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From July 26 through July 30, 1984, daily surveillances of the Unit Vent Flow Rate Monitor channel check was not performed in accordance with Technical Specification 3.3.3.11 and Action Statement 46. Plant procedure PT/1/A/4600/02, Periodic Surveillance Items, was approved daily although surveillance item number 79 which is done to verify that the flow rate monitor is in service and has an indicated flow, was not properly completed. Unit 1 was in Mode 6, shortly after initial fuel loading, at this time.

This incident is classified as a Personnel Error, with a contributing cause, Administrative/Procedural Deficency.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO 3150-0104

	EXPINES 8/31/85									
FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)	PAGE (3)							
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The surveillance procedure PT/1/A/4600/02 is used to verify compliance with Tech Spec Surveillance Items which have a frequency of verification from once per twelve hours to once per seven days. The daily surveillance items are required to be performed between 0300 and 0600.

The Technical Specification involved in this incident is T. S. 3.3.3.11(b). It states in part that a minimum of one (1) channel of unit vent flow rate monitoring instrumentation shall be OPERABLE at all times. If less than one (1) channel is OPERABLE, the unit vent release may continue for up to thirty (30) days provided that the flow rate is estimated at least once per four (4) hours. Surveillance Requirement 4.3.3.11 of this Tech Spec requires that the unit vent flow rate monitor channel check be performed once per twenty-four (24) hours.

On July 25, 1984, the computer point Al104, Unit Vent Flow Rate, was not operable, and therefore it could not be used to verify the acceptance criteria for Surveillance Item #79. The acceptance criteria requires that the Unit Vent Flow Rate Monitor be in service with greater than zero SCFM indicated by computer point All04. The Operator who performed the test could not sign-off item #79 but did record the discrepancy on the discrepancy sheet. Shift Supervisor A resolved this discrepancy by filling in "Work Request in" under the "action taken" column of the Discrepancy Sheet. He then signed-off the action as completed but left item #79 unsigned. When Operations Engineer A reviewed the completed test, he noticed this inconsistency and determined that item #79 could be signed-off if Unit Vent local flow gauge (IVAP8300) was used to verify the acceptance criteria. Unit Supervisor A had 1VAP8300 checked as suggested by Operations Engineer A and had item #79 signed-off. If the test discrepancy had not been corrected on time, Tech Spec 3.3.3.11(b) would not have been satisfied.

On the next day, Shift Supervisor A again signed-off the discrepancy with item #79 blank eventhough he had been informed by Unit Supervisor A that local flow gauge could be used to verify the acceptance criteria. Operations Engineer A took the procedure to Unit Supervisor B for resolution. Unit Supervisor B resolved the discrepancy by changing "Work Request In" to "Complying with Tech Spec Action Item" and left item #79 unsigned. He did not make any entry to the Tech Spec Action Item Logbook or take additional action to comply with Tech Specs. With item #79 unsigned, the Unit Vent gaseous release flow rate should have been estimated at least once per four hours for up to 30 days. Unit Supervisor B did not make the Logbook entry or perform the 4-hour flow estimation and therefore, failed to satisfy Tech Spec 3.3.3.11(b).

On July 27 and 28, 1984, Shift Supervisor B failed to satisfy Tech Spec 3.3.3.11(b) by resolving item #79 discrepancy as "Complying with Tech Spec Action Item" eventhough no entry was made to the Tech Spec Action Item Logbook or any 4-hour flow estimation performed as required by Tech Spec 3.3.3.11(b).

On July 29 and 30, 1984, Shift Supervisor A once again failed to satisfy Tech Spec 3.3.3.11(b) by signing "Work Request In" for item #79 discrepancy while no Logbook entry was made and no 4-hour flow estimation was performed.

The failure to satisfy Tech Spec 3.3.3.11(b) is attributed mainly to the confusion in clearing Tech Spec Surveillance discrepancies. The failure to satisfy Tech Spec

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EVELPER 8/31/05

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may also be attributed to a procedural deficiency. PT/1/A/4600/02 allowed only the use of computer point AllO4 to check the channel operability for item #79, thereby, not providing flexibility for the Supervisors to respond when this computer point was out of service.

CORRECTIVE ACTION

PT/1/A/4600/02 was revised on 7/31/84 so that all available indications can be used to verify channel and instrumentation operability.

Licensed Personnel will be upuated on clearing Tech Spec Surveillance discrepancies.

The subsequent revision of PT/1/A/4600/02 provides flexibility in verifications while retaining accuracy.

Personnel update will provide skills in resolving Tech Spec Surveillance discrepancies and help to eliminate similar incidents in the future.

SAFETY ANALYSIS

The radiation and flow instrumentation of the Unit Vent is essential for the continuous monitoring of potential off-site radioactive gaseous release to ensure the public health and safety.

In this incident Catawba Unit 1 was initially loaded with new fuel and has not yet gone critical. No radioactive gas could be released through the Unit Vent.

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

DUKE POWER COMPANY

P.O. BOX 3318€ CHARLOTTE, N.G. 28242

HAL B. TUCKER VICE PRESIDENT NUCLEAR PRODUCTION

August 29, 1984

TELEPHONE (704) 373-4531

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

Subject: Catawba Nuclear Station, Unit 1 Docket Nos. 50-413

Gentlemen:

Pursuant to 10 CFR 50.73 Sections (a) (1) and (d), attached is Licensee Event Report 413/84-04 concerning Daily Surveillance of Unit Vent Flow Rate Improperly Performed. This event was considered to be of no significance with respect to the health and safety of the public.

Very truly yours,

The 13. Tucken

Hal B. Tucker

RWO:slb

Attachment

cc: Mr. James P. O'Reilly, Regional Administrator
U. S. Nuclear Regulatory Commission
Region II
101 Marietta Street, NW, Suite 2900
Atlanta, Georgia 30323

Records Center Institute of Nuclear Power Operations 1100 Circle 75 Parkway, Suite 1500 Atlanta, Georgia 30339

NRC Resident Inspector Catawba Nuclear Station

American Nuclear Insurers c/o bottie Sherman, ANI Library The Exchange, Suite 245 279 Farmington Avenue Farmington, CT 06032

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Document Control Desk August 29, 1984 Page 2

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