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FACIL:50-275	Diablo Canyon Nuclear Power Plant, Unit 1, Pacific Ga 05000)275
AUTH.NAME	AUTHOR AFFILIATION	
MALONE, D.D.	Pacific Gas & Electric Co.	
SHIFFER, J.D.	Pacific Gas & Electric Co.	
RECIP.NAME	RECIPIENT AFFILIATION	

SUBJECT: LER 88-031-00:on 881226, liquid radwaste discharge w/radiation monitor RM-18 inoperable due to personnel error. W/8 ltr. PEREPART OF THE A SIZE: 7

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NRC Form 306A (9-83)	LICENSEE EVENT REPORT (LER) TEXT CONTINUATION							
FACILITY NAME (S)		DOCKET NUMBER (2)	<u> </u>	LER NUMBER (6)		PAGE (3)		
			YEAR	SEQUENTIAL S RE	UNDER			
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I. PLANT CONDITIONS

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Units 1 and 2 were in Mode 1 (Power Operation) at 100% power.

II. DESCRIPTION OF PROBLEM

A. Problem:

On December 26, 1988, at approximately 1700 PST, in preparation for discharging chemical drain tank (CDT) 0-2, predischarge liquid sample results were provided to the Auxiliary Building auxiliary operator (AO) and an independent valve alignment of the discharge flow path was performed by the chemistry technician, Auxiliary Building Senior AO, and the Unit 1 AO. In addition, a functional check of the liquid radwaste (WD) discharge radiation monitor (RM) RM-18 and functional check of discharge valves (WD)(V) RCV-18/FCV-477 were performed by the Auxiliary Building Senior AO between 1701 and 1704 PST. The valve alignment and functional check were performed in accordance with Operating Procedure (OP) G-1:II, "Liquid Radwaste System - Processing and Discharge of Liquid Radwaste."

On December 26, 1988, at 1705 PST, discharge permit No. 88-389 was authorized by the Unit 1 Shift Foreman (SFM) and given to the Auxiliary Building Senior AO.

On December 26, 1988, between 1720 and 1736 PST, CDT 0-2 discharge was completed and at 1753 PST the discharge permit was returned to the SFM for his signature.

On December 26, 1988, at 1805 PST, the Unit 1 Control Operator observed that the Rad Monitor System Failure (PK11-22) and Rad Monitor System in Test (PK11-23) alarms were active with no known testing in progress. The Control Operator directed the Assistant Control Operator (ACO) to verify the status of the radiation monitors. The ACO discovered that the operation selector switch for RM-18 was in the RESET position, thus making RM-18 inoperable. It was determined that the RM-18 operation selector switch was inadvertently left in the RESET position during the functional check performed prior to discharge No. 88-389, and that RM-18 was therefore inoperable during discharge. This inoperability was reported to the shift foreman who then directed that a postdischarge CDT 0-2 sample be analyzed.

Technical Specification (TS) 3.3.3.9 requires that RM-18 be OPERABLE during liquid radwaste discharges. Action 40 of Table 3.3-12 allows discharges when RM-18 is inoperable provided two independent samples are collected and analyzed prior to the discharge. Since RM-18 was

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bi	Β.	Inoper	able compo	onents, or	systems	that contril	outed to t	he event:		
		Liquid inoper	radwaste able cond	discharge ition foll	monitor owing the	RM-18 was in predischarg	nadvertent ge functio	ly left in a nal check.	n	
	с.	Dates	and approx	cimate tim	es for ma	jor occurrer	nces:			
		1. De	cember 26	, 1988, at	1701 PST	operato selecto positio	or leaves or switch on followi charge fun	in RESET ng		
·		2. De	cember 26	, 1988, at	1720 PST	0-2 ini inopera	itiated wi able. Dis		т	
		3. De	cember 26	, 1988, at	1808 PST	Contro alarms inopera to the	l Operator and finds	18 returned ode and	e _.	
		4. De	cember 26	, 1988, at	1924 PST	on CDT	0-2 found tent with	mple results to be predischarge		
	D.	Other	systems o	r secondar	y functio	ns affected	:			,
		None.				ų				
	E.	Method	of disco	very:						
• • •		associ testin	ated with g in prog he operat	the radia ress. Whe	tion moni	that contro tors were a itors were (for RM-18)	ctive with checked, i	no known t was found		

