

LICENSEE EVENT REPORT

Attachment 1
LL2-81-0088

CONTROL BLOCK: _____ (1)

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 | P | A | T | M | I | 2 | 2 | 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | - | 0 | 0 | 3 | 4 | 1 | 1 | 1 | 1 | 4 | _____ | 5
7 8 9 14 15 25 26 57 58
LICENSEE CODE LICENSE NUMBER LICENSE TYPE CAT 58

CON'T
0 1 | R | E | P | O | R | T | S | O | U | R | C | E | L | 6 | 0 | 5 | 0 | 0 | 0 | 3 | 2 | 0 | 7 | 0 | 2 | 2 | 6 | 8 | 1 | 1 | 8 | 0 | 3 | _____ | 9
7 8 60 61 68 69 74 75 80
REPORT SOURCE DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)
0 2 | On February 26, 1981 at 0525 hours the "A" Emergency Diesel Generator DF-X-1A was
0 3 | started per surveillance requirements. The diesel started, accelerated to speed
0 4 | and then tripped after approximately 15-20 seconds. This is not a violation of Tech.
0 5 | specs. This report is made pursuant to section 6.9.1.9(b) of the Tech. Specs. because
0 6 | the action statement of Spec. 3.8.1.1(a) was entered unintentionally. This event had
0 7 | no effect on the plant, its operation, or the health and safety of the public.
0 8 | _____
7 8 9

0 9 | SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP SUBCODE VALVE SUBCODE
E E (11) X (12) Z (13) ENGINE (14) Z (15) Z (16)
7 8 9 10 11 12 13 18 19 20
EVENT YEAR SEQUENTIAL REPORT NO. OCCURRENCE CODE REPORT TYPE REVISION NO.
8 1 (17) _____ 0 0 6 (18) / 0 3 (19) L (20) _____ 0 (21)
21 22 23 24 26 27 28 29 30 31 32
ACTION TAKEN FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED NPRD-4 FORM SUB PRIME COMP SUPPLIER COMPONENT MANUFACTURER
X (18) X (19) Z (20) Z (21) 0 0 0 0 (22) Y (23) N (24) A (25) F O I O (26)
33 34 35 36 37 40 41 42 43 44 47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)
1 0 | The trip was initially thought to be the result of insufficient prelude but this
1 1 | was later discounted. At present, no other cause can be identified. To investigate
1 2 | other possible causes, brush recorders are being installed to monitor several compon-
1 3 | ents in the starting circuitry. Once installed, the diesels will be started under
1 4 | varying conditions in an attempt to isolate the cause.
7 8 9

1 5 | FACILITY STATUS % POWER OTHER STATUS (30) METHOD OF DISCOVERY DISCOVERY DESCRIPTION (32)
X (28) 0 0 0 (29) Recovery Mode B (31) Operator Observation
7 8 9 10 12 13 44 45 46 80
1 6 | ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36)
Z (33) Z (34) N/A N/A
7 8 9 10 11 44 45 80
1 7 | PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION (39)
0 0 0 (37) Z (38) N/A
7 8 9 10 11 12 13 80
1 8 | PERSONNEL INJURIES NUMBER DESCRIPTION (41)
0 0 0 (40) N/A
7 8 9 10 11 12 80
1 9 | LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION (43)
Z (42) N/A
7 8 9 10 80
2 0 | PUBLICITY ISSUED DESCRIPTION (45)
N (44) N/A
7 8 9 10 80
NRC USE ONLY

LICENSEE EVENT REPORT
NARRATIVE REPORT
TMI-II
LER 81-06/03L-0
EVENT DATE - February 26, 1981

I. EXPLANATION OF OCCURRENCE

At 0525 hours on February 25, 1981, the A Emergency Diesel Generator, DF-X-1A, was started per surveillance requirements. The diesel started, accelerated to speed and then tripped after approximately 15-20 seconds. The cause of the failure was investigated by the operators. The operators determined the problem was probably due to inadequate prelube. The problem was corrected and the diesel was started at 0545 hours. The diesel was declared operable at 0652 hours after completion of the operability surveillance.

This is not a violation of Technical Specifications. This report is submitted pursuant to Section 6.9.1.9(b) of the Tech. Specs. because action statement 3.8.1.1(a) was entered unintentionally.

II. CAUSE OF THE OCCURRENCE

Inadequate prelube of the diesel was later discounted as the cause of this failure.

To investigate other possible causes for this failure, brush recorders are being installed to monitor several components in the starting circuitry. Once these recorders are installed the diesels will be started under varying conditions, attempting to isolate any faults.

During the investigation of this failure it was determined that scavenger air pressure was approximately 50% of normal. This was possibly a contributing factor in this diesel failure.

III. CIRCUMSTANCES SURROUNDING THE OCCURRENCE

At the time of the occurrence, the Unit 2 facility was in a long-term cold shutdown state. The reactor decay heat was being removed via loss to ambient. Throughout the event there was no effect on the Reactor Coolant System or the core.

IV. CORRECTIVE ACTIONS TAKEN OR TO BE TAKEN

IMMEDIATE

The apparent problem was corrected, the diesel started and the surveillance completed to show operability.

LONG TERM

Work request to replace the combustion air intake filter media has been submitted. Other long term corrective actions are pending a determination of actual cause.

V. COMPONENT FAILURE DATA

N/A

TO: Referring Physician Dr. Spurgeon Green

NRC Regional Office
Office of Inspection and Enforcement

Also send copy to:
U.S. Nuclear Regulatory Commission
c/o Document Management Branch
Washington, D.C. 20555



REPORT OF DIAGNOSTIC MISADMINISTRATION

Date of report 3-31-81 Date of Incident 3-30-81

Licensee Saint Joseph Hospital Number 12-610-02

Address 333 N. Madison Avenue

City, State Joliet, Illinois 60435

Referring Physician Dr. Spurgeon Green

Signature X [Handwritten Signature]

Description of event a) A shipment of DTPA (Brain and Kidney reagent) was received on the same day as a sample of MDP (Bone agent) was delivered.

b) Both are packaged in identical blue packages, although the labels are different.

c) After the injection of the patient, the static images were noticed to be of a "different nature". The vials were then examined and found to be bone agents rather than brain agents.

Effect on patient None, other than possible extra day in hospital.

Preventive action Separate the two different materials and instruct technologists to examine the labels on the vials.

This report is to be sent within ten (10) days after the end of calendar quarter in which the incident occurred.

The Medical Isotope Committee and the licensee (administration) has been informed of this incident.

Submitted by: Ram Basavatia

[Signature], Radiation Safety Officer