

LICENSEE EVENT REPORT

CONTROL BLOCK / / / / / / / (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

/0/1/ /V/A/N/A/S/1/ (2) /0/C/-/0/0/0/0/0'-/0/0/ (3) /4/1/1/1/1/ (4) / / / (5)

/0/1/ REPORT SOURCE /L/ (6) /0/5/0/0/0/3/3/8/ (7) /0/8/2/6/8/2/ (8) /0/9/2/2/8/2/ (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

/0/2/ / On August 26, 1982, with the reactor core removed to the spent fuel pit, the ma- /
/0/3/ / nipulator Crane Area Monitor (RM-RMS-162) failed to meet the Acceptance Criteria /
/0/4/ / of the periodic calibration and was declared inoperable. Since the Containment /
/0/5/ / Gaseous and Particulate Monitors remained operable to provide the required /
/0/6/ / isolation feature, the health and safety of the public were not affected. This /
/0/7/ / event is reportable pursuant to T.S. 6.9.1.9.d. /
/0/8/ /

SYSTEM CAUSE CAUSE COMP. VALVE
CODE CODE SUBCODE COMPONENT CODE SUBCODE SUBCODE
/0/9/ /B/A/ (11) /E/ (12) /F/ (13) /I/N/S/T/R/U/ (14) /E/ (15) /Z/ (16)
(17) LER/RO EVENT YEAR REPORT NO. OCCURRENCE REPORT REVISION
NUMBER /8/2/ /-/ /0/5/8/ / / /0/3/ /L/ /-/ /0/

ACTION FUTURE EFFECT SHUTDOWN ATTACHMENT NPRD-4 PRIME COMP. COMPONENT
TAKEN ACTION ON PLANT METHOD HOURS SUBMITTED FORM SUB. SUPPLIER MANUFACTURER
/A/ (18) /Z/ (19) /Z/ (20) /Z/ (21) /0/0/0/0/ (22) /Y/ (23) /N/ (24) /N/ (25) /W/1/2/0/ (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

/1/0/ / This event was caused by instrument drift greater than the ±3 percent response /
/1/1/ / requirement of the periodic test. The monitor assembly was found to be weak /
/1/2/ / which caused the drift. The assembly was replaced and the monitor and instrument /
/1/3/ / loop calibrated. /
/1/4/ /

FACILITY STATUS %POWER OTHER STATUS (30) METHOD OF DISCOVERY DISCOVERY DESCRIPTION (32)
/1/5/ /H/ (28) /0/0/0/ (29) / NA / /B/ (31) / Routine Test /

ACTIVITY CONTENT AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36)
/1/6/ /Z/ (33) /Z/ (34) / NA / / NA /

PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION (39)
/1/7/ /0/0/0/ (37) /Z/ (38) / NA /

PERSONNEL INJURIES NUMBER DESCRIPTION (41)
/1/8/ /0/0/0/ (40) / NA /

LOSS OF OR DAMAGE TO FACILITY (43) TYPE DESCRIPTION
/1/9/ /Z/ (42) / NA /

PUBLICITY ISSUED DESCRIPTION (45) NRC USE ONLY
/2/0/ /N/ (44) / NA / / / / / / / / / / / / / /

NAME OF PREPARER W. R. CARTWRIGHT PHONE (703) 894-5151

Description of Event

On August 28, 1982, while performing a calibration of the Manipulator Crane Area Monitor, it was determined that the monitor response did not meet the Test Acceptance Criteria. For a source value of 17.02 mr/hr, the monitor response was 11.2 mr/hr. Since the monitor response at the T.S. 3.3.3.1 trip setpoint of less than or equal to 50 mr/hr is fairly linear to the source checkpoint, the trip setpoint established for this monitor (45 mr/hr on May 25, 1982) would have exceeded the T.S. Table 3.3-6 value. This event occurred with the core defueled. However, since there was no external cause for the instrument drift, this monitor is considered to have been inoperable since it's last calibration. The unit was in Mode 6 during this period. This event is reportable pursuant to T.S. 6.9.1.9.d.

Probable Consequences of Occurrence

The Manipulator Crane Area Monitor is required during Mode 6 (reactor vessel head removed) to provide for automatic containment purge and exhaust isolation in the event of a fuel element rupture or fuel handling accident. This requirement is amplified by the operability requirements for Containment Ventilation System of T.S. 3.9.9. In addition to this monitor, the same containment isolation features are provided by the Containment Gaseous and Particulate Monitors RM-RMS-159 and 160. These channels remained operable as required by T.S. 3.3.3.1 and T.S. 3.9.9. In addition, the Manipulator Crane Area Monitor, even with the demonstrated response error, would have provided the trip function at about 60 mr/hr. Since none of the trip functions were challenged and RM-RMS-159 and 160 remained operable, the health and safety of the public were not affected.

Cause of Event

This event was caused by the gradual degradation of the monitor's detector. This is considered a natural end of life failure.

Immediate Corrective Action

The monitor assembly was replaced and the instrument loop was recalibrated.

Scheduled Corrective Action

No further action required.

Action Taken To Prevent Recurrence

No further action required.

Generic Implications

This event is considered an isolated failure.