

LICENSEE EVENT REPORT

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

01 | F | L | T | P | S | 4 | 2 | 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | - | 0 | 0 | 3 | 4 | 1 | 1 | 1 | 1 | 4 | 5
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

01 | L | 5 | 0 | 5 | 0 | 0 | 0 | 2 | 5 | 1 | 7 | 0 | 3 | 1 | 7 | 8 | 2 | 3 | 0 | 3 | 3 | 1 | 8 | 2 | 9
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

02 | While transferring water from the Unit 3 refueling cavity to the Unit 3
03 | refueling water storage tank (RWST) some water was inadvertently directed
04 | to the Unit 4 RWST. Approximately 11,000 gallons of water containing
05 | approximately 122 millicurie of gross activity overflowed to the ground
06 | around the tank. Although no release limits were approached, the release
07 | of this water was unintentional and unmonitored. The health and safety
08 | of the public was not affected.

09 | SYSTEM CODE: F L C 11 | CAUSE CODE: D 12 | CAUSE SUBCODE: Z 13 | COMPONENT CODE: Z Z Z Z Z Z Z Z 14 | COMP SUBCODE: Z 15 | VALVE SUBCODE: Z 16
17 | LER/RO REPORT NUMBER: 8 2 | EVENT YEAR: 8 2 | SEQUENTIAL REPORT NO.: 0 0 2 | OCCURRENCE CODE: 0 1 | REPORT TYPE: T | REVISION NO.: 0
18 | ACTION TAKEN: G 18 | FUTURE ACTION: Z 19 | EFFECT ON PLANT: Z 20 | SHUTDOWN METHOD: Z 21 | HOURS: 0 0 0 0 | ATTACHMENT SUBMITTED: N 23 | NRC FORM SUB: N 24 | PRIME COMP SUPPLIER: Z 25 | COMPONENT MANUFACTURER: Z 9 9 9 9 25

10 | CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)
11 | This transfer was performed in accordance with a procedure that did
12 | not provide for verification that a possible flow path to the Unit 4
13 | RWST was blocked. The water transfer operation was immediately
14 | terminated. The area involved was surveyed and decontaminated or isolated
15 | as appropriate. The inadequate procedure was corrected.

16 | FACILITY STATUS: E 18 | % POWER: 1 0 0 0 29 | OTHER STATUS: NA 30 | METHOD OF DISCOVERY: A 31 | DISCOVERY DESCRIPTION: Operator Observation 32

17 | ACTIVITY CONTENT RELEASED: L 33 | M 34 | AMOUNT OF ACTIVITY: 122 Millicuries 35 | LOCATION OF RELEASE: Area around RWST 36

18 | PERSONNEL EXPOSURES NUMBER: 0 0 0 37 | TYPE: Z 38 | DESCRIPTION: NA 39

19 | PERSONNEL INJURIES NUMBER: 0 0 0 40 | DESCRIPTION: NA 41

20 | LOSS OF OR DAMAGE TO FACILITY TYPE: Z 42 | DESCRIPTION: NA 43

21 | PUBLICITY ISSUED: N 44 | DESCRIPTION: NA 45

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Additional Event Description and Probable Consequences

On Wednesday evening, March 17, 1982, an operation was performed to transfer water from the Unit 3 refueling cavity to the Unit 3 refueling water storage tank (RWST). This operation was performed in accordance with a procedure that did not provide for verification that a possible flow path to the Unit 4 RWST was blocked. As a result, some water was also transferred to the Unit #4 RWST causing it to overflow. Approximately 11,000 gallons of water containing approximately 122 millicurie gross radioactivity overflowed to the ground around the tank. Some of this water entered the storm drains to the canal system which receives normal releases. While no release limits were approached, the release of this water was unintentional and unmonitored.

The RWST high level alarm annunciator target was "in", however since maintenance had been working on the level transmitter associated with the low level alarm, the reactor operator assumed that the high level alarm target was in as a result of the work being performed by maintenance and therefore ignored it. Further investigation revealed that the high level alarm annunciator window was found to be exchanged with the Technical Specification limit window. A possible explanation of this error can be found in the fact that in December 1981, plant change and modifications (PC/M 80-100 for Unit 3 and 80-101 for Unit 4) were implemented to install a Magnetrol level transmitter for the RWST. At this time, the windows (Panel G 8-1, 8-2) for Unit 4 were reversed to make them look like Unit 3's windows. However, even though Operating Procedure 0208.9, "Annunciator List" was updated to reflect this change, the paper work was in progress and the actual controlled procedure change had not made it to the control room.

Additional Cause Description and Corrective Action

The root cause of the overflow was found to be procedure inadequacy. The procedure in question did not provide for verification of the proper valve line-up. Also, the overflow could have been minimized or even prevented if the RWST high level alarm would have been operating as designed.

As part of the corrective action, the water transfer operation was immediately terminated and the level was reduced in the Unit 4 RWST to stop the overflow as expeditiously as possible. The area involved was surveyed and decontaminated or isolated with barriers as appropriate. The procedure was corrected and issued.