

ABNORMAL RELEASES

There were a total of two (2) abnormal releases for 2007. The 2007 abnormal releases are summarized below:

1. Leak in Waste Gas System

On 10/16/07 during data review, operations noted a negative trend in total volume for the routine Waste Gas System inventory. Further investigation determined that a Waste Gas Decay Tank Release had not occurred for an atypical length of time. Ventilation monitor trend plots and weekly gas grabs were reviewed and indicated no activity. It was determined that a very small leak had been present for as much as 6 months. Engineering determined that approximately 3,000 cubic feet of waste gas was lost.

Cause: Leakage was identified at the Gas Analyzer Panel pump. The Gas Analyzer was isolated until repairs could be performed. Leakage stopped. From this location all release would have exited through Unit One Auxiliary Building Ventilation.

Corrective

Action: 129 Waste Gas Decay Tank (WGDT), the inservice tank, was sampled for nuclide mix. The identified mix was used in the release calculations but, activity levels were determined to be unrepresentatively low, due to the extended time period of release.

Activity levels of the identified mix were extrapolated to the level of the sample taken for a last WGDT release performed prior to the leak:

Nuclide	uCi Released	Gamma Dose (mrad)	Beta Dose (mrad)
Ar-41	1.08E+02	1.08E-06	3.80E-07
Kr-85	9.59E+04	2.00E-04	1.77E-06
Kr-85M	7.62E+01	1.61E-07	1.00E-07
Xe-133	2.44E+04	2.74E-04	9.22E-05
Xe-135	1.32E+03	3.48E-06	2.72E-06
TOTAL		4.79E-04	9.72E-05
H3	1.26E+03 uCi	2.16E-06 mrem	

Activity was applied to abnormal release file RAC0193, as a Unit One Auxiliary Building Release. Release duration was conservatively set at 1 week and total dose was applied to the month of October, the 4th Quarter.

Event was captured in the site's Action Request System: CAP-01115005. Repairs were accomplished and the Gas Analyzer was returned to service.

Result: The dose from the activity released represented a small percentage of the total dose and was a very small percentage of limits. The dose did not impose upon the health and safety of the public.

The event was reported to the NRC Region 3 Radiation Protection (RP) Inspector, at the time of the event.

2. Leaking 11 Steam Generator Relief

On 6/17/07, while performing a surveillance procedure on 11 Steam Generator Safety Relief, CV-31084 did not completely reseal. Discharge piping temperatures increased. The isolation was shut and the valve was stroked in an attempt to reset. It was determined that CV-31084 did reseal as evidenced by decreasing downstream temperatures.

Cause: CV-31084 did not fully reseal during performance of surveillance procedure. When the valve was unisolated, following performance of the SP, it leaked.

Corrective

Action: CV-31084 was reisolated and stroked. Leakage ended. Work Request #25903 was issued.

Engineering provided a volume released. Based on this volume it was determined that a one second release with the valve full open would conservatively represent the release volume.

The Steam Generators were sampled and a release file was created to document the release.

The dose consequences were determined to be:

H3 1.53E+01 uCi 2.6E-09 mrem

Activity was applied to abnormal release file RAB0060, as an 11 Steam Generator Steam Release.

Event was captured in the site's Action Request System: CAP-01097198.

Result: The dose from the activity released represented a small percentage of the total dose and was a very small percentage of limits. The dose did not impose upon the health and safety of the public.

The event was reported to the NRC Region 3 Radiation Protection (RP) Inspector, at the time of the event.