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FACIL:50-410 Nine Mile Point Nuclear Station, Unit 2, Niagara Moha 05000410
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SUBJECT: LER 88-060-00:on 881010,Tech Specs noncompliance due to missed surveillance on radiation monitor 2SWP*RE146B. W/8 ltr.

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NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Nine Mile Point Unit 2	0 5 0 0 0 410	1 OF 04

TITLE (4) Technical Specification Non-Compliance due to Missed Surveillance on Radiation Monitor 2SWP*RE146B - Programmatic Deficiency

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)
									N/A	0 5 0 0 0
10	10	88	88	060	00	11	28	88	N/A	0 5 0 0 0

OPERATING MODE (9)	4	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	000	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	
Pasquale Volza, Radiation Protection Manager	315	349-2429

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 October 28, 1988 at 1210 hours, with the reactor mode switch in "SHUTDOWN" (Operational Condition 4), the Operations Department determined that a Limiting Condition for Operation (LCO) as defined by Technical Specification (TS) 3.3.7.9 had been exceeded at Nine Mile Point Unit 2 (NMP2). The LCO was exceeded when the Service Water System radioactive liquid effluent monitor, 2SWP*RE146B, was inoperable for approximately 17 days without observing the proper TS Action Item. The monitor was inoperable due to a missed surveillance test. At the time of this determination reactor coolant pressure was ambient and reactor coolant temperature was approximately 101 degrees Fahrenheit.

The root cause of this event has been determined to be a programmatic deficiency.

Immediate corrective actions taken by the Niagara Mohawk licensed operators were: (1) declare monitor 2SWP*RE146B inoperable; (2) instruct the Chemistry Department to take grab samples; and (3) have the Radiation Protection Department perform the required surveillance test.

Additional corrective actions for this event are: (1) the Surveillance Procedure report format has been modified so completion dates will be documented for each independent component; and (2) a Lessons Learned transmittal will be issued to all applicable departments.

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Nine Mile Point Unit 2	0 5 0 0 0 410	88	— .060	— 00	02 OF 04

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

I. DESCRIPTION OF EVENT

On October 28, 1988 at 1210 hours, with the reactor mode switch in "SHUTDOWN" (Operational Condition 4), the Operations Department determined that a Limiting Condition for Operation (LCO) as defined by Technical Specification (TS) 3.3.7.9 had been exceeded at Nine Mile Point Unit 2 (NMP2). The LCO was exceeded when the Service Water System radioactive liquid effluent monitor, 2SWP*RE146B, was inoperable for approximately 17 days without observing the proper TS Action Item. The monitor was inoperable due to a missed surveillance test. At the time of this determination reactor coolant pressure was ambient and reactor coolant temperature was approximately 101 degrees Fahrenheit.

The sequence of events which resulted in this TS violation is as follows.

On October 7, 1988 at 0400 hours, 2SWP*RE146B was declared inoperable due to a spurious alert and high alarm signal on the monitor. A work request (WR 135192) was issued to investigate the cause of the alarms. This action generated an entry in Equipment Status Log (ESL), #88-693.

Per TS 3.3.7.9, Action 130 "With the number of channels OPERABLE less than required by the Minimum Channels OPERABLE requirement, effluent releases via this pathway may continue provided that, at least once per 12 hours, grab samples are collected and analyzed for radioactivity", the Station Shift Supervisor (SSS) dispatched chemistry personnel to obtain periodic 12 hour grab samples.

At 0745 hours, the Radiation Protection (RP) Department commenced surveillance procedure N2-RSP-RMS-M003, "Monthly Source Check of DRMS (Digital Radiation Monitoring System) Technical Specification Radiation Monitors", which included monitor 2SWP*RE146B. The SSS notified the RP technicians that WR 135192 was still open.

At 0830 hours, the RP technicians notified the SSS, they had successfully completed their surveillance without source checking 2SWP*RE146B.

