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ACCESSION NBR:8712290098 DOC.DATE: 87/12/21 NOTARIZED: NO DOCKET #
 FACIL:50-263 Monticello Nuclear Generating Plant, Northern States 05000263
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SUBJECT: LER 87-024-00:on 871121,false assumption of test completion
 causes missed sampling for inoperative process monitor.
 W/8 ltr.

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 TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

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INTERNAL:	ACRS MICHELSON		1	1		ACRS MOELLER		2	2
	AEOD/DOA		1	1		AEOD/DSP/NAS		1	1
	AEOD/DSP/ROAB		2	2		AEOD/DSP/TPAB		1	1
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	NRR/DEST/ADS		1	0		NRR/DEST/CEB		1	1
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	REG FILE 02		1	1		RES DEPY GI		1	1
	RES TELFORD, J		1	1		RES/DE/EIB		1	1
	RGN3 FILE 01		1	1					
EXTERNAL:	EG&G GROH, M		5	5		FORD BLDG HOY, A		1	1
	H ST LOBBY WARD		1	1		LPDR		1	1
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LICENSEE EVENT REPORT (LER)

Expires 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Monticello Nuclear Generating Plant	10 15 10 10 10 2 6 3 1	OF 0 3

TITLE (4)	False Assumption of Test Completion
Causes Missed Sampling for an Inoperative Process Monitor	

EVENT DATE (5)	LER NUMBER (6)	REPORT DATE (7)	OTHER FACILITIES INVOLVED (8)
MONTH DAY YEAR	SEQUENTIAL REVISION	MONTH DAY YEAR	FACILITY NAMES DOCKET NUMBERS
	NUMBER NUMBER		
1 1 8 7 8 7 - 0 2 4 - 0 0		1 2 2 1 8 7	10 5 10 10 10 1

OPERATING MODE (9)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following)(11)
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POWER LEVEL (10)	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
	20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
	20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER
	20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	(Specify in
	20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	Abstract
	20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	below and
				in Text, NRC Form 366A)

LICENSEE CONTACT FOR THIS LER (12)
NAME
TELEPHONE NUMBER
AREA CODE

Ellis Pfeffer, Radiation Protection Specialist	6 1 2 2 9 5 - 5 1 5 1
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)
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CAUSE	SYSTEM	COMPONENT	MANUFAC TURE	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFAC TURE	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)	EXPECTED	MONTH	DAY	YEAR
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YES (If yes, complete EXPECTED SUBMISSION DATE)	NO	SUBMISSION DATE (15)
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ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)
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During a routine plant shutdown and refueling outage, the Service Water Discharge Pipe Gross Radioactivity Monitor (SWDPGRM) was found to have been in an inoperable condition without grab samples being collected for longer than 8 hours time.

The missed sample was due to personnel error when the Shift Chemistry Radiation Protection Specialist (RPS) requested completion of the monitor operability test, but did not verify that a functional test required to clear an inoperable condition on the Service Water Monitor had been completed, before he secured his sampling routine.

After investigation of the circumstances, the RPS realized that informal communications had caused required samples to be missed. He then resumed 8 hour sampling. The situation was discussed in detail with his supervisors. He was counseled concerning proper shift turnover and surveillance verification. Applicable logs and procedures are being reviewed for possible revision to assist in preventing future occurrences of this nature.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)	PAGE (3)
Monticello Nuclear Generating Plant	05000263	YEAR SEQUENTIAL REVISION NUMBER NUMBER 87 - 024 - 00 02 OF 03	

TEXT (If more space is required, use additional NRC Form 366A's) (17)

DESCRIPTION

On November 21, 1987, at 2115 hours Central Standard Time (CST), it was discovered that the Service Water Discharge Pipe Gross Radioactivity Monitor (SWDPGRM) had been in an inoperable condition for eighteen and one-half hours without a grab sample being collected. The Reactor was in the shutdown mode and was shutdown at the time of the event. Technical Specifications Table 3.8.1 specifies that when the minimum channels are inoperable service water discharge may continue for up to 30 days provided that at least once every 8 hours a grab sample is collected and analyzed for gross beta and gamma radioactivity at an LLD of 1.0E-7 uci/ml.

