

### LICENSEE EVENT REPORT

CONTROL BLOCK: \_\_\_\_\_ (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 | P | A | T | M | I | 2 | 2 | 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | 0 | - | 0 | 0 | 0 | 3 | 4 | 1 | 1 | 1 | 1 | 1 | 4 | \_\_\_\_\_ | 5  
7 8 9 14 15 25 26 57 CAT 58

CON'T  
01 | REPORT SOURCE | L | 6 | 0 | 5 | 0 | 0 | 0 | 0 | 3 | 2 | 0 | 7 | 0 | 3 | 1 | 1 | 1 | 8 | 1 | 8 | 0 | 4 | 1 | 0 | 8 | 1 | 1 | 9  
7 8 60 61 68 69 74 75 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 | On March 11, 1980, I&C personnel requested permission from the Operations Shift  
03 | foreman to enter the EPICOR-II building to trouble shoot a problem in a portion  
04 | of radiation monitor ALC-RM-18. The Shift Foreman was not aware that the  
05 | monitor would be removed from service for the troubleshooting and therefore did  
06 | not initiate air grab samples as required by action statement 37 of Environmental  
07 | Tech. Spec. 2.1.3 when the monitor was removed from service. This event had no  
08 | effect on the plant, its operation or the health and safety of the public. 80

09 | SYSTEM CODE | M | C | 11 | CAUSE CODE | A | 12 | CAUSE SUBCODE | C | 13 | COMPONENT CODE | I | N | S | T | R | U | 14 | COMP. SUBCODE | X | 15 | VALVE SUBCODE | Z | 16  
7 8 9 10 11 12 13 18 19 20  
17 | LER/RO REPORT NUMBER | 8 | 1 | 21 | SEQUENTIAL REPORT NO. | 0 | 0 | 7 | 24 | OCCURRENCE CODE | 0 | 1 | 28 | REPORT TYPE | L | 30 | REVISION NO. | 0 | 32  
22 | EVENT YEAR | 8 | 1 | 22 | SHUTDOWN METHOD | Z | 21 | HOURS | 0 | 0 | 0 | 0 | 37 | ATTACHMENT SUBMITTED | Y | 23 | NRC-4 FORM SUB. | N | 24 | PRIME COMP. SUPPLIER | L | 25 | COMPONENT MANUFACTURER | N | 3 | 0 | 5 | 26  
33 34 35 36 40 41 42 43 44 47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 | This event was the result of insufficient communication between the I&C  
11 | personnel and the Shift Foreman. Upon realization that the monitor was out of  
12 | service, the Shift Foreman initiated the requirements of the action statement. All  
13 | Operations and Maintenance Foreman were instructed by memo to increase their  
14 | efforts to prevent a recurrence of this type of event. 80

15 | FACILITY STATUS | X | 28 | % POWER | 0 | 0 | 0 | 29 | OTHER STATUS | Recovery Mode | 30 | METHOD OF DISCOVERY | A | 31 | DISCOVERY DESCRIPTION | Operator Observation | 32  
7 8 9 10 11 12 13 44 45 46 80

16 | ACTIVITY RELEASED | Z | 33 | CONTENT | Z | 34 | AMOUNT OF ACTIVITY | N/A | 35 | LOCATION OF RELEASE | N/A | 36  
7 8 9 10 11 44 45 80

17 | PERSONNEL EXPOSURES NUMBER | 0 | 0 | 0 | 37 | TYPE | Z | 38 | DESCRIPTION | N/A | 39  
7 8 9 10 11 12 13 80

18 | PERSONNEL INJURIES NUMBER | 0 | 0 | 0 | 40 | DESCRIPTION | N/A | 41  
7 8 9 10 11 12 80

19 | LOSS OF OR DAMAGE TO FACILITY TYPE | Z | 42 | DESCRIPTION | N/A | 43  
7 8 9 10 80

20 | PUBLICITY ISSUED | N | 44 | DESCRIPTION | N/A | 45  
7 8 9 10 80

NAME OF PREPARER Steven D. Chaplin

PHONE (717) 948-8461

NRC USE ONLY

8104200319

LICENSEE EVENT REPORT  
NARRATIVE REPORT  
TMI-II  
LER 81-07/01L-0  
EVENT DATE - March 11, 1981

I. EXPLANATION OF OCCURRENCE

At 0800 hours on March 11th, the I&C Foreman and I&C Engineer requested permission from the Operations Shift Foreman to enter the EPICOR-II Building to trouble shoot a problem in a portion of radiation monitor ALC-RM-18. It was not made clear to the Shift Foreman or the EPICOR-II operators that the radiation monitor would be removed from service. The I&C personnel assumed it was realized that the monitor would have to be taken out of service for the trouble shooting. At 0900 hours the radiation monitor was removed from service. The Shift Foreman, unaware that the monitor has been removed from service, did not initiate grab samples as required by the action statement of Environmental Tech. Spec. (ETS) 2.1.3. At 0030 hours on March 12th, the operator discovered the monitor was out of service and informed the Shift Foreman. The Shift Foreman initiated the taking of the gas grab samples as required by the Tech. Spec. action statement. At the time of this occurrence the EPICOR-II system was not in service.

This event is reportable as a violation of ETS 2.1.3 action statement #37 and is submitted in accordance with section 5.6.2(a) of the ETS.

II. CAUSE OF THE OCCURRENCE

Cause of this event was inadequate communication between maintenance and operation personnel which resulted in the Tech. Spec. monitor being removed from service without proper follow-up actions being initiated.

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

When the radiation monitor was discovered out of service, the Shift Foreman initiated the requirement of the action statement. The first grab gas sample was obtained at 0220 hours on March 12th.

LONG TERM

All Operation and Maintenance Foreman were instructed by memo to increase their efforts to prevent a recurrence of this type of event.

V. COMPONENT FAILURE DATA

N/A