On October 10, 1988 at 2000 hours the Chemistry Department obtained their final sample at 2SWP*RE146B.

At 2145 hours, the SSS cleared entry #88-693 (WR 135192 was closed) from the ESL, put 2SWP*RE146B back in service, and relieved the Chemistry Department of obtaining any additional grab samples.

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

On October 28, 1988, as a result of NMP2 LER (Licensee Event Report) 88-53, RP Supervision performed a subsequent review of the October 7, 1988 test results for N2-RSP-RMS-M003 and determined that 2SWP*RE146B had been declared operable and had not been source checked as required by TS. October 10, 1988 was the last day the surveillance test for 2SWP*RE146B could be performed without it being overdue.

The RP supervisor then informed the SSS of the missed surveillance. The SSS after reviewing this information then declared 2SWP*RE146B inoperable at 1210 hours on October 28, 1988.

There were no inoperable systems or components at the start of this event which contributed to this event. No component failures occurred as a result of this event.

II. CAUSE OF EVENT

The root cause of the event has been determined to be programmatic deficiency. The RP personnel did not follow up on WR 135192 status after October 7, 1988, to perform the required surveillance testing upon restoration of 2SWP*RE146B to an operable status even though the procedure was completed with WR 135192 open.

A contributing factor was that the RP surveillance test results were not reported by individual testable components or channels, instead by procedure completion. Thus, if RP personnel would have tracked 2SWP*RE146B for source check status, the database would have shown it done on October 7, 1988.

III. ANALYSIS OF EVENT

The requirements of TS 3.3.7.9 are provided to assure that the release of radioactive materials in liquid effluents to unrestricted areas will be maintained within the requirements of 10CFR20.

Even though monitor 2SWP*RE146B was not operable as defined by TS, the monitor was in service and monitoring the liquid effluent through its pathway. Additionally the post-event surveillance test proved the monitor to be working properly. Therefore, we can state with confidence that the monitor was working properly during the event, performing its detection function.

Thus, it is concluded that there were no significant releases and no adverse safety consequences resulted from this event.

The monitor was inoperable for approximately 17 days.

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

IV. CORRECTIVE ACTIONS

1. The Planning Department has installed nine reporting attachments in the Preventive Maintenance/Surveillance Test database. Each testable component has its own attachment for this particular procedure.

2. A Lessons Learned Transmittal will be issued to all departments performing surveillance tests explaining the event and its importance.

V. ADDITIONAL INFORMATION

A. Identification of Components Referred to in this LER

Component	IEEE 803 EIIS Funct	IEEE 805 System ID
Service Water System	N/A	BI
Radiation Monitor	MON	BI
Digital Radiation Monitoring System	MON	IL

B. Failed Components - None

C. Previous Similar Events -

LER 88-53 is related. LER 88-53 discussed a missed surveillance test due to inadequate tracking (surveillances of multiple components were tracked in a single item).

The experience learned with LER 88-53 did not prevent LER 88-60 because it was an existing condition.

NIAGARA MOHAWK

NMP41667

NINE MILE POINT—UNIT 2/P.O. BOX 63, LYCOMING, NY 13093/TELEPHONE (315) 343-2110

November 28, 1988

United States Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

RE: Docket No. 50-410
LER 88-60

Gentlemen:

In accordance with 10 CFR 50.73, we hereby submit the following Licensee Event Report:

LER 88-60 Is being submitted in accordance with 10 CFR 50.73 (a) (2) (i) (B), "Any operation or condition prohibited by the plant's Technical Specifications".

A 10 CFR 50.72 report was made at 1304 hours on October 28, 1988.

This report was completed in the format designated in NUREG-1022, Supplement 2, dated September 1985.

Very truly yours,

J. L. Willis
General Superintendent
Nuclear Generation

JLW/DAC/mjd

Attachments

cc: Regional Administrator, Region 1
Sr. Resident Inspector, W. A. Cook

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Cert No P967928906