ACCELERATED POSTRIBUTION DEMONSTRATION SYSTEM (RIDS)

ACCESSION NBR:9210200304 DOC.DATE: 92/10/09 NOTARIZED: NO DOCKET # FACIL:50-275 Diablo Canyon Nuclear Power Plant, Unit 1, Pacific Ga 05000275 AUTH.NAME AUTHOR AFFILIATION SISK, D.P. Pacific Gas & Electric Co. RUEGER, G.M. Pacific Gas & Electric Co. RECIP.NAME RECIPIENT AFFILIATION SUBJECT: LER 92-017-00:on 920912, time limit for surveillance required by TS 4.11.2.6, including allowed extension of TS 4.0.2 not met. Caused by inadequate turnover checklist instructions. CAP D-18 will be revised as required by TS.W/921009 ltr. DISTRIBUTION CODE: IE22T COPIES RECEIVED:LTR | ENCL TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc. NOTES: RECIPIENT COPIES RECIPIENT COPIES ID CODE/NAME LTTR ENCL ID CODE/NAME LTTR ENCL PD5 LA 1 1 PD5 PD ROOD,H 1 INTERNAL: ACNW 1 2 1 1 2 2 **ACRS** 2 AEOD/DOA. AEOD/DSP/TPAB AEOD/ROAB/DSP NRR/DET/EMEB 7E 1 NRR/DLPQ/LHFB10 1 NRR/DLPQ/LPEB10 NRR/DOEA/OEAB NRR/DREP/PRPB11 2 NRR/DST/SELB 8D NRR/DST/SICB8H3 NRR/DST/SPLB8D1 1 1 NRR/DST/SRXB 8E REG_FILE 02 RES/DSIR/EIB RGN5 FILE 01 1 2 1 1 EXTERNAL: EG&G BRYCE, J.H 2 L ST LOBBY WARD 1 NRC PDR 1 NSIC MURPHY, G.A 1 NSIC POORE, W. 1 NUDOCS FULL TXT

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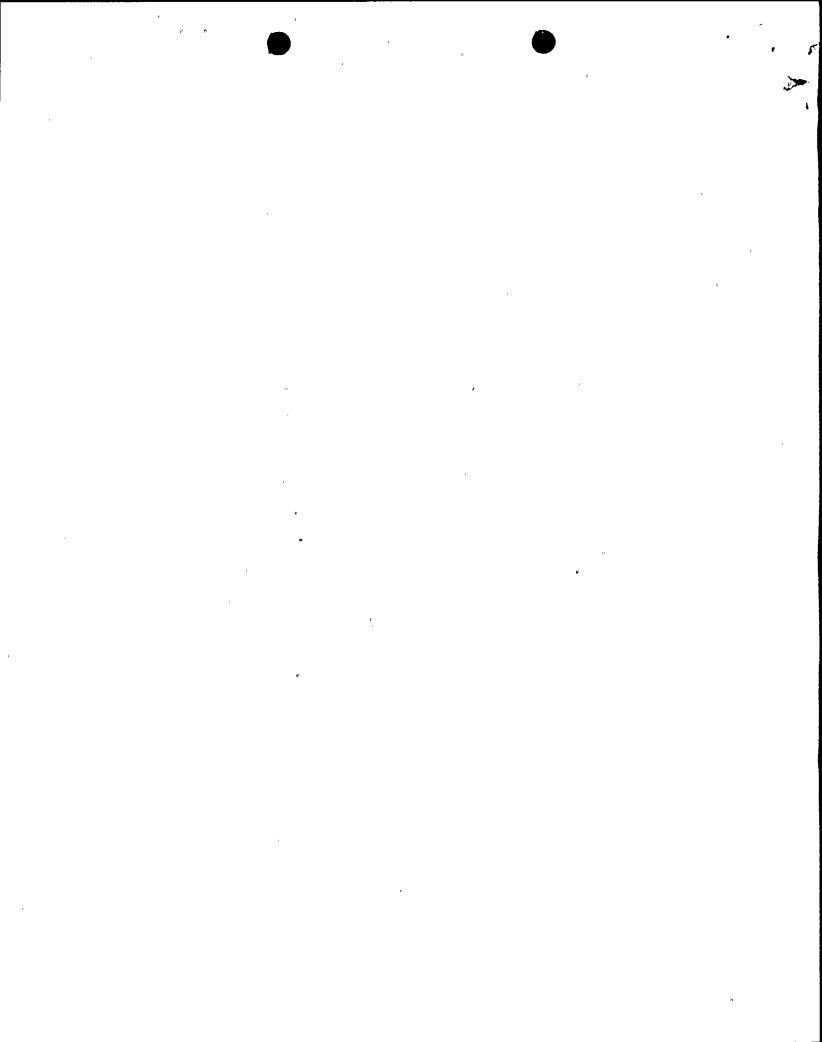
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Pacific Gas and Electric Company