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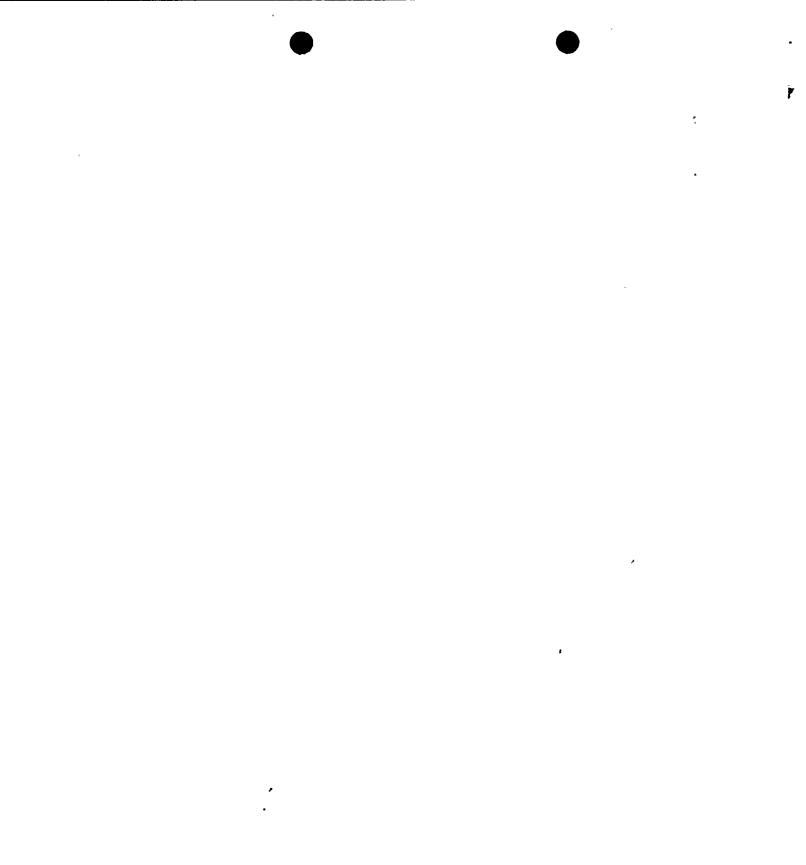
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RC Form 366A 83}	LICENSEE EVENT REPORT (LER) TEXT CONTINUATION APPROVED ONB NO 3150-0104
	LICENSEE EVENT REPORT (LER) TEXT CONTINUATION APPROVED OMB NO 3150-0104 EXMIRES 8/31/88
CILITY NAME (1)	DOCKET NUMBER (2) LER NUMBER (6) PAGE (3) VEAR SEQUENTIAL REVISION NUMBER - NUMBER
	ANYON UNIT 1 0 5 0 0 0 2 7 5 8 8 -0 3 1 -0 0 0 4 0F 0 6
F.	Operator actions:
	The mode selector switch for RM-18 was returned to the OPERATE position. The Shift Foreman was notified of the discovery that RM-18 had been inoperable during the discharge of CDT O-2. The Shift Foreman requested that a CDT O-2 postdischarge sample be taken and analyzed.
G.	Safety System Responses:
	None.
TTT. CALL	SE_OF_THE_PROBLEM
	Immediate Cause:
Α.	
*	The immediate cause of the problem was that the RM-18 operation selector switch had been left in the RESET position, which rendered RM-18 inoperable, during the discharge of CDT 0-2.
Β.	Root Cause:
	The root cause of the event was determined to be personnel error, cognitive, in that a non-licensed senior auxiliary operator did not adequately verify that the RM-18 operation selector switch was returned to OPERATE following performance of the predischarge functional check.
	An additional cause was that the operator performed the RM-18 functional check without having the procedure OP G-1:II in-hand. This procedure governing liquid radwaste discharges contains steps which verify that all alarms have cleared once the monitor is returned to the OPERATE mode. These checks were not performed. During discussions with the operator following the event, the operator stated that he did not believe that he was required to have the procedure "in hand" since the functional check of RM-18 was a relatively simple routine task. Nuclear Plant Administrative Procedure NPAP A-100, "General Authorities and Responsibilities of Nuclear Plant Operators," states that procedures shall be present and followed step-by-step for tasks which are extensive and complex, infrequently performed or those in which operations must be performed in a specified sequence. The functional check of RM-18 should have required direct use of the procedure.

