NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Oconee Nuclear Station, Unit 2	0 5 0 0 0 2 7 0	1 OF 0 3

TITLE (4)
Unit Vent Radiation Monitor Inoperable Without Establishing Manual Sampling

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 5 0 0 0
1 2	1 9	8 5	8 5	0 0 9	0 0	0 1	1 5	8 6		0 5 0 0 0

OPERATING MODE (9)	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
Philip J. North	AREA CODE: 7 0 4 — 3 7 3 - 7 4 5 6

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)

On December 19, 1985 at 0815 hours, with Unit Vent Radiation Monitor 2RIA-45 out-of-service, a review of Technical Specification 3.5.5.2 revealed that required grab samples performed on an eight hour frequency were not established.

The cause of the incident was determined to be personnel error. The review of Technical Specifications by Operations personnel did not take into account the requirements for grab samples while effluents are exhausted via the Unit 2 vent.

Immediate corrective action was to sample the Unit 2 vent system for noble gas activity. Supplemental corrective actions include the return of 2RIA-45 to service, and counseling of appropriate Operations personnel. Grab sample results were verified to be within 10 CFR 20 limits.

Although grab samples were not established as required, three monitors were operable and monitoring the Unit 2 Vent system with sufficient sensitivity. Alarm setpoints are calculated to assure that the alarm will occur prior to exceeding 10 CFR 20 limits. No abnormal radioactive noble gas concentrations were released via the Unit 2 vent system while 2RIA-45 was out of service. Therefore, the health and safety of the public were not affected.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

DESCRIPTION OF OCCURRENCE:

On December 18, 1985, with Unit 2 at 100% full power, during the 0800 to 1630 hour shift, the Instrument and Electrical (I&E) crew was performing the annual calibration of the vent system noble gas radiation monitor (2RIA-45). At 1625 per the calibration procedure, the I&E Supervisor informed the Control Room Senior Reactor Operator of the procedure's direction to declare the instrument channel inoperable due to out of tolerance high values on the log ratemeter output.

Since no Unit 2 release from the waste gas tanks or the containment purge was in progress or expected, after referring to Technical Specification 3.5.5, Control Room Personnel determined that the inoperable status of 2RIA-45 would be accepted without continued effort by I&E to correct the out of tolerance conditions. Shift turnover sheets correctly made reference to Technical Specification sections for compensatory action and stated the criteria of 2RIA-45 must be operable prior to refueling or containment purge. However, no mention was made of the monitoring of the gaseous effluents from the unit ventilation system or from the unit air ejectors.

On December 19, 1985, at 0025 hours, Technical Specification 3.5.5.2 was violated as a result of 2RIA-45 being taken out-of-service without establishment of grab samples at an eight hour frequency as the contingency requirement.

On December 19, 1985, at approximately 0630 to 0700 hours, discussions between the Control Room Operators and the Shift Health Physics Technician prompted a review of T.S. 3.5.5.2. The review led to the discovery at 0815 of 2RIA-45 being out-of-service for greater than eight hours, without monitoring by grab sample. At 0830 hours, a grab sample was taken and analyzed for noble gas activity. At 1125 hours, work was completed and 2RIA-45 was returned to service.

CAUSE OF OCCURRENCE:

Personnel error is the root cause of this event. The review of T.S. 3.5.5.2 by Operations Personnel took into account the first paragraph of compensatory action, but not the second paragraph which contained the once per eight hour grab sample frequency while effluents are exhausted via the Unit 2 vent.

A contributing cause of this incident was the less than adequate communication between Operations and Health Physics when plant status information was exchanged at the 1900 to 0700 shift start. The information exchange had the potential to prevent the T.S. violation by alerting the Health Physics shift of the need to take a grab sample prior to exceeding the eight hour time period. If the shift start information exchange had included the inoperable 2RIA-45, the Health Physics program of grab sampling as the contingency requirement for loss of 2RIA-45 would have been initiated.

CORRECTIVE ACTION:

The immediate corrective action was to sample the Unit 2 vent system for noble gas activity. Grab sample results were verified to be within 10 CFR 20 limits for release to the unrestricted area.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

Supplemental corrective action included satisfactory completion of procedure to permit 2RIA-45 to be returned to service, and the counseling of appropriate operations personnel regarding this incident.

There are no planned or recommended corrective actions.

ANALYSIS OF OCCURRENCE:

During the period when 2RIA-45 was inoperable, 2RIA-43, 2RIA-44, and 2RIA-46 were operable and monitoring the Unit 2 Vent System with particulate channel (2RIA-43) and the iodine channel (2RIA-44) sufficiently sensitive to radioactive noble gas to give indication of abnormal concentrations of radioactive materials in the effluents. In addition to the Unit 2 vent system radiation monitors, the individual system process radiation monitors on the Unit 2 Air Ejectors (2RIA-40) and on the Auxiliary Building Ventilation System (1RIA-32) were operable and sensitive to radioactive noble gas.

If an abnormal concentration had occurred, the alarm setpoints for these radiation monitors are calculated to assure that the alarm will occur prior to exceeding the limits of 10CFR20. No abnormal radioactive noble gas concentrations were discharged via the Unit 2 vent system during the time 2RIA-45 was out-of-service as confirmed by the redundant radiation monitors and the grab sample results. Therefore, the health and safety of the public were not affected by this incident.

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January 20, 1986

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

Subject: Oconee Nuclear Station
Docket Nos. 50-269, -270, -287
LER 270/85-09

Gentlemen:

Pursuant to 10 CFR 50.73 Sections (a) (1) and (d), attached is Licensee Event Report 270/85-09 concerning manual sampling that was not established while a unit vent radiation monitor was inoperable.

This report is being submitted in accordance with 50.73 (a)(2)(i). This event is considered to be of no significance with respect to public health and safety.

Very truly yours,

Hal B. Tucker/jgm

Hal B. Tucker

PJN/jgm

Attachment

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