U. S. NUCLEAR REGULATORY COMMISSION NRC FORM 366 (7.77) Attachment 1 LICENSEE EVENT REPORT LL2-81-0179 (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION) CONTROL BLOCK: J(1)(2) 0 0 -0 0 0 0 03 T M 0 0 LICENSE NUMBER LICENSEE CODE CON'T 0 REPORT 5 0 0 0 3 2 0 7 0 6 1 3 8 (6)0 8 0 1 SOURCE DOCKET NUMBER EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10) At 0330 hours on June 13, 1981, the Control Room Ventilation system failed to 0 2 automatically switch to recirculation mode upon receipt of the initiating signal 0 3 from HP-R-220. The signal was generated as a result of an atmospheric temrerature 0 4 inversion in the local environment. This event had no effect on the plant, its 5 operation or the health and safety of the public. 0 6 SYSTEM COMP VALVE CAUSE CAUSE COMPONENT CODE SUSCODE CODE SUBCODE E (15 C (13 T Z (16) K TBR A | A | (11 A (12 REVISION REPORT SEQUENTIAL EVENT YEAR REPORT NO CODE TYPE NO. LER/RO 0 | 1 | 8 11 1011 L 0 5 REPORT NUMBER 28 ATTACHMENT SUBMITTED COMPONENT MANUFACTURER NPRD-4 FORM SUB. PRIME COMP. EFFECT ON PLANT SHUTDOWN METHOD ACTION FUTURE HOURS SUPPLIER N 24 Z Z (21 01010 0 Y A H Z (25 (26)CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27) The lead I & C Foreman failed to return the radiation monitor interlocks to normal 1 0 upon completion of the calibration as required by the procedure. The ventilation system was immediately switched into the recirculation mode manually. The foreman was counselled on the necessity of following procedures fully. 4 80 0 METHOD OF DISCOVERY FACILITY (30)DISCOVERY DESCRIPTION (32) % POWER OTHER STATUS Recovery Mode 01 0 A (31 Operator Observation 80 CONTENT ACTIVITY LOCATION OF RELEASE (36) AMOUNT OF ACTIVITY (35 RELEASED OF RELEASE Z N/A N/A Z (34) (33) 6 80 10 11 PERSONNEL EXPOSURES DESCRIPTION (39) TYPE NUMBER 10 0 (37) Z (38 N/A 80 PERSONNEL INJURIES DESCRIPTION (41) NUMBER 0 0 (40) 01 N/A 80 LOSS OF OR DAMAGE TO FACILITY (43) DESCRIPTION N/A Z (42) 80 8107240408 810713 PUBLICITY NRC USE ONLY DESCRIPTION (45) PDR ADOCK 05000320 SUED N (44) S PDR N/A 68 69 80 (717) 948-8461 Steven D. Chaplin NAME OF PREPARER. PHONE:

Attachment 2 LL2-81-0179

# LICENSEE EVENT REPORT NARRATIVE REPORT

<u>TMI-II</u> LER 81-015/01L-0 EVENT DATE - June 13, 1981

#### I. EXPLANATION OF OCCURRENCE

At 0335 hours on June 13, 1981, the Control Room Ventilation Radiation Monitor, HP-R-220 alarmed due to a temperature inversion in the local environment. The Control Room Operator, while verifting the automatic actions this alarm causes, noted the ventilation had not automatically shifted and immediately placed it into the recirculation mode. An investigation determined that the interlock defeat key switch was in the defeat position. The key switch was returned to normal and the interlock tested satisfactorily.

Subsequent investigation determined that the key switch was left in the defeat position following a calibration of the radiation monitor on June 12, 1981. The Lead I&C Foreman had been training a technician on radiation monitor calibration. Due to the forman's familiarity with the procedure and the radiation monitor the procedure was not closely followed. As a result the step to return the key switch to normal was overlooked.

### II. CAUSE OF THE OCCURRENCE

The cause of this event was the Lead I&C Foreman failing to return the radiation monitor interlocks to normal at completion of calibration as required in the procedure.

#### 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 fans were immediately started and the radiation monitor interlocks were returned to normal.

The forman's supervisor discussed this event with him. He was instructed that procedures must be used to prevent this type of situation, and that he should not rely only on his past experience.

#### LONG TERM

N/A

## V. COMPONENT FAILURE DATA

N/A