Update Report: Previous Report Date - January 6, 1984

NRC FORM 366 (12-81) 10 CFR 50

U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

APPROVED BY OMB 3150-0011

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

0 1	LICENSEE CODE: P A S E S 1 (2)	LICENSE NUMBER: 0 0 - 0 0 0 0 0 - 0 0 (3)	LICENSE TYPE: 4 1 1 1 1 (4) CAT (5)

CON'T

0 1	REPORT SOURCE: L (6)	DOCKET NUMBER: 0 5 0 0 0 3 8 7 (7)	EVENT DATE: 1 2 0 9 8 3 (8)	REPORT DATE: 0 2 2 8 8 4 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 Between December 4 thru 9, 1983, the alarms/indication/records for the sample flow
0 3 rate of the Standby Gas Treatment Vent Radiation Monitor was lost. A Micropro-
0 4 cessor analyzing the flow rate data failed; the word "Normal" was printed for the
0 5 channel output during each daily surveillance. When discovered, LCO per T.S.
0 6 3.3.7.11 was entered, the microprocessor was replaced and the system returned to
0 7 service. During the event, sample flow was not l[illegible]t and all other alarms/indica-
0 8 tion/printouts functioned properly. There was no effect on public health & safety.

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
0 9	S C (11)	E (12)	G (13)	I N S T R U (14)	Y (15)	Z (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 3	—	1 6 8	/	0 3	X	—	1

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER (26)
A (18)	Z (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	A (25)	E 0 7 0

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of this event was the failure of the microprocessor, which was replaced.
1 1 The daily surveillance procedure is being changed to give the operator more in-
1 2 formation to interpret the output and to ensure that the word "Normal" is not re-
1 3 lied upon as the sole indicator of channel condition.
1 4

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1 5	G (28)	0 0 0 (29)	NA	B (31)	Surveillance Test

	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
1 6	Z (33)	Z (34)	NA	NA

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION (39)
1 7	0 0 0 (37)	Z (38)	NA

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
1 8	0 0 0 (40)	NA

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
1 9	Z (42)	NA

8403020315 840228
PDR ADOCK 05000387
S PDR

PUBLICITY

	ISSUED	DESCRIPTION (45)
2 0	N (44)	NA

NRC USE ONLY

NAME OF PREPARER B.L. Wilks PHONE (717)542-2181, X3239

ATTACHMENT

LER # 83-168/03X-1

Pennsylvania Power & Light Company
Susquehanna Steam Electric Station
Docket Number: 50-387

On December 9, 1983, it was discovered that the channel monitoring sample flow rate (one of eleven channels on the Eberline Control Terminal) for the Standby Gas Treatment Vent Radiation Monitor was not functioning properly; an LCO was entered in accordance with T.S. 3.3.7.11. At this time, the sample flow rate measured by the Air Monitor Panel was approximately 1 cfm, which was normal for the vent flow rate at the time. The sample flow rates taken in accordance with Technical Specification at four hours intervals were normal.

Investigations of recorded data from December 4 indicated that requests for data from the channel resulted in '0.00 E+00' cfm being printed by the control terminal. The PRINT, ALLSTAT, ENTER command (the command used for daily surveillance) list channel 11 (sample flow rate) as NORMAL. No alarms accompanied the zero flow recorded by the control terminal. All evidence indicates that the particulate, iodine, noble gas and vent flow channels of the SBGTS vent monitor continued to operate properly. History files and data requested from these channels were normal during the time the sample flow channel was inoperable. According to the control terminal printout, alarm functions for the other channels were operable.

Some of the alarms or status changes recorded during this time were:

a. CK SRCI (check source) on Channels 01,03,05,06,07 and 09.
b. TRN ALM (trent alarm) on Channel 0603.
c. ALT ALM (alart alarm) on Channel 0601 (This was an invalid alarm which occurs routinely on +0.00 E+00.
d. FLUSH on Channels 01,03,04,05,06,07, and 09 (This status change occurred during changeout of iodine cartridge and particulate filter and cleared when flush was stopped.)

The weekly particulate filter and iodine cartridge installed in the monitor on December 2, 1983, and removed on December 9, 1983 showed levels lower than detectable when counted.

Analysis indicates sample flow was not lost between December 2 and 9, 1983 as evidenced by the noble gas concentration recorded during this time for the period during which sample flows are not available, estimated sample flow rates can be calculated based on vent flow rates and will be used for the determination fo release rates from the vent.

The failure of the alarms, indication and records for the Standby Gas Treatment Vent Radiation Monitor sample flow rate was caused by the microprocessor analyzing the data. The microprocessor was replaced and the control terminal was returned to service.

The acceptance criteria for the channel checks has been revised to provide the operator with more information in determining operability. Additional changes to acceptance criteria are being considered and will be implemented as necessary to improve the information available to the operator.

During this event there was no effect on public health and safety.

PP&L Pennsylvania Power & Light Company
Two North Ninth Street • Allentown, PA 18101 • 215/770-5151

February 28, 1984

U.S. Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

SUSQUEHANNA STEAM ELECTRIC STATION
LICENSEE EVENT REPORT 83-168/03X-1
ER 100450 FILE 841-23
PLA-2105

Docket No. 50-387
License No. NPF-14

Attached please find a copy of Licensee Event Report No. 83-168/03X-1. This event was orginally determined to be reportable per Technical Specification 6.9.1.9.c on January 6, 1984 in that, alarms and indications for the sample flow rate of the Standby Gas Treatment Vent Radiation Monitor was lost without notification and went undetected between December 4 and 9, 1983. Revision 1 of this Licensee Event Report provides additional information concerning the corrective actions to be taken as a result of the event.

H.W. Keiser
Superintendent of Plant-Susquehanna

BLW/pjg

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