

LICENSEE EVENT REPORT

CONTROL BLOCK: \_\_\_\_\_ (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 | M | A | Y | K | R | 1 | 2 | 0 | 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | 0 | - | 0 | 0 | 3 | 4 | 1 | 1 | 1 | 1 | 4 | \_\_\_\_\_ | 5  
7 8 9 14 15 25 26 30 57 CAT 58  
LICENSEE CODE LICENSE NUMBER LICENSE TYPE

CON'T

0 1 | L | 6 | 0 | 5 | 0 | 0 | 0 | 0 | 0 | 2 | 9 | 7 | 1 | 0 | 1 | 2 | 8 | 1 | 2 | 8 | 1 | 2 | 6 | 8 | 2 | 9  
7 8 60 61 68 69 74 75 80  
REPORT SOURCE DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | While in Mode 6 and performing OP-4613, "Reactor Permissive Circuit  
0 3 | Calibration and Functional Test", bistables 420 and 423 were found out  
0 4 | of Technical Specification limits. During subsequent review it was found  
0 5 | that a Technical Specification misinterpretation had been written into  
0 6 | the procedure in 1977. The requirements are found in T.S.4.3.1.2 and  
0 7 | Table 3.3-1. There is no impact on the safety analysis and therefore no  
0 8 | adverse effect on the public health or safety.  
7 8 9 80

0 9 | I | A | 11 | A | 12 | C | 13 | I | N | S | T | R | U | 14 | X | 15 | Z | 16  
7 8 9 10 11 12 13 18 19 20  
SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP. SUBCODE VALVE SUBCODE  
17 | LER/RO REPORT NUMBER | 8 | 2 | 21 | 22 | - | 23 | 0 | 3 | 5 | 24 | 26 | / | 27 | 0 | 1 | 28 | 29 | T | 30 | - | 31 | 0 | 32  
EVENT YEAR SEQUENTIAL REPORT NO. OCCURRENCE CODE REPORT TYPE REVISION NO.  
ACTION TAKEN FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED NPRD-4 FORM SUB. PRIME COMP. SUPPLIER COMPONENT MANUFACTURER  
E | 18 | Z | 19 | Z | 20 | Z | 21 | 0 | 0 | 0 | 0 | Y | 23 | N | 24 | N | 25 | N | 3 | 3 | 5 | 26  
33 34 35 36 37 40 41 42 43 44 47  
CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | The root cause of this event is attributed to a misinterpretation of  
1 1 | this Technical Specification. When discovered steps were immediately  
1 2 | taken to correct the condition. Personnel were reminded of the  
1 3 | importance of Technical Specification compliance and extreme care be  
1 4 | taken in their interpretation. No further corrective actions necessary.  
7 8 9 80

1 5 | H | 28 | 0 | 0 | 0 | 29 | N/A | 30 | B | 31 | Surveillance Test | 32  
7 8 9 10 12 13 44 45 46  
FACILITY STATUS % POWER OTHER STATUS METHOD OF DISCOVERY DISCOVERY DESCRIPTION

1 6 | Z | 33 | Z | 34 | N/A | 35 | N/A | 36  
7 8 9 10 11 44 45  
ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY LOCATION OF RELEASE

1 7 | 0 | 0 | 0 | 37 | Z | 38 | N/A | 39  
7 8 9 11 12 13  
PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION

1 8 | 0 | 0 | 0 | 40 | N/A | 41  
7 8 9 11 12  
PERSONNEL INJURIES NUMBER DESCRIPTION

1 9 | Z | 42 | N/A | 43  
7 8 9 10  
LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION

2 0 | N | 44 | N/A | 45  
7 8 9 10  
ISSUED DESCRIPTION  
8211020067 821026  
PDR ADOCK 05000029  
S PDR  
NRC USE ONLY  
78 79 80

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LER 82-035/01T-0  
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#### Event Description And Probable Consequences

While in Mode 6 and performing procedure OP-4613, "Reactor Permissive Circuit Calibration and Functional Test", bistable 420 was found to be out of both procedural and Technical Specification limits (17.64 MWe).

In reviewing the procedural requirements and the associated Technical Specification requirements, it was discovered that not only bistable 420 was out of Technical Specification limits but also bistable 423, and in the way the procedure was written, they were calibrated that way.

This is contrary to Technical Specification 4.3.1.2 and Table 3.3-1.

Bistable 420 was calibrated to actuate at 15.12 to 16.56 MWe instead of prior to  $\geq 15$  MWe increasing and bistable 423 was calibrated to actuate at 12.96 to 14.4 MWe instead of prior to  $\leq 15$  MWe decreasing. This procedural inadequacy has existed since 6/16/77.

The effect of these small changes in the permissive circuit deenergizing/energizing has no impact on the results of the Yankee reference safety analysis. Therefore, there could be no plant operation beyond the assumptions used in the reference safety analysis. There were no adverse consequences to the public health or safety.

#### Cause Description And Corrective Actions

The cause of this event is attributed to a misinterpretation of the Technical Specification. In turn, this misinterpretation was translated into procedure to functionally test and calibrate the circuit.

When the error was discovered, steps were immediately implemented to correct it. A minor circuit modification will be implemented to facilitate calibration and the procedure will be revised to ensure that its properly tested and calibrated to satisfy the Technical Specification requirements.

Personnel were reminded of the importance of Technical Specifications and that extreme care should be used in their interpretation. No further corrective actions are necessary.