACID STORAGE TANK. THE SAFETY INJECTION FLOW RATE CAPABLE  
017 OF BEING DELIVERED TO THE CORE WOULD HAVE BEEN SLIGHTLY REDUCED BY THIS ERROR. PUBLIC  
018 HEALTH AND SAFETY WERE NOT AFFECTED. THIS IS THE FIRST OCCURRENCE. (SEE SUPPLEMENT)

SYSTEM CODE S F (11)		CAUSE CODE A (12)		CAUSE SUBCODE X (13)		COMPONENT CODE Z Z Z Z Z Z Z (14)						COMP SUBCODE Z (15)		VALVE SUBCODE Z (16)			
EVENT YEAR 8 3 (21) (22)		SEQUENTIAL REPORT NO. 0 9 2 (24) (25) (26)		OCCURRENCE CODE 0 1 (28) (29)		REPORT TYPE T (30)		REVISION NO. 0 (32)									
ACTION TAKEN X (33)		FUTURE ACTION H (34)		EFFECT ON PLANT Z (35)		SHUTDOWN METHOD Z (36)		HOURS 0 0 0 0 (37) (38) (39) (40)		ATTACHMENT SUBMITTED Y (41)		NPRD-4 FORM SUB N (42)		PRIME COMP. SUPPLIER Z (43)		COMPONENT MANUFACTURER Z 9 9 9 (44) (45) (46) (47)	

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

110 INVESTIGATION IDENTIFIED THE CAUSE TO BE FAILURE TO CLOSE VALVES AFTER SAMPLING. UPON  
111 DISCOVERY OF THE LEAK THE VALVES WERE CLOSED AND THE LEAK TERMINATED. APPROPRIATE  
112 ADMINISTRATIVE ACTIONS HAVE BEEN TAKEN WITH THE INDIVIDUAL INVOLVED. EVALUATION BY SITE,  
113 CORPORATE AND WESTINGHOUSE PERSONNEL HAVE DETERMINED THAT ALTHOUGH THE BORON INJECTION  
114 SYS. WAS SLIGHTLY DEGRADED, THE SYS. WOULD HAVE PERFORMED ITS DESIGN SAFETY FUNCTION.

FACILITY STATUS		% POWER		OTHER STATUS		METHOD OF DISCOVERY		DISCOVERY DESCRIPTION				
1	5	E	28	1	0	0	29	NA	B	31	OPERATOR OBSERVATION	32
ACTIVITY		CONTENT		AMOUNT OF ACTIVITY		LOCATION OF RELEASE						
1	6	Z	33	Z	34	NA	NA	35	36			
PERSONNEL EXPOSURES		NUMBER		TYPE		DESCRIPTION						
1	7	0	0	0	37	Z	38	NA				
PERSONNEL INJURIES		NUMBER		DESCRIPTION								
1	8	0	0	0	40			NA				
LOSS OF OR DAMAGE TO FACILITY		TYPE		DESCRIPTION								
1	9	Z	42			NA						

PUBLICITY  
 ISSUED DESCRIPTION 45  
 8 9 10  
 8310170611 831010  
 PDR ADOCK 05000316  
 S PDR  
 NRC USE ONLY

NAME OF PREPARER R. A. PALMER

PHONE 616-465-5901

ATTACHMENT TO LER# 83-092-01T-0

SUPPLEMENT TO EVENT DESCRIPTION

DURING A ROUTINE SAMPLING OF THE BORON INJECTION TANK (BIT), SAMPLING VALVES AT THE OUTLET OF THE TANK WERE INADVERTENTLY LEFT PARTIALLY OPEN. THE AFTER SAMPLING VALVING CONFIGURATION CREATED A 1.25 GPM LEAK TO WASTE. THE BIT REMAINED FULL DURING THIS INCIDENT AS IT WAS ON RECIRCULATION WITH THE BORIC ACID STORAGE SYS. THE BORIC ACID "LOST" WAS NOTED AS A DROP IN A BORIC ACID STORAGE TANK. THE SAFETY INJECTION FLOW RATE CAPABLE OF BEING DELIVERED TO THE CORE UPON RECEIPT OF AN SI SIGNAL WOULD HAVE BEEN SLIGHTLY REDUCED FROM THE VALUE ASSUMED IN THE UPDATED FSAR ANALYSIS BY THIS ERROR. PUBLIC HEALTH AND SAFETY WERE NOT AFFECTED. THIS IS THE FIRST OCCURRENCE. THIS REPORT IS BEING SUBMITTED PER REQUIREMENTS OF TECHNICAL SPECIFICATION 6.9.1.12.f.