## PROBLEMENT OF STREET



P.O. BOX 270 HARTFORD, CONNECTICUT 06101 (203) 666-6911

January 29, 1982 MP-2-5043

Mr. Ronald C. Haynes Regional Administrator, Region 1 Office of Inspection and Enforcement U. S. Nuclear Regulatory Commission 631 Park Avenue King of Prussia, Pennsylvania 19406

Reference:

Facility Operating License No. DPR-65

Docket No. 50-336

Reportable Occurrence RO-50-336/82-1/4T-0

Dear Mr. Haynes:

This letter forwards Prompt Licensee Event Report 82-1/4T-0 required to be submitted within ten days pursuant to Millstone Unit 2 Appendix B Environmental Technical Specifications, Section 5.6.2.a (1), concerning an inoperable liquid radwaste discharge radiation monitoring recorder (ETS 2.4.2.3.A).

An additional three copies of the report are enclosed.

Yours truly,

NORTHEAST NUCLEAR ENERGY COMPANY

Station Superintendent

Millstone Nuclear Power Station

EJM/JB:mo

Attachment: LER RO-82-1/4T-0

Director, Office of Inspection and Enforcement, Washington, D.C. (30) Director, Office of Management Information and Program Control,

Washington, D.C. (3)

U. S. Nuclear Regulatory Commission, c/o Document Management Branch,

Washington, D.C. 20555

## ATTACHMENT TO LER 82-1/4T-0

Event Description and Probable Consequences
With the plant shut down for refueling, a liquid radioactive waste discharge was made to Long Island Sound. Immediately after the discharge was completed, it was realized that an I & C Technician had taken the radioactivity recorder out of service for calibration. No radiation monitor alarms were received during the discharge, indicating no station discharge limits were exceeded. Environmental Technical Specification section 2.4.1.3.c requires that the radioactivity of the wastes be recorded continuously. The event was reported as required by E.T.S. section 5.6.2.a.(1).

Cause and Corrective Action
The radioactivity recorder was removed from service by a technician as part of a calibration procedure. He was not aware a discharge was in progress. A prerequisite of the calibration procedure is that a discharge is not in progress. The problem arose because the discharge was not in progress at the time the procedure was started. The technician left the control room prior to the start of the discharge, returned after the discharge was in progress, and then removed the recorder from service. A sign has been attached to the recorder to state that the SS or SCO be contacted prior to removal of the recorder from service in order to verify that a discharge is not in progress. In addition the event has been reviewed with the personnel involved.