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U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES 8/31/85

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### BACKGROUND

NRC Form 366A

A Nuclear Station Modification (NSM) is a planned change to a structure, system or component at an operational Nuclear Station and is accomplished in accordance with the requirements and limitations of applicable codes, standards, specifications, licenses, and safety restrictions. An NSM request form is normally initiated by the Projects Services Section at the station. Once the design of the NSM is completed, the appropriate design drawings and information are transmitted to the Construction Maintenance Division (CMD). CMD will assemble the Project Team Commitment Package (COMPAK) through a series of meetings involving C'D, appropriate station representatives, and Design Engineering, if necessary.

Implementation of modifications has been performed under the work request program in conjunction with the shutdown request (F-13A) program. An F-13A is used to document installation activities. All work performed under F-13As must have a companion work request to document follow-up activities. One step of the COMPAK development is the initiation of the required F-13As and NSM Work Requests containing the required system isolation. Projects Services shall approve the NSM and notify station groups, as appropriate, of the NSM implementation. The Projects Services accountable engineer is to ensure that copies of marked drawings are sent to Operations or Chemistry prior to return of the affected system to operable status.

The Waste Gas (WG) System (EIIS:WE) is a closed loop system which transfers, receives, processes and contains radioactive gases from contaminated fluids. Decay tanks (EIIS:TK) are used in the system for storage of these gases.

There are four gas traps (EIIS:TRP) located in the WG system at low point drains. These traps are designed to allow liquid to drain into a sump without releasing gas. As the gas/liquid mixture enters the trap, the gas is forced out of the top of the trap and into the suction of one of the WG compressors.

The Auxiliary Building Filtered Exhaust System (EIIS:VF) is the portion of the Auxiliary Building Ventilation (VA) System that serves areas of the Auxiliary Building which are subject to potential contamination. During normal plant operation, two filtered exhaust trains operate as two 50% capacity components. Each filter train is equipped with a bypass section, which is the normal mode of operation. The VA radiation monitor (EIIS:IL) (EMF-41) monitors twelve points throughout the Auxiliary Building every hour, sampling each point for five minutes. Upon indication of a radiation level equal to or above 3000 counts per minute (cpm), EMF-41 enters a Trip 1 condition, and a yellow light will become illuminated on the EMF panel. Upon receiving indication of a radiation level equal to or above 4000 cpm, EMF-41 will enter a Trip 2 condition. In Trip 2, a red light will become illuminated on the EMF panel and an audible alarm (EIIS:RA) will sound in the Control Room. Upon receiving a Trip 2 indication, the VA system will automatically swap to direct air flow through the filter trains. At the time of this incident, Technical Specification 3.3.2 was interpreted that any automatic actuation of VA from the Bypass to the Filter mode is an Engineered Safety Feature (ESF) actuation.

NRC Form 366A (9-63)	LICENSEE EVENT REPOR	RT (LER) TEXT CONT	TINUATION	U.S. NUCLEAR REGU APPROVED OM EXPIRES 8/31/	LATORY COMMISSION B NO 3150-0104 85
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The Unit Vent Airborne Monitor continuously monitors the gaseous, iodine, and particulate activity levels in the Auxiliary Building Ventilation System and other potentially radioactive sources which are released through the Unit Vent. The Unit Vent Airborne Monitor consists of three EMF monitors, which are EMF-35, EMF-36, and EMF-37. EMF-36 is the gaseous activity monitor, and it is limited to a maximum of 1.4 mrem/day of noble gases to be released through the Unit Vent. A Trip 2 indication of any of the three EMF's will isolate the Containment Purge Ventilation (VP) and Containment Air Release and Addition (VQ) Systems and trip the VA System.

Technical Specification 3.11.2.1 requires that the dose rate due to radioactive materials released in gaseous effluents from the site to areas at and beyond the site boundary for noble gases be less than or equal to 500 mrem/year to the whole body.

