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DUKE POWER

April 16, 1990

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

Subject: McGuire Nuclear Station Unit 1
Docket No. 50-369
Licensee Event Report 369/90-03

Gentlemen:

Pursuant to 10 CFR 50.73 Sections (a)(1) and (d), attached is Licensee Event Report 369/90-03 concerning a missed required technical specification surveillance on the Unit 1 Ventilation Unit Condensate Drain Tank. This report is being submitted in accordance with 10 CFR 50.73(a)(2)(i)(B). This event is considered to be of no significance with respect to the health and safety of the public.

Very truly yours,

Tony L. McConnell

T.L. McConnell

DVE/ADJ/cbl

Attachment

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April 16, 1990

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MC-815-04
(20)

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) McGuire Nuclear Station, Unit 1										DOCKET NUMBER (2) 0 5 0 0 0 3 6 9 1 OF 0 5										PAGE (3) 1 OF 0 5																													
TITLE (4) A Technical Specification Required Surveillance On The Unit 1 Ventilation Unit Condensate Drain Tank Was Missed Because Of An Inappropriate Action																																																	
EVENT DATE (5) MONTH DAY YEAR 0 3 1 6 9 0 9 0 - 0 0 0 3 - 0 0 0 4 1 6 9 0										LER NUMBER (6) SEQUENTIAL NUMBER 0 0 0 3 - 0 0 0 4 1 6 9 0										REPORT DATE (7) MONTH DAY YEAR 0 3 1 6 9 0 9 0 - 0 0 0 3 - 0 0 0 4 1 6 9 0										OTHER FACILITIES INVOLVED (8) FACILITY NAMES N/A DOCKET NUMBER(S) 0 5 0 0 0 0																			
OPERATING MODE (9) 0										THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)																																							
POWER LEVEL (10) 0 0 0										20.402(b)										20.406(c)										50.73(e)(2)(iv)										73.71(b)									
										20.406(e)(1)(i)										50.36(e)(1)										50.73(e)(2)(v)										73.71(c)									
										20.406(e)(1)(ii)										50.36(e)(2)										50.73(e)(2)(vii)										OTHER (Specify in Abstract below and in Text, NRC Form 366A)									
										20.406(e)(1)(iii)										X 50.73(e)(2)(ii)										50.73(e)(2)(viii)(A)																			
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LICENSEE CONTACT FOR THIS LER (12)																																																	
NAME Alan Sipe, Chairman, McGuire Safety Review Group																				TELEPHONE NUMBER AREA CODE 7 0 4 8 7 5 - 4 1 8 3																													
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																																																	
CAUSE										SYSTEM										COMPONENT										MANUFACTURER										REPORTABLE TO NRCDS									
SUPPLEMENTAL REPORT EXPECTED (14)																																																	
YES (If yes, complete EXPECTED SUBMISSION DATE)																				X NO										EXPECTED SUBMISSION DATE (15)										MONTH DAY YEAR									

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

On March 9, 1990, at approximately 1945 hours, Radiation Protection (RP) personnel contacted Operations personnel to determine when the Unit 1 Ventilation Unit Condensate Drain Tank (VUCDT) would be pumped out. RP personnel were informed the Unit 1 VUCDT had been pumped out earlier in the evening by Operations personnel. RP personnel were scheduled to perform a channel check while the tank was being pumped out. Operations personnel were required by procedure to contact RP personnel prior to pumping out the Unit 1 VUCDT so this channel check could be performed. RP personnel stated they did not receive a call from Operations personnel, thereby, causing RP personnel to miss a Technical Specification (TS) surveillance. Unit 1 was in No Mode (no fuel in the reactor) at the time. This event is assigned a cause of Inappropriate Action because of failure to properly follow the correct procedure. Operations personnel apparently did not call RP personnel as was required in the Operations procedure. The corrective action planned to prevent this event from recurring will be for Operations to evaluate procedure enhancements and RP will enhance the radioactive liquid waste release procedure.

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APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

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TEXT (If more space is required, use additional NRC Form 388A's) (17)

EVALUATION:

Background

The VUCDT is a collection point for condensate from the Containment and Auxiliary Building [EIIS:NF] ventilation units. Normally, the activity in this tank [EIIS:TK] will be well below permissible levels for discharge. Releases made are monitored by a weekly sample taken from a composite of the tanks effluent. Also, an in-line radiation monitor [EIIS:RI], EMF-44, continuously monitors all VUCDT effluents.

According to Technical Specification 3.3.3.8, the surveillance requirement states that each radioactive liquid effluent monitoring instrumentation channel shall be demonstrated operable by performance of a channel check.

For the VUCDT, a channel check consists of flow verification during periods of release. The instruments used to verify flow consist of a totalizer [EIIS:FQ] and composite sampler. This verification shall be made at least once per twenty four hours on days during which continuous, periodic, or batch releases are made.

When in a continuous release mode, each VUCDT release is not logged in the Operations Liquid Waste Release (LWR) logbook because the LWR is utilized for a full week. The only log entries made are when the LWR is initiated and again when it is closed out at the end of the week. During batch releases, however, a different LWR is used for each release. Therefore, a log entry is made at the beginning and end of each release. RP personnel call Operations personnel at the end of the week with the total gallons release under the continuous release LWR and at the end of each batch when under a batch release LWR.

Description of Event

On March 9, 1990, at 1600, RP personnel performed a once per 4 hour tour of the Control Room [EIIS:NA]. The Unit 1 VUCDT was 75 percent full. LWR No. 186 had been started on March 5, 1990 to document liquid releases from the Unit 1 VUCDT according to procedure HP/0/B/1003/02, Radioactive Liquid Waste Release, Section 4.4 VUCDT Release (Continuous Mode). When the VUCDT level reaches 80 percent, Operations personnel are required by procedure OP/1/A/6500/01A, VUCDT Operation, section 2.13, to notify RP personnel. This notification is to advise RP personnel that a release will be made using the existing release documentation and have RP personnel ensure the VUCDT flow totalizer and composite sampler channel check surveillance is up to date.

