

CONTROL BLOCK: [] [] [] [] [] [] (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

[01] P A S E S I [2] 0 0 - 0 0 0 0 0 - 0 0 [3] 4 1 1 1 1 [4] [] [5]
7 8 9 LICENSEE CODE 14 15 LICENSE NUMBER 25 26 LICENSE TYPE 30 37 CAT 58

CONT

[01] REPORT SOURCE [L] [6] 0 5 0 0 0 0 3 8 7 [7] 0 1 0 4 8 3 [8] 0 2 0 3 8 3 [9]
7 8 60 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

[02] During the Startup Testing Program, the "D" Average Power Range Monitor
[03] channel was inoperable after failing the weekly functional surveillance. This
[04] is reportable per 6.9.1.9.a. No adverse consequences existed because actual
[05] power to flow conditions did not exceed the setpoint while the channel was
[06] inoperable.
[07]
[08]

[09] SYSTEM CODE [I A] [11] CAUSE CODE [A] [12] CAUSE SUBCODE [X] [13] COMPONENT CODE [Z Z Z Z Z Z] [14] COMP. SUBCODE [Z] [15] VALVE SUBCODE [Z] [16]
7 8 9 10 11 12 13 14 15 16 17 18 19 20

[17] LER/RO REPORT NUMBER [] [18] EVENT YEAR [8 3] [19] SEQUENTIAL REPORT NO. [0 0 9] [20] OCCURRENCE CODE [] [21] REPORT TYPE [L] [22] REVISION NO. [0]
21 22 23 24 25 26 27 28 29 30 31 32
ACTION TAKEN [E] [18] FUTURE ACTION [F] [19] EFFECT ON PLANT [Z] [20] SHUTDOWN METHOD [Z] [21] HOURS [0 0 0 0] [22] ATTACHMENT SUBMITTED [Y] [23] NPRO-4 FORM SUB. [N] [24] PRIME COMP. SUPPLIER [Z] [25] COMPONENT MANUFACTURER [Z 9 9 9] [26]
33 34 35 36 37 38 39 40 41 42 43 44 45 46 47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

[10] Review of the past drift history of the channel and the lack of failed compon-
[11] ents resulted in the conclusion that human error was the probable cause. The
[12] channel gains were adjusted and the surveillance passed. The pot that was
[13] probably inadvertently adjusted will be modified to distinguish it from
[14] other pots.

[15] FACILITY STATUS [B] [28] % POWER [0 7 2] [29] OTHER STATUS [n/a] [30] METHOD OF DISCOVERY [B] [31] DISCOVERY DESCRIPTION [surveillance] [32]
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 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

[16] ACTIVITY CONTENT RELEASED OF RELEASE [Z] [33] Z [34] AMOUNT OF ACTIVITY [n/a] [35] LOCATION OF RELEASE [n/a] [36]
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 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

[17] PERSONNEL EXPOSURES NUMBER [0 0 0] [37] Z [38] DESCRIPTION [n/a] [39]
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 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

[18] PERSONNEL INJURIES NUMBER [0 0 0] [40] DESCRIPTION [n/a] [41]
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 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

[19] LOSS OF OR DAMAGE TO FACILITY TYPE [Z] [42] DESCRIPTION [n/a] [43]
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 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

[20] PUBLICITY ISSUED DESCRIPTION [N] [44] DESCRIPTION [n/c] [45]
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 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

8302230139 830203
PDR ADOCK 05000387
S PDR

NAME OF PREPARER D.G. Mitchell

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NRC USE ONLY

Attachment

Licensee Event Report 83-009/03L-0

During the Startup Test program, the Average Power Range Monitor channel "D" was declared inoperable after failing to trip during a weekly surveillance test. This is reportable per Technical Specification 6.9.1.9.a. There were no adverse consequences in that the action statement was met and the power-to-flow limits were not exceeded while the channel was inoperable.

Investigation of the event revealed no failed components. Past history of this channel shows no drift to the extent observed in this case, further, the channel has not drifted out of tolerance in subsequent weekly functional checks. Based on the above, it would appear that human error was the cause. Surveillance procedures are performed on these channels by both Operations and Instrument & Controls Sections. Both procedures, done on a daily and weekly basis, require adjustment to the APRM gains. An adjustment of the incorrect pot could produce a setpoint deviation as observed in this event.

A calibration of the thermal trip setpoints, upscale alarms and high flow clamped setpoints were performed. All indicated within specification. The APRM "D" channel was adjusted and the surveillance passed. To prevent recurrence action has been initiated to clearly differentiate the pot which changes APRM setpoint, thus making it recognizable to personnel performing APRM surveillances.