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NRC Form 286A 19-831 LICENSEE	E EVENT REPORT (LER) TEXT CONTINU	UATIO	N	U.S. NUCLEAR REGULATORY COMMISSION APPROVED OMB NO 3150-0104 EXPIRES: 8/31/88				N
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IV. ANALYSIS OF THE PROBLEM

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The initial sample of the tank taken prior to the discharge found the tank activity to be well within TS 3.11.1.1 and 3.11.1.2, allowable discharge limits. Following the discharge, a second sample was taken from the remaining contents of the tank. The results of the second sample were consistent with the initial sample, and verified that no activity change had occurred during the discharge. Therefore, based upon these sample analyses, the discharge was well within TS allowable discharge limits. Thus the health and safety of the public were not affected by this event.

V. CORRECTIVE ACTIONS

- A. Immediate Corrective Actions:
 - 1. RM-18 was returned to service and a TS status sheet filed to document the time period over which the monitor was inoperable.
 - The remaining contents of CDT 0-2 was analyzed; it was verified that the activity in the tank was the same as was found in the initial sample analysis.
- B. Corrective Actions to Prevent Recurrence:
 - 1. The operator involved in the event was counselled regarding the need for strict procedural compliance.
 - 2. The event will be reviewed with all operations department personnel via an Operations Incident Summary emphasizing the need for strict procedural compliance and the need to review the requirements of NPAP A-100 with respect to procedure usage.
 - 3. NPAP A-100 will be revised to more clearly define when operations department personnel are required to have a procedure "in-hand" when performing functions. In addition, a new Operations Department Policy will be issued to reinforce these requirements and provide specific examples.

VI. ADDITIONAL INFORMATION

A. Failed Components:

None.

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9-631 LICENSEE EVENT REPORT (LER) TEXT CONTINUATION APPROVED ONB NO 3150-0104 EXPIRES: 8/31/86 *ACILITY NAME (1) DOCKET NUMBER (2) LER NUMBER (6) PAGE (3) *ACILITY NAME (1) YEAR SEGULATIAL REVISION		O .		Ο	,						
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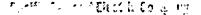
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There Stree San Francisco, CA 94106 415/972-7000 TWX 910-372-6587 James D. Shiffer Vice President Nuclear Power Generation

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January 24, 1989

PG&E Letter No. DCL-89-016

U.S. Nuclear Regulatory Commission Attn: Document Control Desk Washington, D.C. 20555

Re: Docket No. 50-275, OL-DPR-80 Diablo Canyon Unit 1 Licensee Event Report 1-88-031-00 Liquid Radwaste Discharge With Radiation Monitor RM-18 Inoperable Due to Personnel Error

Gentlemen:

Pursuant to 10 CFR 50.73, PG&E is submitting the enclosed Licensee Event Report concerning a liquid radwaste discharge with radiation monitor RM-18 inoperable due to personnel error.

This event has in no way affected the public's health and safety.

Kindly acknowledge receipt of this material on the enclosed copy of this letter and return it in the enclosed addressed envelope.

Sincerely,

D. Shiffer

cc: J. B. Martin M. M. Mendonca P. P. Narbut B. Norton H. Rood B. H. Vogler CPUC Diablo Distribution INPO

Enclosure

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