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DOCKET # ACCESSION NBR:9301210231 DOC.DATE: 93/01/14 NOTARIZED: NO FACIL:50-397 WPPSS Nuclear Project, Unit 2, Washington Public Powe 05000397 AUTHOR AFFILIATION AUTH.NAME MACKAMAN, C. Washington Public Power Supply System BAKER, J.W. Washington Public Power Supply System RECIPIENT AFFILIATION RECIP.NAME R I SUBJECT: LER 92-046-00:on 921215, night technicians failed to collect main condenser offgas sample within TS time requirements, D due to personnel error. Memo issued that will address requirements for shift personnel.W/930114 ltr. S DISTRIBUTION CODE: IE22T COPIES RECEIVED:LTR / ENCL / SIZE: 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 D 1 1 PD5 LA PD5 PD 1 1 1 CLIFFORD, J D 2 1 1 2 2 1 1 1 INTERNAL: ACNW **ACRS** 2 AEOD/DOA AEOD/DSP/TPAB AEOD/ROAB/DSP 1 NRR/DET/EMEB 7E NRR/DLPQ/LHFB10 NRR/DLPQ/LPEB10 NRR/DOEA/OEAB NRR/DREP/PRPB11 2 2 1 1 NRR/DST/SELB 8D NRR/DST/SICB8H3 1 1 NRR/DST/SPLB8D1 1 1 ' 1 NRR/DST/SRXB 8E REG FILE 02 RES/DSIR/EIB · 1 RGN5 FILE 01 1 1 EXTERNAL: EG&G BRYCE, J.H L ST LOBBY WARD R NRC PDR NSIC MURPHY, G.A 1 NSIC POORE, W. 1 NUDOCS FULL TXT 1 I D S

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WASHINGTON PUBLIC POWER SUPPLY SYSTEM

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January 14, 1993 G02-93-015

Docket No. 50-397

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

SUBJECT: NUCLEAR PLANT WNP-2, OPERATING LICENSE NPF-21 LICENSEE EVENT REPORT NO. 92-046

Transmitted herewith is Licensee Event Report No. 92-046 for the WNP-2 Plant. This report is submitted in response to the report requirements of 10CFR50.73 and discusses the items of reportability, corrective action taken, and action taken to preclude recurrence.

Sincerely,

J. W. Baker

of Haused for

WNP-2 Plant Manager (Mail Drop 927M)

JWB/CDM/lr Enclosure

cc: Mr. J. B. Martin, NRC - Region V

Mr. R. Barr, NRC Resident Inspector (Mail Drop 901A, 2 Copies)

INPO Rcords Center - Atlanta, GA

. Mr. D. L. Williams, BPA (Mail Drop 399)

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On December 15, 1992, the night shift chemistry technicians failed to collect a main condenser offgas sample within the time required by Technical Specification 3.3.7.12 and Table 3.3.7.12-1 (Explosive Gas Monitoring Instrumentation). Contrary to the Technical Specifications eight hour requirement, a grab sample was not collected during the 11 hour and 21 minute period between 1246 hours on December 15, 1992, and 0007 hours on December 16, 1992.

No immediate corrective actions were required since the Technical Specification surveillance was current at the time of the event discovery.

The root cause was a work practice personnel error. A contributing cause was the ineffective implementation of chemistry department policies and practices.

This event posed no threat to the health and safety of either the public or plant personnel.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION			
FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (8)	PAGE (3)
Machington Muclosu Dlant Unit 2	1	Year Number Rev. No.	
Washington Nuclear Plant - Unit 2	0 5 0 0 0 3 9 7	92 046 00	2 OF 6
FAILURE TO COLLECT AN OFFGAS SAM	IPLE WITHIN TECHNICAL SE	PECIFICATION TIME REQUI	REMENTS

Plant Conditions

Power Level - 100% Plant Mode - 1 (Power)

Event Description

On December 15, 1992, night shift chemistry technicians failed to collect a main condenser offgas sample within the time required by Technical Specification 3.3.7.12 and Table 3.3.7.12-1 (Explosive Gas Monitoring Instrumentation). Contrary to the Technical Specifications eight hour requirement, a grab sample was not collected during the 11 hour and 21 minute period between 1246 hours on December 15, 1992, and 0007 hours on December 16, 1992. This was discovered while recording the sample collection information in the Chemistry Log Book. The night shift chemistry technician noticed that the last offgas sample had been collected at 1246 hours on December 15, 1992, and not 1615 hours as assumed by the night shift lead chemistry technician.

