1 1	IL C NUCLEAR DECUT ATONY CONSTRUCTOR
/0/1/	LICENSEE EVENT REPORT CONTROL BLOCK / / / / / (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION) /V/A/N/A/S/1/ (2) /0/0/-/0/0/0/0/-/0/0/ (3) /4/1/1/1/1/ (4) / / / (5) LICENSEE CODE LICENSE NUMBER
/0/1/	$\frac{\text{REPORT}}{\text{SOURCE}} \frac{/L}{/} (6) \frac{\frac{10}{5} \frac{0}{0} \frac{3}{3} \frac{3}{8}}{\text{DOCKET NUMBER}} (7) \frac{\frac{10}{8} \frac{2}{7} \frac{8}{2}}{\text{EVENT DATE}} (8) \frac{\frac{10}{9} \frac{2}{2} \frac{3}{2}}{\text{REPORT DATE}} (9)$
10/2/	/ On Annuat 27, 1082, with Wait 1 de Mode 6, and Weit 2 de Mode 2, the West 11 at 1 de Mode 6
10/2/	/ Unit P. Coccesso Peddetder Detector received and Unit 2 in Mode 3, the Ventilation /
10/15/	/ vent b Gaseous Radiation Detector response was found to exceed the Acceptance /
10/5/	/ criteria of the calibration test. Since the radiation level at the alarm setpoint/
10/5/	/ with the induced inaccuracy would be a small fraction of the release limits, the /
10/0/	/ health and safety of the public were not affected. This event is reportable
10/11	/ 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/B/ (11) /E/ (12) /F/ (13) /I/N/S/T/R/U/ (14) /E/ (15)/Z/ (16)SEQUENTIALOCCURRENCEREPORTLER/ROEVENT YEARREPORT NO.CODETYPENO.
(1)	NUMBER /8/2/ /-/ /0/5/9/ /\/ /C/3/ /L/ /-/ /0/
ACTION TAKEN	FUTURE EFFECT SHUTDOWN ATTACHMENT NPRD-4 PRIME COMP. COMPONENT ACTION ON PLANT METHOD HOURS SUBMITTED FORM SUB. SUPPLIER MANUFACTURENT
<u>/A</u> / (1	8) $\underline{/Z}/(19)$ $\underline{/Z}/(20)$ $\underline{/Z}/(21)$ $\underline{/0/0/0/2}/(22)$ $\underline{/Y}/(23)$ $\underline{/N}/(24)$ $\underline{/N}/(25)$ $\underline{/G/0/6/3/}(26)$
/1/0/	(This event was caused by the gradual deterioration of the photomultiplier tube (
/1/1/	/ and preamplifier in the detector. The defective parts were replaced and the
/1/2/	/ channel was recalibrated
/1/3/	/ channel was recalibrated.
11/1/	· / /
/1/4/	FACILITY METHOD OF
/1/5/	$\frac{1}{H} (28) \frac{1000}{29} \frac{1}{B} (30) \frac{1}{B} (31) \frac{1}$
/1/6/	ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36) /Z/ (33) /Z/ (34) / NA / NA / PERSONNEL EXPOSURES // // NA /
/1/7/	NUMBER TYPE DESCRIPTION (39) /0/0/0/ (37) /Z/ (38) / NA / PERSONNEL INJURIES / /
/1/8/	NUMBER DESCRIPTION (41) /0/0/0/ (40) / NA LOSS OF OR DAMAGE TO FACILITY (43)
/1/9/	<u>/Z/</u> (42) / NA PUBLICITY /
/2/0/	ISSUED DESCRIPTION (45) NRC USE ONLY /N/ (44) / NA ////////////////////////////////////
	NAME OF PREPARER W. R. CARTWRIGHT PHONE (703) 894-5151 9210010168 320922 PDR ADOCK 05000338 PDR

Virginia Electric and Power Company North Anna Power Station, Unit No. 1 Attachment: Page 1 of 1 Docket No. 50-338 Attachment to LER 82-059/03L-0

Description of Event

On August 27, 1982, while performing a channel calibration on the Ventilation Vent B Gaseous Monitor, the detector response was found to be about 27 percent less than the calibration source. This exceeded the Acceptance Criteria of ±10 percent. In accordance with T.S. 3.3.3.1, this channel was considered inoperable since the alarm setpoints of Table 3.3-6 were exceeded. The actions of T.S. 3.9.12 were implemented and a program for daily grab samples was instituted in accordance with E.T.S. 2.2.4.

Probable Consequences of Occurrence

The ventilation vent gaseous monitor is required by T. S. 3.3-6 to specifically monitor fuel building ventilation exhaust for indication of damage to spen. fuel elements. In addition, the Environmental Technical Specification (E.T.S 2.2.4) requires a continuous monitoring of gaseous effluents. Since the gaseous radiation levels at the alarm setpoints are a small fraction (about 5%) of the release limits, the actuation of the alarm, even with the inaccuracy, would have provided sufficient indication of an abnormal gaseous release. Since the actions of T.S. 3.9.12 were implemented and the daily grab samples were taken until the channel was repaired the health and safety of the public were not affected.

Cause of Event

This event was caused by the gradual deterioration of the monitor's photomultiplier tube and preamplifier. This is considered a natural end of the life failure.

Immediate Corrective Action

The photomultiplier tube and preamplifier were replaced. The channel was calibrated satisfactorily.

Scheduled Corrective Action

No further actions required.

Action Taken To Prevent Recurrence

No further actions required.

Generic Implications

This event is considered an isolated failure.