77 Beale Street San Francisco, CA 94106 415/973-4684 Gregory M. Rueger Senior Vice President and General Manager Nuclear Power Generation

October 9, 1992

PG&E Letter No. DCL-92-219



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

Re: Docket No. 50-275, OL-DPR-80
Docket No. 50-323, OL-DPR-82
Diablo Canyon Units 1 and 2
Licensee Event Report 1-92-017-00
Technical Specification 3.11.2.6 Not Met due to Inadequate
Instructions on the Shift Chemistry Technician Turnover Checklist

Gentlemen:

Pursuant to 10 CFR 50.73(a)(2)(i)(B), PG&E is submitting the enclosed Licensee Event Report concerning a missed surveillance of the gas decay tanks due to inadequate instructions of the shift chemistry technician turnover checklist. This surveillance is required by Technical Specification 4.11.2.6.

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

Sincerely,

Gregory M. Rueger

c: Ann P. Hodgdon

John B. Martin Philip J. Morrill

Harry Rood

CPUC

Diablo Distribution

INPO

DC1-92-TC-N041

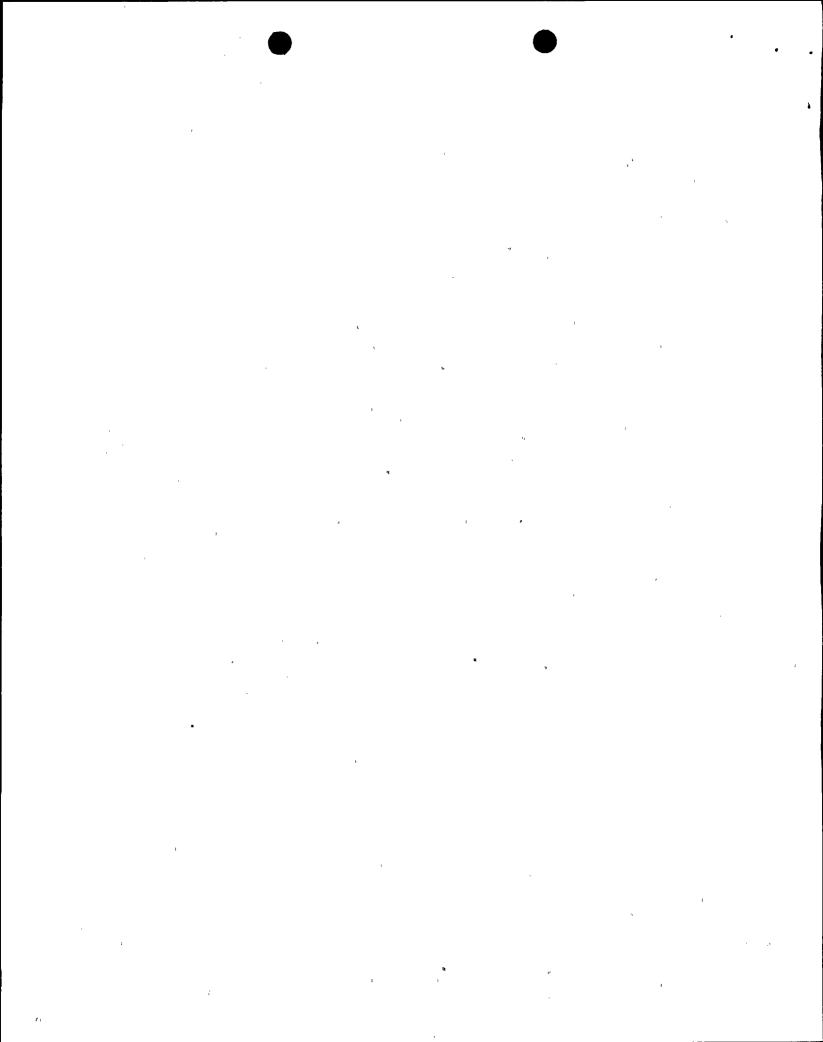
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LICENSEE EVENT REPORT (LER)																										
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TITLE (4)	TECHNICAL SPECIFICATION 3.11.2.6 NOT MET DUE TO INADEQUATE INSTRUCTIONS ON THE SHIFT CHEMISTRY TECHNICIAN TURNOVER CHECKLIST																									
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ABSTRACT (16)

| YES (if yes, complete EXPECTED SUBMISSION DATE)

