NRC FORM 366
(7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

0 1 | F L T P S 3 (2) | 0 0 - 0 0 0 0 0 0 - 0 0 (3) | 4 1 1 1 1 (4) | | (5)
LICENSEE CODE | LICENSE NUMBER | LICENSE TYPE | CAT

CON'T 0 1 | REPORT SOURCE L (6) | 0 5 0 0 0 2 5 0 (7) | 0 3 1 0 8 1 (8) | 0 3 2 4 8 1 (9)
DOCKET NUMBER | EVENT DATE | REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 During refueling shutdown while in the process of transferring laundry
0 3 water to a monitor tank, the monitor tank overflowed. Some of the overflow
0 4 water backed up the drain header to the floor of the component cooling
0 5 water pump and heat exchanger room. Some of this water potentially could
0 6 have entered the storm drain system from other normal drains in this room.
0 7 This is reportable pursuant to TS 6.9.2.a.9.
0 8

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

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 1	—	0 0 5	/	0 1	T	—	0

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

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The transfer of laundry water was immediately terminated. The monitor tank
1 1 was removed from service for a level instrumentation channel check.
1 2 Evaluation results indicated no significant water if any entered the
1 3 normal drain system. However, the potential for this unintended flow path
1 4 does exist and alterations are being evaluated.

1 5 | FACILITY STATUS: H (28) | % POWER: 0 0 0 (29) | OTHER STATUS (30): N/A | METHOD OF DISCOVERY: A (31) | DISCOVERY DESCRIPTION (32): Operator Observation

1 6 | ACTIVITY RELEASED OF RELEASE: L (33) | CONTENT: M (34) | AMOUNT OF ACTIVITY (35): 2.1 E-5 curies total | LOCATION OF RELEASE (36): Area surrounding CCW pumps

PERSONNEL EXPOSURES
1 7 | NUMBER: 0 0 0 (37) | TYPE: Z (38) | DESCRIPTION (39): NA

PERSONNEL INJURIES
1 8 | NUMBER: 0 0 0 (40) | DESCRIPTION (41): NA

LOSS OF OR DAMAGE TO FACILITY (43)
1 9 | TYPE: Z (42) | DESCRIPTION: NA

PUBLICITY
2 0 | ISSUED: N (44) | DESCRIPTION (45): NA | NRC USE ONLY

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Additional Event Description and Probable Consequences:

During refueling shutdown, an evolution was in progress to transfer laundry water to the A Monitor Tank. The monitor tank overflowed to the waste holdup tank drain system, but the pipe size to the waste holdup tank was not sufficient to handle the amount of overflow. As a result, some of the overflow backed up into the component cooling water pump and heat exchanger area and may have overflowed into the storm drain system which discharges to the intake canal. However, no contamination was detectable via smear samples on the storm drain lip. The volume which overflowed could not be determined, however, it is bounded by the volume of the laundry tank - 600 gallons. The concentration of radionuclides in the water which overflowed was 2.8 E-6 μCi/ml for Co-58, 5.8 E-6 μCi/ml for Co-60, and 8.0 E-7 μCi/ml for Cs-137, which was well below the limits specified in 10 CFR 20 Appendix B Table II, Column 2. This is considered reportable pursuant to TS 6.9.2.a.9.

Additionally, notification pursuant to the requirements of 10 CFR 50.72 was not made. This action was based on the interpretation that the low activity which potentially could have been released was not significant and therefore not reportable.

Additional Cause Description and Corrective Actions:

Upon discovery of the overflow, the transfer of laundry water was immediately terminated. Water spilled as a result of the overflow was confined to the area adjacent to the safety injection pumps and the Unit #3 component cooling water pumps, and potentially a storm drain system. The maximum activity of the spill was 21 μ curies. This activity is based on A Monitor Tank sample data.

Control and cleanup of the contaminated area was promptly initiated. The A Monitor Tank was removed from service for a channel check of the level instrumentation. Results of the channel check indicate that instrument error was not the cause of the overflow. The root cause of the overflow appears to be a combination of an inadequate written instruction for the evolution and personnel error in that the written instruction was not followed.

The management actions that have been planned/instituted are:

1. Revise the written instruction to provide proper guidance in making transfers between the laundry tank and monitor tanks.
2. Reinstruct personnel in strict compliance to procedures.
3. Revise procedure to require that any accidental, unplanned, or uncontrolled radioactive release or potential release resulting from spills, etc., (except normal or expected releases from maintenance or other operational activities) be reported pursuant to 10 CFR 50.72.
4. Evaluation of the interface between radioactive and non-radioactive drain systems and of the overflow/siphon break protection for the montitor tanks. Until the evaluation can be completed, the radioactive drains in the Unit #3 component cooling water pump area will be sealed.