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)
Indian Point Unit 2	0 5 0 0 0 2 4 7	1 OF 0 4

TITLE (4)
Plant Vent Gas Releases Without Completion of Surveillance Test for Monitor R-14

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
0 3	0 3	8 6	8 6	0 1 2	0 1	0 6	2 7	8 6		0 5 0 0 0

OPERATING MODE (9)	N	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)	20.405(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
Michael Blatt, Manager	9 1 4 9 2 6 - 5 1 2 7

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	
A				N							

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)

During the time period between March 3-17, 1986, while the Unit was at cold shutdown for a refueling outage, releases from the Large Gas Decay Tanks occurred although a monthly source check of the plant vent noble gas activity monitor, R-14, had not been completed. A step in the test procedure, although accomplished, was not strictly adhered to. Consequently, the additional sampling, analysis, and verification of release rate calculations when the monitor is not in service were not performed as required by Technical Specifications.

The need for strict procedure adherence was reinforced with involved personnel.

Subsequently, satisfactory operation of R-14 during the entire period was confirmed. The health and safety of the public were not affected.

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Plant and System Identification:

Westinghouse 4-loop Pressurized Water Reactor

Identification of Occurrence:

In a review on March 25, 1986 of Significant Occurrence Report 86-119 it was discovered that Large Gas Decay Tank releases had occurred between March 3 and March 17, 1986 at times when the plant vent monitor should have been deemed out-of-service because its test had not been completed within the required surveillance interval and independent sampling from the Large Gas Decay Tanks had not been conducted.

Event Date: March 3, 1986

Discovery Date: March 25, 1986

Report Due Date: April 24, 1986

Past Similar Occurrences: None

Description of Occurrence:

Indian Point 2 was at cold shutdown during a refueling outage. Technical Specification Table 4.10-4 requires a monthly source check of the plant vent noble gas activity monitor, R-14, but the check was not performed within the required interval.

The test, PT-61, "Process Radiation Monitor Source Check" was issued February 7, 1986 and was scheduled to be conducted between February 11 and 18, 1986. It was completed on time for four other monitors included in the test.

The check of R-14 was to be conducted on either February 17 or 18. The monitor is accessed by a steel ladder located outdoors. Periods of various types of precipitation, including freezing precipitation, occurred intermittently, beginning late on February 16 and continuing through February 18, making access to R-14 unsafe. When data cannot be

obtained, there are provisions for entering "N/A" in the appropriate data sheet. The technician used the "N/A" entry in this instance, and although it was correct, it was not appropriate because acceptable numerical values were required. Based on the "N/A" entry he later incorrectly recorded satisfaction of the test criteria. Consequently, the Senior Watch Supervisor (SWS) concluded that test operability criteria were satisfied.

The Test organization received the test for final evaluation on February 25, 1986. Upon review by the Test Engineer it was discovered that R-14 had not been tested and therefore the test had not passed as originally recorded. On February 28, the Test Engineer returned the test to the Instrument and Control Section via a Test Resolution Report to correct the record and initiate the required Significant Occurrence Report. A follow-up date of March 10 was indicated. On March 18 the next monthly surveillance test was satisfactorily completed. On March 21 a Significant Occurrence Report was issued confirming the missed surveillance. The monitor was not declared inoperable at that time because the monthly surveillance for March had already been satisfactorily completed. Thus during the missed interval the monitor was in fact capable of performing its intended function, notwithstanding the missed surveillance interval.

Since the required surveillance was not completed for the period between February 25 and March 17 the monitor should have been declared inoperable.

Analysis of Occurrence:

This event is reportable because the required surveillance interval was exceeded and releases that occurred from March 3-17, 1986 were not made in accordance with Technical Specification section 3.9.B.2.

During this 15 day period the equivalent of 15 Large Gas Decay Tanks were released without the additional sampling, analysis, and verification of release rate calculations as required by Technical Specification Table 3.9-2, Actions 1 and 6 when the subject monitor is inoperable.

The health and safety of the public were not affected since the monitor did in fact perform its intended function during the entire time period. All alarms and indication were verified to be working during an additional surveillance test on March 7, and daily channel checks of the monitor indicated proper operation during this time period. The required source check was completed on March 18 and it confirmed proper monitor operation during the period since the prior surveillance.

Cause of Occurrence:

The cause of this event was personnel failure to strictly adhere to a procedure step. The test, as it was initially returned to the Test group for evaluation, was thought to have been completed on time and to have satisfied all operability criteria. If the test had been failed the surveillance interval requirement would have been satisfied and available alternative actions would have been taken to permit the releases that occurred.

Corrective Action:

During the review of this event, and the interviews that were conducted with personnel involved, the correct completion of this type of test procedure was reinforced.

To further prevent recurrence, the provision in the general instruction issued with each surveillance test, which permitted discretionary use of an "N/A" entry, has been withdrawn. The use of an "N/A" entry continues to be permitted on a case by case basis in surveillance tests. Additional guidance has been given to personnel with test-related responsibilities concerning situations that require the attention of and action by the SWS.

John D. O'Toole
Vice President

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June 27, 1986

Re: Indian Point Unit No. 2
Docket No. 50-247
LER-86-012-01

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

Dear Sirs:

Licensee Event Report LER-86-012-00 was submitted on April 24, 1986 in accordance with the requirements of 10 CFR Part 50.73. A revision to that LER is attached. Margin bars indicate changes from the initial submittal.

Very truly yours,

John D. O'Toole

attach.
cc: Dr. Thomas E. Murley,
Regional Administrator - Region I
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