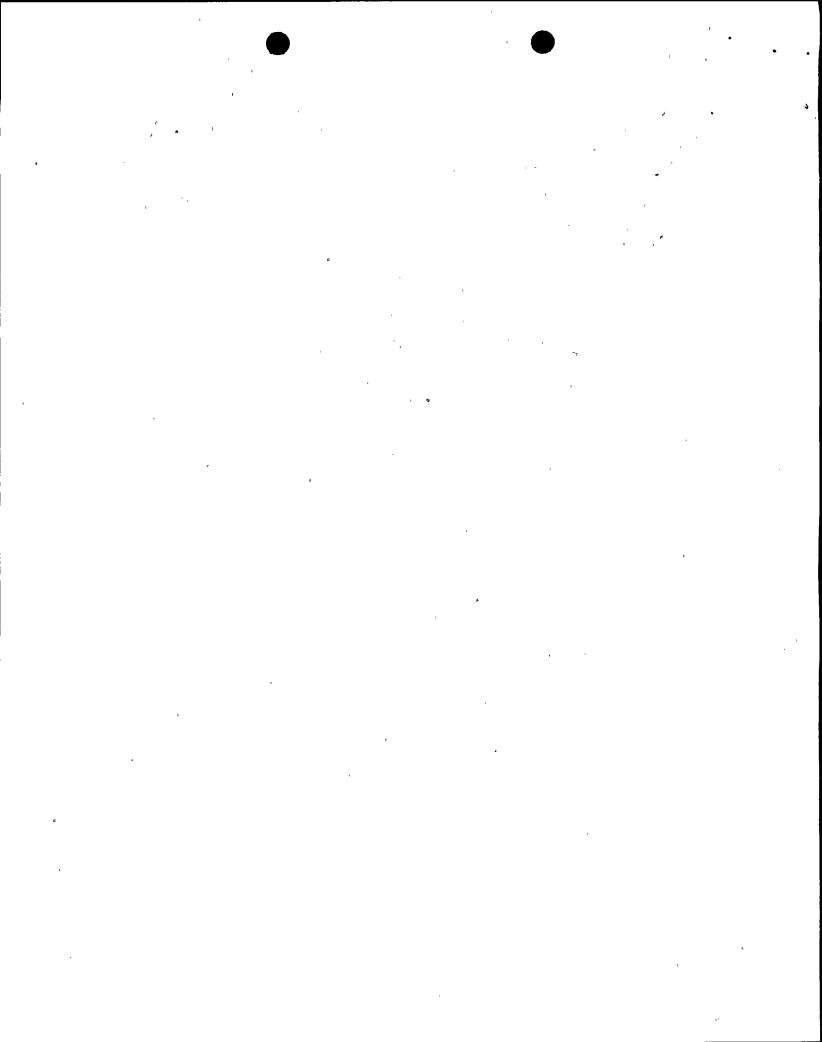
On September 12, 1992, at 1420 PDT, the time limit for the surveillance required by Technical Specification (TS) 4.11.2.6, including the allowed extension of TS 4.0.2, was exceeded. This required entry into TS 3.11.2.6 action a., which requires immediate action that was not performed.

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DATE (15)

The root cause of this event was inadequate shift chemistry technician turnover checklist instructions. The checklist instructions failed to specify the time requirements of TS 4.11.2.6.

The shift chemistry technician turnover checklist was revised. Chemistry Analysis Procedure D-18, "Chemical Analysis Procedure Noble Gas Decay Tank(s) in Terms of Equivalent XE-133," will be revised to explicitly state the 24-hour time limit required by TS 4.11.2.6.



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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6) PAGE (3)	⅃
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DIABLO CANYON UNIT 1	0 5 0 0 0 2 7 5	92 - 0 1 7 - 0 0 2 0 5	

TEXT (17)

I. Plant Conditions

Unit 1 was in Mode 1 (Power Operation) at 80 percent power and Unit 2 was in Mode 1 (Power Operation) at 100 percent power.