# DESCRIPTION OF INCIDENT

NSM CN-50110 Revision 1 was written to provide level instrumentation and reach rods on seven of the WG Suction Header Low Point Drain Valves (EIIS:V), the Recycle Holdup Tank Eductor Low Point Drain Valve, and the Recycle Holdup Tank Line Low Point Drain valve. The NSM was approved by the Station Manager on November 20, 1984. The use of F-13A programs for the installation of station modifications was scheduled to cease at commercial operation of Unit 2. At that time, all F-13A's were to be converted to work requests. This date was extended to approximately January 1, 1987, for certain modifications agreed upon by Station, QA, and CMD personnel. After receipt of NSM CN-50110 Rev. 1, CMD began assembly of the COMPAK. On August 13, 1986, the responsible CMD Mechanical Technical Support Technician initiated Shutdown Request F-13A F00725 to install the reach rods on the nine WG drain valves. F-13A F00725 was marked NO ISOLATION REQUIRED to perform work. On September 3, 1986, an Integrated Scheduling Engineer marked Operations (OPS) as the operational control group on F-13A F00725. On September 25, 1986, Projects initiated Work Request 11168 NSM for stroking of the nine WG drain valves. On September 29, 1986, Projects completed the Implementation Plan for Work Request 11168 NSM. On December 1, 1986, CMD contacted OPS prior to beginning work, and the OPS Unit Supervisor signed the F-13A for CMD to begin work. During the first tow weeks of December, preliminary work on the NSM was in progress. On approximately December 18, 1986, the CMD crew began installing the reach rods onto the WG drain valves. During this time, the CMD crew had the NSM package containing F-13A F00725 and the Implementation Plan for Work Request 11168 NSM; however, Work Request 11168 NSM was not with the NSM package. On January 5, 1987, the CMD crew completed the installation of the reach rods. At this time, CMD began stroking the valves to verify operation of the reach rods. At 1030 hours, Health Physics (HP) noticed high background radiation on a local frisker in the Decon Room. HP and Radwaste Chemistry (RW) began to search for the source of the radiation. At 1145 hours, HP discovered EMF-41 in Trip 1 condition and notified Control Room personnel. At 1200 hours, RW discovered that Waste Gas Decay Tank (WGDT) C had experienced a pressure loss of between 30 and 40 pounds. RW suspected that a drain trap had failed. At 1230 hours, RW notified HP of the gas leak problem. RW isolated a WG drain trap, isolated purge from the Unit 1 and Unit 2 Volume Control Tanks, and tripped both WG

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compressors. At 1237 hours, EMF-41 experienced a Trip 2 alarm which realigned VA to the Filter mode. Control Room personnel acknowledged apparently the audible alarm without recognizing EMF-41 Trip 2 as being the source. At 1245 hours, RW discovered the CMD crew stroking the WG drain valves. At this time, RW realized that WG Drain Trap T-04 must have failed. RW began to verify the position of the nine WG valves. At 1319 hours, RW isolated WGDT C. At 1340 hours, RW notified the Shift Supervisor of the gas leak. At 1410 hours, RW discovered valve 1WG-340, WG Suction Header Low Point Drain #3, was 75% open and valve 1WG-350, WG Suction Header Low Point Drain #6, was cracked open. RW closed both valves. RW placed WGDT C into service and monitored it for leakage. No leakage was found. At 1425 hours, RW placed WG compressor A into service. HP obtained a gas sample in order to make the release determination. At 1427 hours, RW placed WG compressor B into service. At 1500 hours, a Staff Health Physicist found EMF-41 in Trip 2 and reset the Trip 2 signal without notifying Control Room personnel. The Staff Health Physicist thought OPS was aware of the Trip 2 signal. He knew that the gas leak problem had been identified and controlled. At 1515 hours, RW and other HP personnel discussed the EMF status; however, they were aware of the Trip 1 condition only. The Unit 2 Nuclear Control Operator (NCO), while performing a walk through of the Control Room, discovered the Unit 2 VA in the Filter mode. The Unit 1 NCO discovered the Unit 1 VA in the Filter mode. Both NCOs discussed the VA alignment with the Shift Senior Reactor Operator and the Unit 2 Supervisor. Being unaware of the EMF-41 Trip 2 condition, they believed VA had been inadvertently left in the Filter mode and the decision was made to realign VA to the Bypass mode. The Shift Supervisor and the Unit 1 Supervisor were not notified of the VA swap. At 1724 hours, the Unit 2 NCO realigned the Unit 2 VA to the Bypass node. At 1812 hours, the Unit 1 NCO realigned the Unit 1 VA to the Bypass mode.

