

LICENSEE EVENT REPORT

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

0 1 | F | L | T | P | S | 3 | 2 | 0 | 0 | - | 0 | 0 | 0 | 0 | - | 0 | 0 | 0 | 3 | 4 | 1 | 1 | 1 | 1 | 4 | 5

LICENSEE CODE 4 15 LICENSE NUMBER 15 18 LICENSE TYPE 20 27 CAT 28

CON'T

0 1 | R | E | P | O | R | T | S | O | U | R | C | E | L | 0 | 5 | 0 | 0 | 0 | 2 | 5 | 0 | 7 | 1 | 1 | 0 | 6 | 8 | 2 | 3 | 1 | 1 | 2 | 0 | 8 | 2 | 9

REPORT SOURCE 30 31 DOCKET NUMBER 38 39 EVENT DATE 74 75 REPORT DATE 30

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | During normal operation, while in the process of transferring laundry water to

0 3 | a monitor tank, the monitor tank overflowed. Some of the overflow water

0 4 | backed up the drain header to the component cooling water pump area and may

0 5 | have entered the area via a floor cleanout opening. Some of this water could

0 6 | have entered the storm drain system from other normal drains in this room.

0 7 | The health and safety of the public was not affected. This is reportable

0 8 | in accordance with TS6.9.2.a.6. A similar LER was reported as LER-250-81-05.

0 9 | SYSTEM CODE | CAUSE CODE | CAUSE SUBCODE | COMPONENT CODE | COMP TUBCODE | VALVE SUBCODE

M | A | 11 | A | 12 | B | 13 | X | X | X | X | X | X | 14 | Z | 15 | Z | 16

17 | LER/RO REPORT NUMBER | EVENT YEAR | SEQUENTIAL REPORT NO. | OCCURRENCE CODE | REPORT TYPE | REVISION NO.

8 | 2 | 0 | 1 | 4 | 0 | 1 | T | 0

ACTION TAKEN | FUTURE ACTION | EFFECT ON PLANT | SHUTDOWN METHOD | HOURS | ATTACHMENT SUBMITTED | NPRO-4 FORM 518 | PRIME COMP SUPPLIER | COMPONENT MANUFACTURER

H | G | Z | Z | 0 | 0 | 0 | 0 | Y | N | Z | Z | 9 | 9 | 9 | 9 | 25

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | The root cause was procedural violation by plant personnel while performing

1 1 | the transfer of water. The evolution was immediately terminated. The monitor

1 2 | tank was taken out of service for a level instrumentation channel check. The

1 3 | floor opening was capped. Additional corrective actions are being taken.

1 4 | _____

1 5 | FACILITY STATUS | % POWER | OTHER STATUS | METHOD OF DISCOVERY | DISCOVERY DESCRIPTION

E | 33 | 10 | 0 | 39 | N/A | A | 37 | Operator observation

1 6 | ACTIVITY CONTENT | AMOUNT OF ACTIVITY | LOCATION OF RELEASE

L | 32 | M | 34 | 9.96E-5 Curies Total | Area surrounding monitor tank

1 7 | PERSONNEL EXPOSURES | DESCRIPTION

0 | 0 | 0 | 37 | Z | 38 | N/A

1 8 | PERSONNEL INJURIES | DESCRIPTION

0 | 0 | 0 | 40 | N/A

1 9 | LOSS OF OR DAMAGE TO FACILITY | DESCRIPTION

Z | 42 | N/A

2 0 | PUBLICLY ISSUED DESCRIPTION | N/A

N | 44 | N/A

NAME OF PREPARER J. Arias, Jr. PHONE: (305) 245-2910, Ext. 353

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Additional Event Description and Probable Consequences

During normal operation, an evolution was in progress to transfer laundry water to the "B" monitor tank. The monitor tank overflowed to the Waste Holdup Tank drain system, but the pipe size to the Waste Holdup Tank was not sufficient to handle the amount of overflow. As a result, some of the overflow backed up into the component cooling water pump area and may have gone into the storm drain system. A survey of the area revealed no significant levels of contamination. The volume of water which overflowed could not be determined; however, it is bounded by the volume of the laundry tanks - 600 gallons. A sample taken from the area surrounding the monitor tank revealed that the concentration of radionuclides in the water was $4.691 \text{ E-}7 \text{ } \mu\text{Ci/ml}$ for Co-58, $2.152 \text{ E-}6 \text{ } \mu\text{Ci/ml}$ for Co-60, $6.205 \text{ E-}7 \text{ } \mu\text{Ci/ml}$ for Cs-134 and $1.191 \text{ E-}6 \text{ } \mu\text{Ci/ml}$ for Cs-137, which is well below the limits specified in 10 CFR 20 Appendix B Table II, Column 2. This is considered reportable pursuant to TS 6.9.2.a.6. The health and safety of the public was not, at any time, affected. A similar LER was reported as LER 250-81-05.

Additional Cause Description and Corrective Actions

Upon discovery of the overflow, the transfer of laundry water was immediately terminated. Water, spilled as a result of the overflow, was confined to the safety injection pump room, the component cooling water pump area for Unit #3, and potentially a storm drain system. The maximum activity of the spill was $10 \text{ } \mu\text{Ci}$. This activity is based on a sample taken from the monitor tanks surrounding area. Control and clean up of the contaminated areas was promptly initiated. The "B" monitor tank was removed from service for a channel check of the level instrumentation. Results of the check revealed that the level instrumentation was not the cause of the overflow. The root cause appears to be procedural violation, in that, written procedures, covering the evolution of laundry water transfer, instruct non-licensed Operations personnel to monitor tank levels at all times while the evolution is taking place.

A review of the event was conducted and based on the findings, the following determinations were made:

1. The reason the floor clean out drain opening was uncapped could not be determined.
2. Operating Procedure 5120 has been revised to administratively limit the filling of the monitor tanks above 90% of total tank level.
3. The floor clean out drain opening has been re-capped and a further review of drains in the component cooling water pump area has been made.
4. Further corrective actions to be taken are as follows:
 - A. Procedure compliance while performing evolutions in which potentially radioactive water is to be transferred, will be emphasized to the non-licensed Operations personnel involved in this occurrence.
 - B. Modify written procedures such that the Plant Supervisor-Nuclear or Nuclear Watch Engineer will be notified of the intent to transfer water to the monitor tanks. Under the discretion of the Plant Supervisor-Nuclear or Nuclear Watch Engineer, non-licensed Operations personnel will be authorized to commence the requested evolution.