II. <u>Description of Event</u>

A. Summary:

On September 12, 1992, at 1420 PDT, the time limit for the surveillance required by Technical Specification (TS) 4.11.2.6, including the allowed extension of TS 4.0.2, was exceeded when a technician failed to perform the required Units 1 and 2 gas decay tanks (GDTs)(WE)(TK) surveillance within the 24-hour time limit. At 1625 PDT, the technician completed the required TS 4.11.2.6 surveillance.

B. Background:

TS 4.11.2.6 requires that the quantity of radioactive material contained in each GDT shall be determined to be within the limit set forth in TS 3.11.2.6 at least once per 24 hours when radioactive materials are being added to the GDT.

Chemistry Analysis Procedure (CAP) D-18, "Chemical Analysis Procedure Noble Gas Decay Tank(s) in Terms of Equivalent XE-133," provides the methodology for determining the quantity of Xenon-133 in a GDT. CAP D-18 states the surveillance must be performed "daily". The shift chemistry technician turnover checklist is used to remind C&RP technicians of procedural requirements.

C. Event Description:

On September 11, 1992, at 0820 PDT, data required by TS 4.11.2.6 was collected from the GDTs.

The shift chemistry & radiation protection (C&RP) technician is assigned the responsibility for taking the daily GDT readings during the dayshift. The technician normally follows a morning routine, which includes monitoring of the GDTs. On the morning of September 12, 1992, the technician went to sample the Unit 2 steam generators (SGs)(AB)(HX), as well as the GDTs. When the technician went to sample the Unit 2 SG, he found the area was secured due to floor painting and would be reopened in the afternoon. The technician then went to complete other assigned duties, and planned to come back later in the afternoon to complete the Units 1 and 2 GDT surveillance.

On September 12, 1992, at 1420 PDT, the time limit for the surveillance required by TS 4.11.2.6, including the allowed extension



FACILITY NAME (1)	DOCKET NUMBER (2)	LER	PAGE (3)		
	ļ · · · · ·	YEAR (SEQUENTIAL NUMBER S	REVISION NUMBER	
DIABLO CANYON UNIT 1	0 5 0 0 0 2 7 5	92 - 0	0 1 7 -	- 00	3 of 5

TEXT (17)

of TS 4.0.2, was exceeded. Also, TS 3.11.2.6 action a. was not met when the discharge of radioactive material to the GDT was not immediately stopped.

On September 12, 1992, at 1625 PDT, the TS 4.11.2.6 surveillance was performed and TS 3.11.2.6 was exited.

On September 12, 1992, at 1655 PDT, upon review of the Shift C&RP desk log, the Chemistry Foreman discovered that the TS 4.11.2.6 time limit, including the allowed extension of TS 4.0.2, was exceeded by 2 hours and 5 minutes.

D. Inoperable Structures, Components, or Systems that Contributed to the Event:

None.

- E. Dates and Approximate Times for Major Occurrences:
 - 1. September 11, 1992; at 0820 PDT: TS 4.11.2.6 surveillance

requirements were satisfied.

2. September 12, 1992; at 1420 PDT: Event Date. TS 3.11.2.6

action a. not met.

3. September 12, 1992; at 1625 PDT: TS 4.11:2.6 surveillance was

performed and TS 3.11.2.6

was exited.

4. September 12, 1992; at 1655 PDT: Discovery Date. The

Chemistry Foreman discovered

that the TS 4.11.2.6

surveillance time limit had

been exceeded.