On January 6, 1987, at 1430 hours, the Staff Health Physicist, while discussing reportability of the incident, informed the Unit 1 NCO of the EMF-41 Trip 2. A review of the Alarm Typer and the EMF Strip Chart revealed that a VA swap to the Filter mode had occurred. The NCO informed the Shift Supervisor that VA had swapped to the Filter mode on the previous day. At 1740 hours, OPS notified the NRC of the EFS actuation in accordance with procedure RP/C/B/5000/13, NRC Notification Requirements.

#### CONCLUSION

At the time of initial NRC notification, this incident was determined to be reportable due to the ESF actuation of automatically realigning VA to the Fi lered mode as specified in RP/C/B/5000/13. This automatic realignment of VA resulted from an EMF-41 Trip 2 actuation. Further review of FSAR Section 9.4.3 has determined that the realignment of VA to the Filtered mode due to an EMF-41 Trip 2 actuation is a normal mode of operation used to meet ALARA considerations. The realignment of VA to the Filtered mode on a LOCA signal constitutes an ESF actuation.

Due to the nature of this incident and the fact that there is no reportable event, several cause codes have been assigned.

NRC Form 366A (9-83)	LICENSEE EVENT REPOR	T (LER) TEXT CONTINU	a.u NOITAU	APPROVED C EXPIRES 8/3	ULATORY COMMISSION MB 140. 3150-0104 1/85
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Cause Code X, Other, has been assigned to this incident due to the failure of WG Drain Trap T-04. The trap failed ot maintain a water seal, resulting in a radioactive gas release to Waste Evaporator Feed Tank Sump B and thus to the Auxiliary Building and out of the Unit Vent. The increased radiation level caused an EMF-41 Trip 2 signal resulting in the automatic realignment of VA to the Filtered mode. RW initiated a Work Request to investigate and repair the failure of WG Drain Trap T-04. Investigation revealed corrosion sediment in the trap. The trap was cleaned and the internals replaced. Functional verification was successfully performed and the work request completed on January 20, 1987, at 1600 hours. Cn January 21, while CMD and RW were stroking the WG valves per Work Request 11168 NSM, WG Drain Trap T-04 failed again. RW initiated another Work Request to investigate and repair. Corrective maintenance was completed; however, the trap did not pass its functional verification. Maintenance personnel plan to remove the trap from the system for further testing. Any other appropriate action will be initiated as required.

WG Drain Trap (EIIS:TRP) T-04 is an Erwel Type A-250 Compressed Air Drain Trap. A review of NPRDS revealed no reportable applications of this trap. This failure is not reportable to NPRDS.

Cause Code E, <u>Management</u>/Quality Assurance Deficiency has also been assigned to this incident. The continuing use of the F-13A program along with the work request program lent confusion to the processing, handling, and installation of station modifications. In addition, no established methods were provided for determining the operational control groups for systems to be used during the work planning phase.

The use of F-13A programs for the installation of station modifications was scheduled to cease at commercial operation of Unit 2 (September 1, 1986). At that time, all F-13A's were to be converted to work requests. This date was extended to approximately January 1, 1987, for certain modifications agreed upon by Station, QA, and CMD personnel. NSM CN-50110, Rev. 1 was one of the extended modifications. During the technical approval review for F-13A F00725, Integrated Scheduling incorrectly identified OPS as the operational control group. The CMD crew thus, contacted OPS prior to starting work on the F-13A. This resulted in RW, the actual operational control group, not being aware of the work being performed. During the investigation of this incident, Chemistry and OPS expressed concerns of this problem also occurring with the use of work requests. Project Services incorrectly routed the NSM package and marked-up drawings for NSM CN-50110, Rev. 1 to OPS instead of RW. This prevented RW from having knowledge of the modification being installed.