WNP-2 entered a Limiting Condition for Operation (LCO) at 0740 hours on December 12, 1992, for explosive gas (hydrogen) monitoring instrumentation, when Offgas Analyzer 12A (OG-AY-12A) was taken out of service for maintenance. Main condenser offgas samples were being collected every four hours in accordance with Technical Specification 3.3.7.12 and Table 3.3.7.12-1. The last four hour sample was collected at 1246 hours on December 15, 1992. The hydrogen concentration was found to be less than one percent by volume, which is acceptable (below the four percent Technical Specifications limit).

Prior to the next scheduled four hour sample collection time at 1615 hours, the Operations Shift Manager notified the day shift lead chemistry technician that the sample collection interval could be increased to eight hours. This is in accordance with the Technical Specifications, if the offgas recombiner temperature remains constant and reactor thermal power has not changed. A decision was made by the chemistry supervisor to start the eight hour clock from the last scheduled sample collection time at 1215 hours, making the next sample due at 2015 hours. Shift turnover to night shift occurred at approximately 1830 hours.

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FAILURE TO COLLECT AN OFFGAS SAM	MPLE WITHIN TECHNICAL SI	PECIFICATION	TIME REQUI	REMI	ENT:	 S	

The night shift lead chemistry technician was made aware of the new eight hour sample collection schedule at turnover. However, he did not know when the last sample was collected. The last sample time was verbally stated by the day shift lead technician at turnover, but was not heard or was misunderstood. The night shift lead technician assumed the last sample time to be 1615 hours based upon the previous night's sample collection schedule and the time of shift turnover. As a result, he mistakenly thought the next sample was due at 0015 hours on December 16, 1992. Accordingly, he assigned his on-shift chemistry technician to collect the offgas sample at 0007 on December 16, 1992, three hours and 21 minutes beyond the eight hour Technical Specifications frequency requirement. The offgas sample was analyzed and the hydrogen concentration was found to be less than one percent. The chemistry department supervision and the Shift Manager were not immediately notified of the Technical Specifications violation when it was discovered by the night shift chemistry technician. Notification was not made until day shift on December 16, 1992.

Immediate Corrective Actions

No immediate corrective actions were required since the Technical Specification surveillance was current at the time of the event discovery.

Further Evaluation and Corrective Action

Further Evaluation

This event is reportable under 10CFR50.73(a)(2)(i)(B) as "Any operation or condition prohibited by the plant's Technical Specifications."

Investigation of this event found that the lead chemistry technicians rely on informal aids and verbal communication almost entirely to pass on information between shifts. The Chemistry LCO Log Book is the official document for controlling LCO sampling times in accordance with PPM 12.13.33, but is not consistently reviewed by the lead chemistry technicians during shift turnovers. The Chemistry Shift Turnover sheet, the Chemistry Log Book, and a 'white board' outside the chemistry offices are the principal references. Although all are informal aids, they are standard parts of chemistry shift turnover work practice. When used together, they provide all necessary turnover information, including LCO sample times. However, the Chemistry Shift Turnover sheet was found not to be adequate to assure required LCO sample times are identified, if used alone. A review of past Chemistry Shift Turnover sheets revealed a wide variance in the information recorded, and prior to this event, recording sample times on the turnover sheet was uncommon.

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TITLE (4) FAILURE TO COLLECT AN OFFGAS SAM	IPLE WITHIN TECHNICAL SE	PECIFICATION T	IME REQUI	REME	NTS	

On December 15, 1992, shift turnover to night shift occurred in the hallway outside of the chemistry laboratory. The oncoming night shift lead chemistry technician was temporarily unable to clear the portal radiation monitor to access the chemistry office, the normal turnover location. The only reference document used during the shift turnover was the Chemistry Shift Turnover sheet, which did not list the required LCO sample time. When the night shift lead technician later accessed the chemistry office, he did not review the Chemistry LCO Log Book, the "white board", or the Chemistry Log Book to confirm the time the next offgas sample was due. These sources all had the correct required information.