F. Other Systems or Secondary Functions Affected:

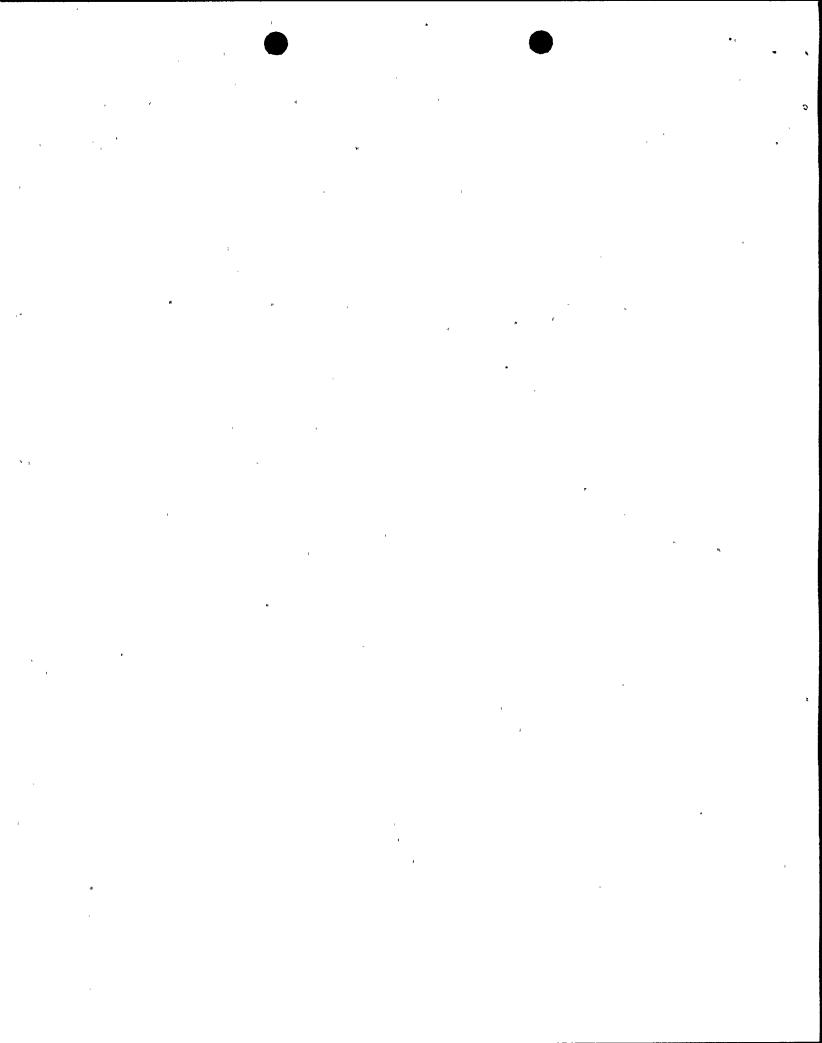
None.

G. Method of Discovery:

On September 12, 1992, at 1655 PDT, while reviewing the Shift C&RP desk log, the Chemistry Foreman discovered that the TS 4.11.2.6 time limit, including the allowed extension of TS 4.0.2, was exceeded by 2 hours and 5 minutes.

H. Operator Actions:

None.



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FACILITY NAME (1)	DOCKET NUMBER (2)		LER NUMBER (6)						
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DIABLO CANYON UNIT 1	0 5 0 0 0 2 7 5	5 92	- 0 1 7	- 00	4 of 5				

TEXT (17)

I. Safety System Responses:

Not Applicable.

III. Cause of the Event

A. Immediate Cause:

The C&RP technician failed to perform the TS 4.11.2.6 surveillance within the required time limit.

B. Root Cause:

The root cause of this event was inadequate shift chemistry technician turnover checklist instructions. The instructions on the checklist specified that the surveillance was to be performed daily and did not specify that the surveillance was to be performed at least once per 24 hours as required by TS 4.11.2.6.