All modification work done under an F-13A must have a companion work request to document follow-up activities or that follow-up activities are not required. Work Request 11168 NSM was the follow-up work request for F-13A F00725 and was written to stroke the WG valves after installation of the reach rods. When the CMD crew started work on F-13A F00725, the follow-up work request was not with the package. The CMD crew felt that the use of an F-13A allowed them more freedom with the

LICENSEE	EVENT	REPORT	(LER)	TEXT	CONTINUATION
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U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB ND. 3150-0104 EXPIRES 8/31/85

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system due to past experiences during the pre-operational phase. An F-13A was perceived to return control of equipment/systems to the Construction Department.

With the F-13A marked as not requiring isolation and with the follow-up work request not with the package, the CMD crew felt justified in operating the WG valves as required to ensure proper installation of the reach rods.

Cause Code A, Personnel Error, has also been assigned to this incident due to violation of procedures and a Station Directive. Upon actuation of the EMF-41 Trip 2 signal, an audible alarm sounded in the Control Room. A red Trip 2 indicating light and an annunciator light illuminated on the EMF panel. Personnel in the Control Room acknowledged the audible alarm without taking proper response action as stated in Operations Management Procedure (OMP) 1-8, Authority of Responsibility of Licensed Reactor Operators and Licensed Senior Reactor Operators. Control Room personnel when interviewed had no knowledge of the alarm or who acknowledged the alarm. A Staff Health Physicist reset the EMF-41 Trip 2 signal, extinguishing the red Trip 2 indicating light and the annunciator light, without approval from or notifying Control Room personnel. This was in contravention of Station Directive 3.15, Activities Affecting Station Operations or Operating Indications and OMP 2-16, Control Room Conduct. Cause Code A, Personnel Error, has also been assigned due to insufficient investigation. The Unit 1 and 2 NCOs discovered the VA systems in Filtered mode prior to shift turnover. They discussed the system status with the Unit 2 Supervisor and the Shift SRO. Being unaware of the EMF-41 Trip 2 condition, the decision was made to return the VA systems to the Bypass mode. The Shift Supervisor was not informed. The NCOs, Unit Supervisor and Shift SRO did nct thoroughly investigate the reason for VA being in the Filtered mode, taking into account the earlier WG release into the Auxiliary Building. The EMF-41 Trip 2 signal and the subsequent VA realignment were not recognized until 1430 hours on January 6, 1987.

Cause Code D, Procedure Deficiency has also been assigned to this incident. RP/C/B/5000/13 incorrectly identified the automatic VA swap due to EMF-41 Trip 2 as an ESF actuation.

There have been no previous Licensee Event Reports involving failure of a WG Drain Trap or the F-13A Program exhibiting inadequate work controls.

## CORRECTIVE ACTION

- (1) WG Decay Tank C was isolated.
- (2) Valves 1WG-340 and 1WG-350, which were left open, were closed.
- (3) A Work Request was initiated and completed to investigate and repair WG Drain Trap T-04.
- (4) This incident was reviewed with involved CMD personnel.