The root cause of this event was a work practices personnel error. The night shift lead chemistry technician did not verify the next required sample time during shift turnover or by reviewing appropriate up-to-date documents. This inattention to detail led to an incorrect assumption that resulted in an offgas sample not being collected within the required time limitations.

A contributing cause was that the chemistry department lacks formal requirements for implementing policies and practices on conduct and duties of chemistry personnel. Management expectations for lead chemistry technician duties and minimum log entries were disseminated through a memorandum dated July 19, 1991. The lead technicians were found not to be in full compliance with the memorandum required action of "review log books".

Further Corrective Action

- 1. On December 16, 1992, an Interoffice Memorandum from the Chemistry Department Manager, concerning this event, was distributed to all chemistry department personnel. The memorandum stressed the importance of strict compliance to the Technical Specifications, and outlined management's expectations as they pertain to shift turnover and the use of the Chemistry Log Book. Each chemistry department employee was required to read and sign for having read the memorandum.
- 2. Procedure PPM 1.3.58, Conduct of Chemistry, will be issued by January 31, 1993. This procedure incorporates the information from previous appropriate memorandums and will help assure consistent implementation of management expectations. Moreover, the procedure will be required reading for chemistry department personnel when issued and following changes or updates, serving to reemphasize department policies and practices. Procedure PPM 1.3.58 will address requirements for shift chemistry personnel attendance and access to logs, personnel aids and pertinent information during turnovers. The Chemistry Shift Turnover sheet will become part of the procedure, requiring a sign off for reading and understanding required turnover items and references, including the LCO Log Book. The procedure will also include requirements to immediately notify department supervision and

LICENSEE EVENT REPORT (TEXT CONTINUATION	·		
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FAILURE TO COLLECT AN OFFGAS SAM	IPLE WITHIN TECHNICAL SE	PECIFICATION TIME REQUI	REMENTS

the Shift Manager of conditions that could potentially result in a violation of a Technical Specification LCO. A Chemistry Standing Order was issued on December 16, 1992 to this effect as a corrective action for LER 92-038 and this event. The Standing Order had not been implemented prior to this December 15, 1992 event because management's original intent was to take credit for the procedure that was to be issued in mid-January, 1993.

Safety Significance

There is no safety significance associated with this event. The offgas was sampled and analyzed within 12 hours of the previous sample. The hydrogen concentration of both the pre-event and post-event samples was less than one percent by volume, which is within the Technical Specification limit of four percent hydrogen by volume. The redundant Main Condenser Offgas Explosive Gas Monitor (OG-AY-12B) was in service during the period of OG-AY-12A inoperability. OG-AY-12B indicated the offgas hydrogen concentration to be less than one percent during this period, validating the grab sample data.

Similar Events

LER 92-038, "Failure to Perform Offgas Analysis Within Technical Specification Time Requirements." This event occurred on October 14, 1992, with the related root cause being a work practice personnel error resulting in a failure to meet a Technical Specification time limitation. Also related, was the problem of slow notification of supervision and the Shift Manager of the Technical Specification violation. The corrective actions were to counsel the chemistry technicians, clarify guidance in the Chemistry LCO Log Book, and initiate a department practice to immediately notify supervision and the Shift Manager of potential Technical Specification LCO violations. The corrective action for slow notification of supervision and the Shift Manager had not been completed at the time of the current event (due January 4, 1993). All other corrective actions had been completed. The previous corrective actions were ineffective in preventing a similar event because the chemistry department lacked formal requirements for implementing department policies and practices. Procedure PPM 1.3.58, Conduct of Chemistry, should prevent recurrence of another similar event by assuring consistent implementation of management expectations, and procedurally requiring review of specified shift turnover items and references relating to Technical Specification LCO activities.

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EIIS Information

<u>Text Reference</u>	EIIS Reference				
	<u>System</u>	Component			
Offgas Analyzer 12A (OG-AY-12A)	WF	AY			
Offgas Analyzer 12B OG-AY-12B)	WF	AY			