IV. Analysis of the Event

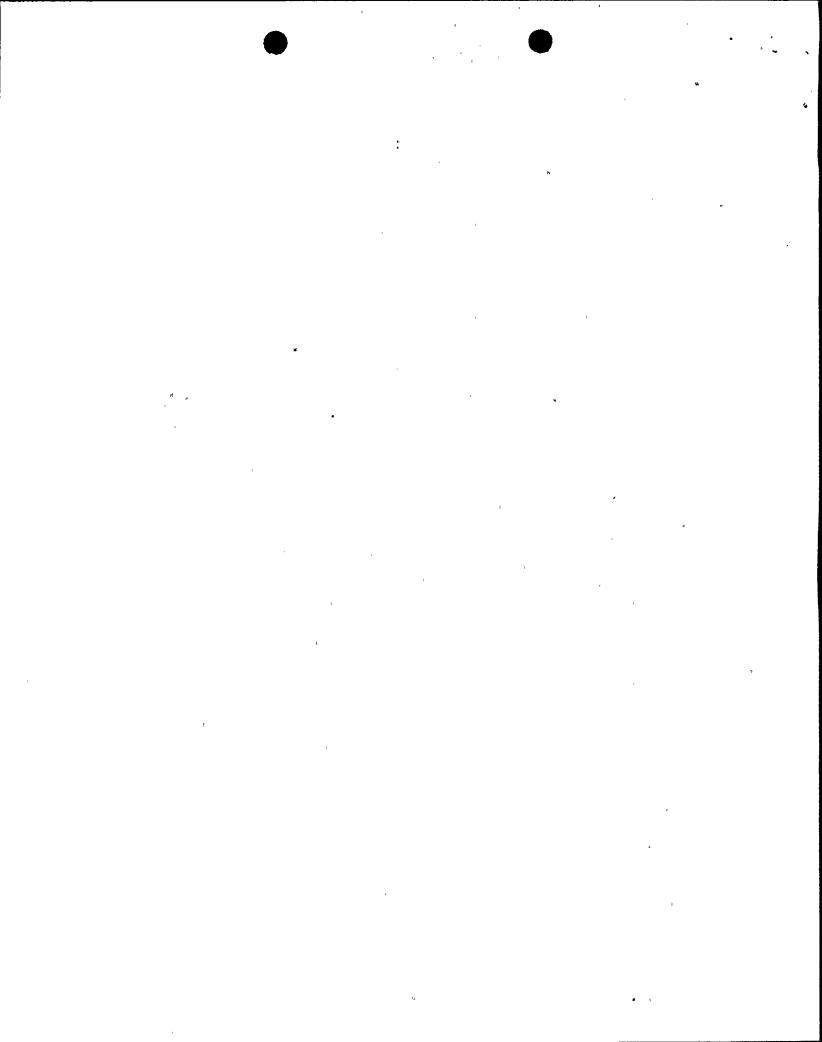
Radiation monitors (IL)(MON) are installed on each GDT to provide alarms in the auxiliary building control room (NF) and the main control room (NA) in the event that the quantity of radioactivity in the GDTs approaches the limit of 100,000 curies of noble gas (as Xenon-133 equivalent). If the limit is exceeded, all gaseous additions to the GDTs will be immediately suspended, and the GDT contents will be reduced to the allowed limit within 48 hours, as required by TS 3.11.2.6 action a.

The Unit 1 reactor coolant system (RCS)(AB) noble gas radioactivity source term was approximately 91 curies (as equivalent Xenon-133) and the Unit 2 RCS noble gas radioactivity source term was approximately 505 curies (as equivalent Xenon-133). Therefore, even if the entire noble gas inventory of both units were transferred to a single GDT, the total combined radioactivity would not have exceeded approximately 600 curies (as equivalent Xenon-133), or less than 1 percent of the limit specified in TS 3.11.2.6.

Thus, the missed GDT surveillance did not adversely affect the health and safety of the public.

V. <u>Corrective Actions</u>

- A. Immediate Corrective Actions:
 - 1. The C&RP technician was counseled on the time requirements of TS 4.11.2.6.



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FACILITY NAME (1)	DOCKET NUMBER (2)		L	PAGE (3)						
		YEAR	3 8	SEQUENTIAL NUMBER		REVISION NUMBER				
DIABLO CANYON UNIT 1	0 5 0 0 0 2 7 5	92	_	0 1 7	_	010	5	OF	5	

TEXT (17)

- 2. The shift chemistry technician turnover checklist was revised to state: "GDT dose rates and pressure readings in accordance with TS 4.11.2.6 and CAP D-18 required once per 24 hours ± 1 hour."
- B. Corrective Actions to Prevent Recurrence:

CAP D-18 will be revised to explicitly state the 24-hour time requirement as required by TS 4.11.2.6.

VI. Additional Information

A. Failed Components:

None.

- B. Previous LERs on Similar Problems:
 - 1. LER 1-88-001-00, "Failure to Perform Plant Vent Air Sampler Flow Estimate Required by Technical Specification 3.3.3.10 due to Personnel Error"

The cause of this event was personnel error in that a technician failed to perform actions identified in Administrative Procedure (AP) A-101S1, "Relieving the Watch." To prevent recurrence, the individual was counseled and the event was reviewed with all chemistry technicians. Because this event did not involve the chemistry technician turnover checklist instructions or ambiguities associated with the word "daily", the corrective actions did not prevent the current LER.

2. LER 1-90-013-00, "Missed Reactor Coolant System Sample due to Personnel Error"

The cause for this event was personnel error in that samples required by TS 4.4.8 were not identified to the oncoming midnight shift technician as required by AP A-101S1. To prevent recurrence, the shift C&RP technicians were counseled and AP A-101S1 was revised. Because this event did not involve the chemistry technician turnover checklist instructions or ambiguities associated with the word "daily", the corrective actions did not prevent the current LER.