The RP technician who performed the Control Room tour stated he thought the Unit 1 VUCDT would be released sometime during his shift. However, RP personnel stated they did not receive a call from Operations personnel informing them the Unit 1 VUCDT would be released. After receiving turnover, RP personnel on shift called Operations personnel on shift, at approximately 1945, to find out when the Unit 1 VUCDT would be released. RP personnel normally close out the LWR for each continuous release on Fridays. Operations personnel informed RP personnel that the Unit 1 VUCDT had already been released and had been secured at 1900. Because RP

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personnel did not perform the TS required channel check during the time the Unit 1 VUCDT was being released, a required TS surveillance was missed. Unit 1 was in No Mode at the time.

Conclusion

This event is assigned a cause of Inappropriate Action because of failure to properly follow the correct procedure. It is concluded that Operations personnel did not contact RP personnel to advise them they would be pumping out the Unit 1 VUCDT. Since RP personnel did not know the tank was being pumped out, they were unable to perform a channel check. This action resulted in RP missing the surveillance requirement.

The Operations Reactor Operators (ROs) assigned to Unit 1 on March 9, 1990, stated they cannot remember making the call or not making the call to RP personnel. Neither RO on duty could remember anything unusual about the Unit 1 VUCDT release on March 9, 1990. Unit 1 was in No Mode at the time and the ROs on duty stated it was a relatively busy day but this is not unusual during an outage. They also stated it is not unusual to be performing more than one job at a time. To the best of their knowledge, the ROs stated they were not tired or distracted.

It is normal practice for Operations personnel to keep procedure OP/1/A/6500/01A, Ventilation Unit Condensate Drain Tank, Enclosure 4.3, Pumping VUCDT to the RC Discharge Using Continuous Release Method, in a folder with other outstanding procedures or to keep the above mentioned procedure in the LWR logbook. Prior to releasing the VUCDT, the procedure enclosure is reviewed at the Operations table. Normally, the RO who starts the procedure enclosure is the one that calls RP. The ROs involved in this event stated they are not sure what they did on March 9, 1990. They do not remember who initiated the VUCDT release.

RP Shift personnel contacted stated they did not receive a call from Operations informing them the Unit 1 VUCDT was to be released. RP Shift personnel maintain a shift logbook and routinely log information concerning daily activities. These activities include entries concerning VUCDT releases. On the day in question, at 0941, an entry was made in the RP Shift logbook stating Operations personnel had called to inform RP personnel that the Unit 2 VUCDT had been put into recirculation. However, there were no entries concerning the Unit 1 VUCDT that day.

This investigation revealed no unusual human factors which appeared to have been a major cause of this event.

Operations personnel will evaluate enhancing procedures OP/1 and 2/A/6500/01A, VUCDT Operation, Enclosure 4.3, Pumping VUCDT to the RC Discharge Using Continuous Release Method and RP personnel will enhance procedure HP/0/B/1003/02, Radioactive Liquid Waste Release, to ensure this event does not recur.

A review of McGuire Licensee Event Reports for the last 24 months revealed 4 events involving TS violations with a cause of Inappropriate Action because of a failure to follow procedures. These events were LERs 369/89-16, 370/89-09, 370/89-13, and

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369/90-05. These events were all separate actions and unrelated to this event. Therefore, this event is considered non-recurring. The corrective actions for these events would not have prevented this event from occurring.

This event is, however, considered a recurring problem because each incident involved missed TS surveillances due to Inappropriate Action because of a failure to follow correct procedures.

This event is not Nuclear Plant Reliability Data System Reportable.

There were no personnel injuries, radiation overexposures, or uncontrolled releases of radioactive material as a result of this event.

CORRECTIVE ACTIONS:

Immediate: None

Subsequent: None

- Planned:
- 1) Operations personnel will evaluate enhancing procedures OP/1 and 2/A/6500/01A, VUCDT Operation, Enclosure 4.3, Pumping VUCDT to the RC Discharge Using Continuous Release Method to make sure RP is notified of an impending VUCDT release and that the flow totalizer and compositor are operational.
 - 2) RP will enhance procedure HP/0/B/1003/02, Radioactive Liquid Waste Release, to inform RP personnel that it is still possible to perform the VUCDT surveillance if the tank is inadvertently pumped out, by requesting Operations to run the VUCDT pump long enough for RP personnel to perform the required channel check.
 - 3) Operations personnel will cover this event with a representative from each shift.
 - 4) RP personnel will cover this event through their ETQS program with the appropriate personnel.

SAFETY ANALYSIS:

Unit 1 VUCDT releases are monitored by Radiation Monitor (EMF) 44, VUCDT Discharge Monitor. As a condition for releasing the VUCDT in the continuous mode, EMF 44 is required to be operable. During the generation of the LWR paperwork, trip 1 and trip 2 setpoints for EMF 44 are determined to prevent any radioactive liquids from being released that would exceed allowable release limits. During the time the Unit 1 VUCDT was released, EMF 44 was operable and did not alarm. The Unit 1 VUCDT totalizer and compositor were checked and found operable on March 5, 1990 when a VUCDT was released and again on March 12, 1990 when another tank was released. A radioisotopic analysis was also performed on March 9, 1990 at 2102 on a composite sample which covered the Unit 1 VUCDT release in question. Based on this

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information, it has been determined that no unquantified radioactive effluent was released from the station.

The health and safety of the public were not affected by this event.