Surveillance Test #346b, Liquid Process Monitor Grab Sampling, had been initiated at 0400 hours CST on November 10, 1987, due to loss of the Service Water Sample Pump. At 0300 hours CST on November 21, 1987, a Service Water Sample was collected and analyzed. Results were less than the LLD of 1.0E-7 uci/ml.

At 1030 hours CST, the 8 hour grab sample requirements had been discontinued. It was assumed that requested operability testing requirements had been successfully completed at this time and that the SWDPGRM was fully operable. The mistake was discovered at 2115 hours CST when the Shift Chemistry Radiation Protection Specialist (RPS), during the course of a discussion with a licensed operator, realized that the monitor was not fully operative. An investigation of the monitor status verified this condition. The Shift Chemistry RPS resumed 8 hour sampling requirements at 2130 hours CST that evening. A sample was collected and analyzed with the results less than the LLD of 1.0E-7 uci/ml. A review of discharge canal monitors verified that no discharge of radioactive liquids had occurred during the missed sample interval.

CAUSE

The root cause of this event was personnel error. There was no unusual characteristics of the work location that directly contributed to the error. It did not result from an error in an approved procedure or non-adherence. After maintenance activities had been completed on the 24 VDC system on November 21, 1987, the Plant Operations group completed Part I (the front panel checks) of Surveillance Test #0289a, the functional test for the Service Water Monitor. The Shift Chemistry RPS then performed Part II (radiation response check) of same test and returned the test to the Operations group with the understanding that Part III (sample flow verification) would be completed by Operations. Part III was not completed until the morning of November 24, 1987. It was assumed that completion of this test had returned the Service Water Monitor to an operable condition. This information was passed on at the Shift Chemistry RPS turnover that morning and the 8 hour grab sampling requirements were discontinued. This was a cognitive error in that the RPS failed to verify that the system was fully operable and was imprecise in communicating the details of the in-progress test to his relief.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL	REVISION	
		NUMBER	NUMBER	NUMBER	
Monticello Nuclear Generating Plant	050002 63	87	-	-	03 OF 03

TEXT (If more space is required, use additional NRC Form 366A's) (17)

ANALYSIS

Missing two required eight-hour samples while the service water monitor was inoperable potentially would have delayed recognition had a leakage of low level radioactivity into the service water system occurred. The Discharge Canal Liquid Process Monitor was operable and would have detected significant activity released to the discharge canal. The samples collected and analyzed immediately prior to and after the incident have been less than LLD of $1.0E-7$ uci/ml. This event could not have had more severe consequences regardless of initial conditions.

CORRECTIVE ACTION

The situation was discussed with the RPS who made the personnel error. Operations Daily Log Part D will be revised to include a requirement to perform a once per shift alarm check on Service Water sample flow (SWSF) to alert the Shift Chemistry RPS should the SWDPGRM become inoperable due to loss of sample flow. Surveillance Test #0289a will be revised so that the Operations group performs the front panel checks and sample flow checks as Part I and II. The RPS will then perform the radiation response check as Part III. Operations Manual Section B.5.11 will be revised to include an annunciator response procedure for loss of SWSF and guidance to operations personnel in the event operability requirements are not satisfied. This event, along with the proposed revisions, will be discussed with all members of the chemistry group at the next weekly group meeting and implemented as part of scheduled operations group training.

ADDITIONAL INFORMATION

Failed Component Identification

None

Previous Similar Events

None



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December 21, 1987

Report Required by
10 CFR Part 50, Section 50.73

US Nuclear Regulatory Commission
Attn: Document Control Desk
Washington DC 20555

MONTICELLO NUCLEAR GENERATING PLANT
Docket No. 50-263 License No. DPR-22

False Assumption of Test Completion Causes
Missed Sampling for an Inoperative Process Monitor

The Licensee Event Report for this occurrence is attached.

for Monica Vlk
David Musolf
Manager - Nuclear Support Services

c: Regional Administrator-III, NRC
NRR Project Manager, NRC
Resident Inspector, NRC
MPCA
Attn: J W Ferman

Attachment

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