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RECIP.NAME RECIPIENT AFFILIATION
Region 2, Atlanta, Office of the Director

SUBJECT: LER 80-007/03L-0:on 800428,vent gas particulate, & iodine monitors considered inoperable due to failure to perform periodic surveillance on schedule.Caused by personnel error. Status board for periodic surveillance items will be kept.

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TITLE: Incident Reports

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U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

EXHIBIT A

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

Line	Field	Value
0 1	Licensee Code (2)	S C N E 3
0 1	License Number (3)	0 0 - 0 0 0 0 0 - 0 0
0 1	License Type (4)	4 1 1 1 1
0 1	CAT (5)	
0 1	CON'T Report Source (6)	L
0 1	Docket Number (7)	0 5 0 0 0 2 8 7
0 1	Event Date (8)	0 4 2 8 8 0
0 1	Report Date (9)	0 5 2 8 8 0

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 It was determined that the Oconee 3 unit vent gas, particulate, and iodine
0 3 monitors were considered to be inoperable as a result of failure to perform
0 4 periodic surveillance on schedule during a Reactor Building purge while the
0 5 unit was at cold shutdown. Since testing verified that the monitors were
0 6 operable and since daily samples were taken as required by Technical Specifica-
0 7 tions, this incident was not significant with respect to safe operation and the
0 8 health and safety of the public were not affected.

Line	System Code (11)	Cause Code (12)	Cause Subcode (13)	Component Code (14)	Comp. Subcode (15)	Valve Subcode (16)
0 9	M C	A	C	I N S T R U	E	Z

LER/RO Report Number (17)	Event Year		Sequential Report No.		Occurrence Code	Report Type		Revision No.
	8 0	—	0 0 7	/	0 3	L	—	0

Action Taken (18)	Future Action (19)	Effect on Plant (20)	Shutdown Method (21)	Hours (22)	Attachment Submitted (23)	NPRD-4 Form Sub. (24)	Prime Comp. Supplier (25)	Component Manufacturer (26)
E	G	Z	Z	0 0 0 0	Y	N	Z	Z Z Z Z

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The surveillance procedure failed to be completed on schedule due to personnel
1 1 error. A status board for periodic surveillance items will be kept. Appro-
1 2 priate personnel will be given written notice regarding the necessity for per-
1 3 forming required surveillance during outages. Further assurance will be pro-
1 4 vided by forwarding completed procedures to appropriate individuals for review.

Line	Facility Status (28)	% Power (29)	Other Status (30)	Method of Discovery (31)	Discovery Description (32)
1 5	G	0 0 0	NA	B	Performance of Periodic Surveillance

Line	Activity Released (33)	Content of Release (34)	Amount of Activity (35)	Location of Release (36)
1 6	Z	Z	NA	NA

PERSONNEL EXPOSURES

Line	Number (37)	Type (38)	Description (39)
1 7	0 0 0	Z	NA

PERSONNEL INJURIES

Line	Number (40)	Description (41)
1 8	0 0 0	NA

LOSS OF OR DAMAGE TO FACILITY (43)

Line	Type (42)	Description
1 9	Z	NA

PUBLICITY

Line	Issued (44)	Description (45)	NRC USE ONLY
2 0	N	NA	

NAME OF PREPARER S. R. Lewis PHONE: (704) 373-8285

8006020343

DUKE POWER COMPANY
OCONEE UNIT 3

Report Number: RO-287/80-7

Report Date: May 28, 1980

Occurrence Date: April 28, 1980

Facility: Oconee 3, Seneca, South Carolina

Identification of Occurrence: Gaseous Waste Releases Made While Gas Monitors Considered Inoperable

Conditions Prior to Occurrence: Cold Shutdown

Description of Occurrence:

A number of gaseous waste releases were made between April 3, 1980 and April 17, 1980 in order to purge the Oconee 3 Reactor Building (RB) while the unit was at cold shutdown. On April 28, 1980 it was determined that the surveillance procedure for the unit vent gas, iodine and particulate monitors, along with three other instrument procedures, had been performed more than 45 days after the previous performance. Thus, the unit vent monitors were considered inoperable from April 4, 1980, when the maximum allowable surveillance period ended, to April 21, when the surveillance was performed. Oconee Nuclear Station Technical Specification 3.10.7 requires that gases discharged through the unit vent be continuously monitored or that appropriate grab samples be taken and analyzed daily. The RB purge was the only scheduled release during that period, and an RB grab sample was taken and analyzed daily.

Apparent Cause of Occurrence:

The monitors were declared inoperable as a result of failure of the periodic surveillance to be performed within the required interval. Two of the four instrument procedures, including the procedure for the unit vent monitors, were believed to have been completed on schedule, although the completed procedures could not be found among the outage planning documentation. It was not determined until after the surveillance periods had elapsed that the procedures had not been completed. The remaining two procedures failed to be performed as required due to the unavailability of appropriate personnel as a result of outage-related work in progress at the time the surveillance was required.

Analysis of Occurrence:

Although the monitors were considered inoperable due to failure to perform periodic surveillance on schedule, they were operable and would have performed their intended functions, as verified when surveillance was performed on April 21. In addition, daily samples were taken from the RB atmosphere and from the unit vent. This incident constituted operation in a degraded mode permitted by a limiting condition for operation and must therefore be reported pursuant to Technical Specification 6.6.2.1.b(2), although it is not considered to be significant with respect to safe operation, and the health and safety of the public were not affected.

Corrective Action:

All four surveillance procedures were completed by April 21, 1980. No corrective action was required in order to restore the monitors to operable status. In order to preclude the recurrence of this type of incident, several actions will be taken. A status board indicating when each periodic surveillance item is due will be kept and used in developing the daily schedule. Appropriate personnel will be given written notice regarding the importance of performing procedures required by the Technical Specifications, even during outages. Periodic procedures will be forwarded directly to the appropriate personnel for verification and review. In addition, an attempt will be made to decrease the time between the printing of the periodic test schedule and its receipt by appropriate individuals.