## 1 04/28/18

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DOCDATE: 04/12/78 DATE RCVD: 04/28/78

DOCTYPE: LETTER NOTARIZED: NO

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SUBJECT: 1

LTR 1 ENCL 1

FORWARDING LICENSEE EVENT REPT (RO 50-305/011) ON 03/29/78 CONCERNING RMS MONITOR R-15 WAS TAKEN OUT OF SVC. . MONITOR R-19 PLACED IN OPERATION, 3 HRS LATER SAMPLE VALVES FOR R-19 WERE NOT OPEN WHICH RESULTED IN A VIOLATION OF

TECH SPEC 3, 9, A, 4, . . W/ATT LE

PLANT NAME: KEWAUNEE

REVIEWER INITIAL: XJM

DISTRIBUTOR INITIAL: DO

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DISTRIBUTION:

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ENCL 45

CONTROL NBR:

78118Q1

SIZE: 1P+1P+1P

THE END \*

## WISCONSIN PUBLIC SERVICE CORPORATION



P.O. Box 1200, Green Bay, Wisconsin 54305

**到** 3

April 12, 1978

Mr. J. G. Keppler, Regional Director Office of Inspection & Enforcement Region III U. S. Nuclear Regulatory Commission 799 Roosevelt Road Glen Ellyn, IL 60137

Dear Mr. Keppler:

Docket 50-305 Operating License DPR-43 Reportable Occurrence LER 78-001/01T-0 and LER 78-010/01T-1

In accordance with the requirements of Technical Specifications, Section 6.9, the attached Licensee Event Report for reportable occurrence LER 78-011/01T-0 is being submitted. This report was sent in 24 hours initially as reportable occurrence 78-09. Please update that report number to 78-11.

An error was made in the event description section of LER 78-010/01T-0 sent by my letter dated April 10, 1978. Attached you will find revision LER 78-010/0T-1 to this report. RESILATION OF DUCKET FILE COPY

Very truly yours,

Senior Vice President

Power Supply & Engineering

sa

Attach.

781180105

cc - Dir, Office of Inspection & Enforcement US NRC, Washington, D. C. 20555 Dir, Office of Mgt Info & Program Control US NRC, Washington, D. C. 20555

APR 14 1978

/ · · ·	CONTROL BLOCK: (PLEASE PRINT OR TY) LL REQUIRED INFORMATION)
0 F	W I K N P 1 2 0 0 - 0 0 0 0 0 0 0 4 1 1 1 1 1 1 1 1 6 5 6 6 6 6 6 6 6 6 6 6
CON'T 0 1 7 8	REPORT L 6 0 5 0 0 0 3 0 5 7 0 3 2 9 7 8 8 0 4 1 2 7 8 9 OCKET NUMBER 68 68 EVENT DATE 74 75 REPORT DATE 80
0 2	EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)  During steady full power operation RMS monitor R-15 was taken out of service because
0 3	a faulty low voltage power supply was causing erratic R-15 operation and spurious
0 4	tripping of S/G blowdown and sample valves. Monitor R-19 was placed in operation,
0 5	however, it was discovered about 3 hours later that the sample valves for R-19 were
06	not open which resulted in a violation of TS 3.9.a.4. Results of S/G blowdown samples
07	before and after this occurrence indicate no radiological release. Therefore, there
0 8	was no release to the environment and no effect on public safety.
	SYSTEM CAUSE CAUSE COMPONENT CODE SUBCODE SUBC
0 9	M C 11 A 12 A 13 V A L V E X (14) Z (15) N (16)  SEQUENTIAL OCCURRENCE REPORT REVISION
	17 REPORT VUMBER 21 22 23 24 26 27 28 29 30 31 32
-	ACTION FUTURE COMPLANT SHUTDOWN METHOD HOURS 22 ATTACHMENT FORM SUB. PRIME COMP. COMPONENT MANUFACTURER  LH 10 H 19 Z 20 Z 21 36 Z 21 37 40 40 41 23 LN 24 Z 25 Z 25 Z 9 9 9 9 9 26
110	CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)  [This incident was caused by a personnel error. The operator failed to open the sample]
	valves while switching to R-19 following the last S/G blowdown trip caused by R-15.
1 2	The involved operator has been counseled regarding this occurrence. This incident will
1 3	be reviewed with all operating crews.
1 4	` 80
7 8	FACILITY STATUS STATUS 30 METHOD OF DISCOVERY DESCRIPTION 32 A 31 Operator observation 45 46
	ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY 35  LOCATION OF RELEASE 36  NA  10  10  10  10  10  10  10  10  10  1
7 8	PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION (39) 0 0 0 37 Z 38 NA
7 8	PERSONNEL INJURIES NUMBER DESCRIPTION 41
1 8 7 8	0 0 0 0 NA 9 11 12 10SS OF OR DAMAGE TO FACILITY (43)
1 9	TYPE DESCRIPTION    Z   (42)   NA   10
ו בו	PUBLICITY ISSUED DESCRIPTION 45
7 8	G. H. Ruiter (414) 433-1329
	NAME OF PREPARER