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RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 90-008-01:on 900402,Tech Spec violation,missed chemistry surveillance due to personnel error.

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August 27 , 1990

United States Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

RE: Docket No. 50-410
LER 90-08 Supplement 1

Gentlemen:

In accordance with 10 CFR 50.73, we hereby submit the following Licensee Event Report:

LER 90-08 Supplement 1	Is being submitted in accordance with 10 CFR 50.73(a)(2)(i)(B), "Any operation or condition prohibited by the plant's Technical Specifications".

This report was completed in the format designated in NUREG-1022, Supplement 2, dated September 1985.

Very truly yours,

Joseph F. Firlit
Vice President - Nuclear Generation

JFF/JM/lmc

ATTACHMENT

xc: Regional Administrator, Region I
Sr. Resident Inspector, W. A. Cook

Cert No P30011572

IE22
1/1

NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Nine Mile Point Unit 2	0 5 0 0 0 4 1 0	1 OF 0 5

TITLE (4)
Technical Specification Violation, Missed Chemistry Surveillance Due To Personnel Error

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
0 4	0 2	9 0	9 0	— 0 0 8	— 0 1	0 8	2 7	9 0	N/A	0 5 0 0 0
									N/A	0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	1 0 0	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 (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
	AREA CODE
Pat Volza, Superintendent Chemistry & Radiation Management	3 1 5 3 4 9 - 2 4 2 9

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

ABSTRACT

At approximately 0900 hours on April 2, 1990, with the plant operating at 100% rated thermal power and the mode switch in the "RUN" position, it was discovered that the monthly offsite dose calculation required to be completed by midnight April 1, 1990, had been missed. This is a violation of Station Technical Specifications Section 4.11.2.2, 4.11.2.3 and Table 4.11.2-1.2. The root cause of this event was personnel error.

Corrective actions taken for this event included 1) completion of the surveillances by 1000 hours, April 2, 1990; 2) disciplinary action for the individuals involved; 3) replacement of the part time chemistry planner with a full time planner; 4) additional instruction to Chemistry Department members on the conduct and scheduling of surveillances, and 5) generation of a Lessons Learned Transmittal.

I. DESCRIPTION OF EVENT

At approximately 0900 hours on April 2, 1990, with the plant operating at approximately 100 percent rated thermal power, it was discovered that the monthly gaseous offsite dose calculation (N2-CSP-7V, Figure 5-M) required by Technical Specification 4.11.2.2 and 4.11.2.3, which was required to be performed by midnight on April 1, 1990, was not completed. The paperwork for the radwaste/reactor building vent monthly tritium sample and analysis (N2-CSP-79 data sheet 3 [vent]) which was necessary to complete the monthly gaseous offsite dose calculation was missing and was due also by midnight April 1, 1990. The information on data sheet 3 was finished on March 26, 1990, but could not be found when it was needed for completing figure 5-M. On March 30, 1990, the technician responsible for completing the surveillance was told that it needed to be completed by April 1, 1990. He was told this again on March 31, 1990. The technician stated that he would have it done by April 1, 1990. When attempting to do the surveillance he could not find data sheet 3. He then became involved with other surveillances and forgot to complete figure 5-M. He was not aware that failure to complete the surveillance by April 1 would result in a Technical Specification violation. On April 2, while reviewing data sheets, figure 5-M was found incomplete and data sheet 3 missing. The surveillances were finished by taking the needed information from other data sheets and historical data.

The fundamental cause of this event has been identified as personnel error. There were no inoperable systems or components at the start of this condition which contributed to this condition. No component failures occurred as a result of this condition.

The duration of this condition was approximately ten hours.

II. CAUSE OF EVENT

A root cause analysis was performed per Site Supervisory Procedure S-SUP-1, "Root Cause Evaluation Program" in conjunction with the Human Performance Enhancement System (HPES) published by the Institute of Nuclear Power Operations.

The fundamental cause of this event has been identified as personnel error. The following causal factors were identified:

1. The technician told the department planner the surveillance would be completed. However, because he was extremely busy completing other surveillances and preparing for upcoming

ones, he forgot about the need to complete the required surveillance.

2. The Chemistry planner did not properly track the surveillance schedule and identify the 1.15 internal due date. In addition, the planner failed to notify the department supervisor of surveillance completion problems and followup on surveillance completion.