NAC Form 386A

NRC Form 366 (9-83)	LICENSEE EVENT REPOR	RT (LER) TEXT CONTINU	U.S. NUCLEAR UATION APPROVE EXPIRES	REGULATORY COMMISSION D OMB NO. 3150-0104 8/31/85
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(5)	OPS reviewed this incident with	all shift personnel		
(6)	OMP 2-16, Control Room Conduct, to verbally notify other approp alarms.	was revised to requ riate Control Room p	ire Control Room pers ersonnel when acknowl	connel edging
(7)	A Technical Specification inter stating that only the realignme constitutes an ESF actuation wa	pretation for Techni nt of VA to the Filt s initiated and appr	cal Specification 3.3 ered mode on a LOCA s oved.	3.2 signal
(8)	Station Directive 3.0.3, Manage	ment of Shutdown Req	uest was deleted.	
(9)	Station Directive 3.10.1, Opera include Projects Services, Plan drawings.	tional Control of Sy ning, and CMD to dis	stems, was revised to tribution of boundary	2
(10)	Maintenance Management Procedur ensure that the responsible pla request which group has operati worked.	e 1.0, Work Request nner will determine onal control of the	Preparation, was revi and indicate on each system/component bein	sed to work g
(11)	All HP personnel were informed be reset only with permission o	that EMF Trip 1 and f Control Room perso	Trip 2 signals/lights nnel.	can
(12)	RP/0/B/5000/13, NRC Notificatio Technical Specification Interpr	n Requirements, was etation for Technica	revised to incorporat 1 Specification 3.3.2	te the
(13)	Station Directive 4.4.4, Proces revised to delete use of the F- are routed to the appropriate o	sing Nuclear Station 13A program and to e perational control g	Modifications, will nsure that all NSM pa roup.	be ackages
(14)	The use of more detailed Implem	entation Procedures	will be initiated.	
(15)	Maintenance will complete testi appropriate action.	ng of WG Drain Trap	T-04 and initiate any	7 other
SAFE	TY ANALYSIS			
Upor the cark indi filt bour maxi 3.11 tank excl	receiving the EMF-41 Trip 2 sig Filter mode as designed. In thi oon filters prior to release out cated the contents were noble ga ering effect on noble gases or t ided by FSAR Section 15.7.1, Radi mum activity in a single WG deca .2.6. This limit assures that i is contents, the resulting whole usion area boundary will not exc	nal, the VA Filtered s alignment, all VA the unit vent. HP a ses and tritium. Th ritium. A radioacti oactive Waste Gas Sy y tank is limited by n the event of an un body exposure to an eed 0.5 rem.	Exhaust Fans swapped exhaust was routed the nalysis of this release we VA carbon filters he ve gas leak of this t estem Leak or Failure. Technical Specificat controlled release of individual at the	l to nrough ase nave no type is The tion the

#### LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR RESULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES: 8/31/86

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The release to the environment was monitored by 1EMF-36, and 1EMF-36 did not experience any high radiation alarms during the release. The estimated total content of the release was 65.94 Curies. The whole body dose at the site boundary was 0.0136 mrem. This is not a contravention of Technical Specification 3.11.2.

Dose was assessed and assigned to the eight individuals directly involved in the area of the release, Room 213, Gas Decay Tank Drain Pump Room, and Room 214, Chemical Drain Tank Room, which are located on the 543 elevation of the Auxiliary Building. The total dose assigned was 51 mrem with the highest individual dose being 23 mrem.

This LER is being provided as a voluntary report.

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

NRC Form 366A

DUKE POWER COMPANY P.O. BOX 33189 CHARLOTTE, N.C. 28242

HAL B. TUCKER VICE PRESIDENT RUCLEAR PRODUCTION TELEPHONE (704) 373-4531

July 13, 1987

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

Subject: Catawba Nuclear Station, Unit 1 Docket No. 50-413 LER 413/87-01-01 (Revision 1)

Gentlemen:

Pursuant to 10 CFR 50.73 Section (a) (1) and (d), attached is Revision 1 to Licensee Event Report 413/87-01 concerning an inadvertent waste gas release due to failure of a waste gas drain trap. This event was considered to be of no significance with respect to the health and safety of the public.

Very truly yours,

Hall B. Turkenpour

Hal B. Tucker

JGT/68/sbn

Attachment

xc: Dr. J. Nelson Grace Regional Administrator, Region II U. S. Nuclear Regulatory Commission 101 Marietta Street, NW, Suite 2900 Atlanta, Georgia 30323

> M&M Nuclear Consultants 1221 Avenue of the Americas New York, New York 10020

INPO Records Center Suite 1500 1100 Circle 75 Parkway Atlanta, Georgia 30339 American Nuclear Insurers c/o Dottie Sherman, ANI Library The Exchange, Suite 245 270 Farmington Avenue Farmington, CT 06032

Mr. P. K. Van Doorn NRC Resident Inspector Catawba Nuclear Station