LICENSEE EVENT REPORT

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

01 | WIKNP1 (2) 00-0000-00 (3) 4 | 1111 (4) [ ] (5)
LICENSEE CODE | LICENSE NUMBER | LICENSE TYPE | CAT

CON'T
01 | REPORT SOURCE L (6) | 05000305 (7) | 030883 (8) | 040783 (9)
DOCKET NUMBER | EVENT DATE | REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 | During full power operation, after completing a containment vent, RM 11/12 sample point
03 | was not switched from the vent position to the containment position. This caused the
04 | RC leak detection system which is sensitive to radioactivity to be inoperable for longer
05 | than 12 hours. Since T.S. 3.1.d.5 only allows this system to be inoperable for 12 hours,
06 | this is reportable per T.S. 6.9.2.a.2. Since the redundant equipment used for monitor-
07 | ing RCS leakage was operable, there was no effect on the health and safety of the
08 | public or plant operation.

09 | SYSTEM CODE CI (11) | CAUSE CODE A (12) | CAUSE SUBCODE A (13) | COMPONENT CODE ZZZZZZ (14) | COMP. SUBCODE Z (15) | VALVE SUBCODE Z (16)

(17) LER/RO REPORT NUMBER: EVENT YEAR 83 | — | SEQUENTIAL REPORT NO. 007 | / | OCCURRENCE CODE 01 | REPORT TYPE T | — | REVISION NO. 0

ACTION TAKEN H (18) | FUTURE ACTION G (19) | EFFECT ON PLANT Z (20) | SHUTDOWN METHOD Z (21) | HOURS 0000 (22) | ATTACHMENT SUBMITTED Y (23) | NPRD-4 FORM SUB. N (24) | PRIME COMP. SUPPLIER Z (25) | COMPONENT MANUFACTURER Z9999 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 | R11/12 sample point was not switched from the vent position to the containment position.
11 | Immediately after this discovery, the operator switched R11/12 to monitor containment.
12 | All shift supervisors reviewed the procedures associated with venting and the need to
13 | be more attentive to control board indications and switch positions. The associated
14 | procedures will be reviewed for possible corrective action.

15 | FACILITY STATUS E (28) | % POWER 100 (29) | OTHER STATUS (30) NA | METHOD OF DISCOVERY A (31) | DISCOVERY DESCRIPTION (32) Operator observation

16 | ACTIVITY RELEASED Z (33) | CONTENT OF RELEASE Z (34) | AMOUNT OF ACTIVITY (35) NA | LOCATION OF RELEASE (36) NA

PERSONNEL EXPOSURES
17 | NUMBER 000 (37) | TYPE Z (38) | DESCRIPTION (39) NA

PERSONNEL INJURIES
18 | NUMBER 000 (40) | DESCRIPTION (41) NA

LOSS OF OR DAMAGE TO FACILITY (43)
19 | TYPE Z (42) | DESCRIPTION NA

PUBLICITY
20 | ISSUED N (44) | DESCRIPTION (45) NA

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PDR ADOCK 05000305
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NRC USE ONLY

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ATTACHMENT TO LER 83-007

R11/R12 Monitor Misalignment Following Venting

Description of Occurrence:

On March 7, 1983, the Containment was vented in order to maintain the Containment pressure below the Tech Spec limit of 2.0 psig. During venting, R11/R12 is lined up to monitor the vent path. Subsequent to the venting operation, R11/R12 was not returned to the containment monitoring position. A subsequent shift check (SP 87-125) did not catch the misalignment and therefore, the 12 hour time limit allowed by T.S. 3.1.d.5 was exceeded. The misalignment was found and corrected on the following morning, March 8, 1983, at about 8:00 a.m.

Safety Considerations:

During the period of time (approximately 17 hours) that R-11 and R-12 was lined up to the vent path instead of containment, there was not a radiation sensitive leak detection system, sensitive to low leak rates available. There were however, several other available leak detection systems sensitive to RCS leakage in Containment, thus minimizing the significance of the loss of R-11 and R-12. The systems available were: containment sump indication, humidity detection, mass balance indication (charging versus letdown), and containment area monitoring. In addition, a grab sample was taken on the evening of March 7th which did not reveal any unusual activity.

Tech Spec surveillance requirements also require the containment air particulate monitor and radiogas monitor to continuously sample containment while the reactor is in operation. Continuous sampling would ensure prompt detection of RCS leakage in containment. With R-11 and R-12 unknowingly out of service, alternate monitoring was not put in service. However, with the above leak detection systems in service, any significant leakage should have been detected promptly.

Corrective Actions:

Immediate corrective action taken was to realign R-11 and R-12 to the containment. In addition, each of the shift supervisors reviewed with their shifts the importance of closely monitoring control board indications and performing shift surveillance SP 87-125.

Long term corrective action will be to review and revise SP 32B-116 to be more compatible with Operating Procedure N-RBV-18B and to include check off's for placing R-11 and R-12 back in alignment with containment. Other release permits will be reviewed for similar upgrading.