

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Fermi 2 DOCKET NUMBER (2) 0 5 0 0 0 3 4 1 1 OF 0 3

TITLE (4)

Loss of Circulating Water Reservoir Decant Line Radiation Monitor

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)														
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)												
0	4	2	4	8	5	8	5	0	0	7	0	0	0	5	2	4	8	5	0	5	0	0	0

OPERATING MODE (9)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5: (Check one or more of the following) (11)
5	20.402(b) 20.406(a)(1)(i) 20.406(a)(1)(ii) 20.406(a)(1)(iii) 20.406(a)(1)(iv) 20.406(a)(1)(v) 20.406(c) 50.36(c)(1) 50.36(c)(2) 50.73(a)(2)(i) 50.73(a)(2)(ii) 50.73(a)(2)(iii) 50.73(a)(2)(iv) 50.73(a)(2)(v) 50.73(a)(2)(vi) 50.73(a)(2)(vii) 50.73(a)(2)(viii)(A) 50.73(a)(2)(viii)(B) 50.73(a)(2)(ix) 73.71(b) 73.71(c) OTHER (Specify in Abstract below and in Text, NRC Form 366A)

LICENSEE CONTACT FOR THIS LER (12)
NAME A.E. Wegele, Compliance Engineer TELEPHONE NUMBER 3 1 1 3 5 1 8 1 6 1 5 1 3 1 3
AREA CODE 3 1 1 3

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)										
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS	
X	IIL	P	G	0	6	3	N			

SUPPLEMENTAL REPORT EXPECTED (14)
YES (If yes, complete EXPECTED SUBMISSION DATE) X NO
EXPECTED SUBMISSION DATE (15) MONTH DAY YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On two occasions between April 23 and 25, 1985, Technical Specification 3.3.7.11.b was violated in that grab samples were not taken within the required eight hour period when discharging effluent from the Circulating Water Reservoir decant line with the radiation monitor inoperable.

The causes of these violations were failure to recognize the requirement to sample in one instance and failure to allow for delays in obtaining the sample in the other instance.

Personnel involved either have or will be required to review the events and their causes. In addition, a procedure to govern the performance of technical specification surveillances and action statements by Chemistry Section personnel has been written and approved.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

On April 23, 1985, at 1655 hours, the Circulating Water Reservoir Decant Pump was started to provide dilution water for a discharge from the radwaste sample tanks. This discharge is also monitored by the Liquid Radwaste Effluent Line monitor which is upstream of the decant line monitor and provides automatic termination of the release if the setpoint is exceeded. The sample tank discharge is then diluted with water from the Circulating Water Reservoir as it is discharged to the lake. The Circulating Water Reservoir Decant monitor monitors the combined discharge.

As the discharge was proceeding, periodic low flow alarms were indicated in the control room for the decant line monitor sampling pump. At approximately 2015 hours on April 23, the decant line sample pump tripped. This was annunciated in the control room. An operator was dispatched to vent the sample line and restart the sample pump and the Nuclear Shift Supervisor (NSS) was informed. The NSS consulted Technical Specification 3.3.7.11.b and determined that the discharge could continue for up to 30 days provided that grab samples were taken every 8 hours. The NSS also contacted the radwaste control room and verified that the Radwaste Effluent monitor was operable. In discussions with the control room operator the NSS stated that the technical specification would not be a problem and that the discharge could continue. The control room operator interpreted this to mean that the technical specification was not applicable since the Radwaste Effluent monitor was operable. Shortly thereafter the sample pump was successfully started and thus no grab sample was taken.

Later that shift, the sample pump (General Atomic Model RD-33-12) tripped again. The control room operator did not consider this a problem because of his earlier misunderstanding of what the NSS had said. Consequently, he did not log the pump trip or attempt to restart the pump nor did he advise the NSS. As a result, the oncoming shift was not made aware of the decant monitor being inoperable and did not detect the low flow alarm window. The discharge continued through the night.

At about 0730 hours on April 24, 1985, the control room operator noticed the low flow alarm from the decant line monitor and stopped the discharge. It was determined that the decant line monitor had been inoperable since about 2015 hours on April 23 without a sample being obtained. This exceeded the eight hour sample requirement by 3-1/2 hours.

At about 0010 hours on April 25, the NSS reminded the Chemistry Section that a sample of the decant line discharge had to be taken by 0400 hours that morning as the previous sample had been drawn at 2000 hours on April 24. The Chemistry Technician assigned to take the grab sample waited until about 0330 hours to prepare and then experienced unexpected delays in reaching the decant line discharge area. Consequently, the sample was not obtained until 0415 hours violating the eight hour requirement.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/85

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

Although the NSS attempted to contact the Chemistry Section to determine the status of the sample, the technicians on the shift were engaged in activities away from the telephone. At 0444 hours, the Chemistry Section leader contacted the NSS and advised him of the time the sample was taken. The NSS recognized the violation and documented the event.

It should be noted that the plant has not reached initial criticality and thus no radioactive effluents were expected and samples taken confirmed this.

The cause of the first failure to obtain a sample within the time required by technical specifications is the miscommunication between the NSS and control room operator concerning the applicability of the technical specification to the decant line monitor. The second failure to obtain a sample on time was caused by not allowing sufficient time for contingencies in reaching the sample point.

All Chemistry Section personnel have read and initialed a memo describing the event and its causes. A procedure has been written and approved to formally address technical specification surveillances and action requirements which are the responsibility of the Chemistry Section. The procedure includes adequate cautions concerning the critical nature of the time periods associated with technical specification requirements. A memo addressing the event and the need to consult technical specifications directly will be placed in the Required Reading Book for Licensed Operators.

**Detroit
Edison**

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May 24, 1985
NP-85-535

U. S. Nuclear Regulatory Commission
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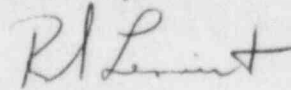
Reference: Fermi 2
NRC Operating License No. NPF-33

Subject: Transmittal of Licensee Event Report No. 85-007

Please find enclosed LER No. 85-007-00, dated May 24, 1985, for a reportable event which occurred on April 24, 1985. As indicated below, a copy of this LER is being sent to the Region III office.

If you have any questions, please contact us.

Sincerely,



R. S. Lenart
Superintendent
Nuclear Production

Enclosure: NRC Forms 366, 366A

cc: Mr. P.M. Byron

Regional Administrator
USNRC Region III
799 Roosevelt Road
Glen Ellyn, Illinois 60137

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