3. Chemistry supervisory oversight of the surveillance tracking program was inadequate. The methods used to track the progress and status of the subject surveillances as defined in Administrative Procedure 8.2 were not effectively utilized by the Chemistry supervisor. Specifically, independent tracking sheets (overdue surveillance reports) were not reviewed.

4. Verbal communications were inadequate. Notification to the Chemistry Supervisor concerning the inability to produce the required document (N2-CSP-79 data sheet 3) needed for completion of Figure 5-M was hindered by poor communications. Communication between the Regulatory Compliance representative and the Generation Engineer responsible for surveillance tracking was also lacking. The individuals did not communicate the status of the surveillance even after the tests appeared on the Overdue Surveillance Report four consecutive days.

III. ANALYSIS OF EVENT

This condition is considered reportable under 10CFR50.73 (a)(2)(i)(B) "Any operation or condition prohibited by the plants Technical Specifications". The monthly offsite dose calculations and reactor/radwaste building vent tritium samples were not performed at the frequencies required by Technical Specification 4.11.2.2, 4.11.2.3 and Table 4.11.2-1.2.

The reactor/radwaste tritium analysis results indicated that tritium concentrations were less than the Technical Specification lower limit of detection and would not have altered the offsite dose calculations which had previously been performed. When the required calculations were completed on April 2, 1990, the offsite dose was determined to be below Technical Specification limits.

This condition did not jeopardize the health and safety of the general public or site personnel nor did it degrade the ability to safely operate or shutdown the unit.

IV. CORRECTIVE ACTIONS

Immediate corrective action was to perform the overdue surveillances. They were completed satisfactorily on April 2, 1990. Additional corrective actions are as follows:

1. Appropriate disciplinary measures have been taken for involved personnel.

2. The Chemistry Department engineer was counseled in the necessity to inform supervision when the 1.15 internal due date is being approached or exceeded and when there are any problems with completing the procedure. The responsibilities for surveillance tracking have been reassigned to a dedicated planner/evaluator in the department.

3. The Chemistry Supervisor has provided additional instruction to department members regarding the conduct and scheduling of surveillances including required notifications/individual responsibilities.

4. Chemistry supervision will henceforth review independent tracking sheets to assure that surveillances are performed on time. The Nuclear Regulatory Compliance Group (NRCG) now notifies the Chemistry Supervisor of surveillances due.

5. A Lessons Learned Transmittal has been generated and will be distributed for review to departments involved with the performance, scheduling, tracking and supervision of surveillance tests.

V. ADDITIONAL INFORMATION

A. Previous similar events:

LER 87-60, "Failure To Perform Shift Checks Results In Missed Technical Specification Surveillance Requirements Due To Personnel Errors". The corrective actions for LER 87-60 would not have prevented this event because they were directed specifically to the Operations Department.

1

LER 88-10, "Missed Surveillance Due To Personnel Error Results In Technical Specification Violation". The corrective actions in LER 88-10 would not have prevented this event because they were directed specifically to the Reactor Physics Department.

LER 88-53, "Technical Specification Violation, Late 125 Volt Battery Surveillance, Due To Personnel Error". The Lessons Learned Transmittal generated for the corrective actions in LER 88-53 should have provided the Chemistry technician performing the surveillance test with the knowledge of 25% allowable extensions and 3.25 rule for Technical Specification surveillances. However, the technician did not correctly recall the allowable extension rules for Technical Specification surveillances or realize the consequences of exceeding the requirements.

LER 88-58, "Technical Specification Violation, Late Average Power Range Monitor Surveillance, Due To Programmatic Deficiency". The corrective actions in LER 88-58 which established Station General Order 89-01 and directed the Nuclear Regulatory Compliance Department to monitor surveillances should have prevented this event. However, poor communications and poor use of the chain of command prevented Chemistry supervision from being aware of the surveillances status. 1

LER 89-27, "Missed Surveillance Due To Inadequate Scheduling And Assignment Results In Technical Specification Violation". The Lessons Learned Transmittal and Chemistry turnover instruction generated for the corrective actions in LER 89-27 should have prevented this event. However, the technician was aware of the need to complete the surveillance but was busy with other tasks and forgot to complete the surveillance.

The listed LER's refer to missed Technical Specification surveillance tests, but the root cause and corrective actions differ from this event.

LER 89-13	LER 88-13	LER 87-41
LER 89-17	LER 88-16	LER 87-46
	LER 88-18	LER 87-61
	LER 88-33	LER 87-83
	LER 88-60	LER 87-67

B. Component identification: none.

C. Failed components: none.