

LICENSEE EVENT REPORT

Attachment 1
4410-82-L-0044

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

0 1 | P A T M I 2 | 2 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 58
LICENSEE CODE LICENSE NUMBER LICENSE TYPE CAT 58

CON'T
0 1 | R E P O R T S O U R C E | L | 6 0 5 0 0 0 3 2 0 | 7 | 1 0 0 7 8 2 | 8 | 1 1 1 1 1 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 | On October 7, 9, and 11, 1982, the Unit II EPICOR II Effluent Radiation Monitor
0 3 | (ALC-RMI-18) Sampler Pump failed resulting in the monitor being declared inoperable.
0 4 | These events are considered reportable under Environmental Tech Spec 5.6.2(b) due to
0 5 | entry into and compliance with the requirements of Environmental Tech Spec 2.1.3.
0 6 | These events had no effect on the plant or the health and safety of the public.
0 7 |
0 8 |

0 9 | M I C | E | B | X X X X X X X | Z | Z |
7 8 9 10 11 12 13 18 19 20
SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP. SUBCODE VALVE SUBCODE

17 | L E R R O R E P O R T N U M B E R | 8 2 | 0 3 2 | 0 3 | L | 0 |
21 22 23 24 26 27 28 29 30 31 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
C | Z | Z | Z | 0 0 0 0 | Y | N | L | Z 9 9 9
33 34 35 36 37 40 41 42 43 44 47
CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | The cause of each failure was a blown fuse for the sampler pump. The pump was replaced
1 1 | to facilitate troubleshooting the pump without keeping the system out-of-service. No
1 2 | discrete cause was found in the pump. A cracked fuse holder was identified and replaced.
1 3 | The holder may have allowed intermittent shorts to ground. Investigation of trouble-
1 4 | shooting practices and associated documentation is underway.

1 5 | X | 0 0 0 0 | Recovery mode | A | Operator observation
7 8 9 10 12 13 44 45 46
FACILITY STATUS % POWER OTHER STATUS (30) METHOD OF DISCOVERY DISCOVERY DESCRIPTION (32)

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

1 7 | 0 0 0 | Z | N/A
7 8 9 10 11 12 13
PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION (39)

1 8 | 0 0 0 | PERSONNEL INJURIES NUMBER DESCRIPTION (41)
7 8 9 10 11 12
8211290527 821111
PDR ADOCK 05000320
S PDR

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

2 0 | N | PUBLICITY ISSUED DESCRIPTION (45)
7 8 9 10
N/A

NAME OF PREPARER Steven D. Chaplin PHONE (717) 948-8461

LICENSEE EVENT REPORT
NARRATIVE REPORT
TMI-II
LER 82-032/03L-0
EVENT DATE - October 7, 1982

I. EXPLANATION OF OCCURRENCE

During the periods of 1330 to 1815 hours on October 7, 1330 to 1615 hours on October 9, and 0945 hours on October 11, to 2045 hours on October 19, 1982, the Unit II EPICOR II Effluent Radiation Monitor (ALC-RMI-18) Sampler Pump failed, resulting in the monitor being declared inoperable. This placed the unit in the action statement of Environmental Technical Specification (Tech Spec) 2.1.3. These events are considered reportable pursuant to Tech Spec 5.6.2.(b).

II. CAUSE OF THE OCCURRENCE

The cause of the failure in each case was the "blowing" of the ALC-RMI-18 Sampler Pump Fuse.

This may have resulted from a cracked fuse holder allowing intermittent shorts to ground.

III. CIRCUMSTANCES SURROUNDING THE OCCURRENCE

At the time of the occurrence, the Unit II facility was in a long-term cold shutdown state. The reactor decay heat was being removed via loss to ambient. Throughout the event there was no effect on the Reactor Coolant System or the core.

IV. CORRECTIVE ACTIONS TAKEN OR TO BE TAKEN

The immediate action taken in each case was to comply with the action statements of Environmental Tech Spec 2.1.3 (i.e. run auxiliary particulate sampler, take noble gas "GRAB" samples, etc.) In each case the Sampler Pump Fuse was replaced. The sampler pump was replaced after the fuse blew on October 11, 1982, to facilitate troubleshooting the pump without maintaining the monitor out-of-service. However, no deficiencies in the pump were identified that would solely account for the blown fuses. Continued investigation resulted in identification of the cracked fuse holder which was then replaced.

GPU is initiating an investigation to be performed by the Safety Review Group and the Operations Department to determine if appropriate troubleshooting practices were utilized during this event and whether the activities performed were appropriately documented. Upon completion of the investigation, an update to this LER will be submitted.

V. COMPONENT FAILURE DATA

N/A