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ACCESSION NBR: 8802030470 DOC. DATE: 88/01/28 NOTARIZED: NO DOCKET #
FACIL: 50-316 Donald C. Cook Nuclear Power Plant, Unit 2, Indiana & 05000316
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RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 88-001-00: on 871230, incorrect sample valve lineup for VRS-2500 auxiliary bldg vent radiation monitor discovered resulting in failure to meet Tech Spec 3.3.3.10 criteria. Caused by personnel error. Procedure changed. W/880129 ltr.

DISTRIBUTION CODE: IE22D COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 5
TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

NOTES:

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	AEOD/DOA	1	1	AEOD/DSP/NAS	1	1
	AEOD/DSP/ROAB	2	2	AEOD/DSP/TPAB	1	1
	ARM/DCTS/DAB	1	1	DEDRO	1	1
	NRR/DEST/ADS	1	0	NRR/DEST/CEB	1	1
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	REG FILE 02	1	1	RES TELFORD, J	1	1
	RES/DE/EIB	1	1	RES/DRPS DIR	1	1
	RGN3 FILE 01	1	1			
EXTERNAL:	EG&G GROH, M	5	5	FORD BLDG HOY, A	1	1
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INDIANA MICHIGAN POWER

January 29, 1988

United States Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

Operating License DPR-58
Docket No. 50-316

Document Control Manager:

In accordance with the criteria established by 10 CFR 50.73 entitled Licensee Event Reporting System, the following report is being submitted:

88-001-00

Sincerely,

W. G. Smith, Jr.
Plant Manager

WGS:afh

Attachment

cc: J. E. Dolan
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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)
DONALD C. COOK NUCLEAR PLANT, UNIT 2	0 5 0 0 0 3 1 6	1 OF 0 4

TITLE (4) MISSED TECHNICAL SPECIFICATION REQUIRED VENT STACK SAMPLING AS A RESULT OF INCORRECT SAMPLE VALVE ALIGNMENT DUE TO PERSONNEL ERROR

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)
1 2	3 0	8 7	8 8	0 0 1	0 0	0 1	2 8	8 8		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)	2	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	0 8 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
L. S. GIBSON - TECHNICAL PHYSICAL SCIENCES SUPERINTENDENT	AREA CODE 6 1 6 — 4 6 5 - 5 9 0 1

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 January 6, 1988, at 1310 hours, it was discovered that the sample valve lineup for VRS-2500, Unit 2 Auxiliary Building Vent Radiation Monitor, was incorrect. As a result of the incorrect lineup Technical Specification 3.3.3.10 Table 3.3-13 Section 3a was not met for continuous noble gas monitoring from December 30, 1987 to January 6, 1988.

The apparent cause of this event was cognitive personnel error. The chemistry technician involved did not restore the valves to their normal alignment after obtaining weekly grab sample off VRS-2500 on December 30, 1987 as per procedure.

After discovery of incorrect valve lineup on January 6, 1988, proper flow was restored to VRS-2500 and the valve lineup was verified correct (completed at 1320 hours).

The chemistry technician involved was counselled and the sampling procedure was changed to require independent verification of the proper valve alignment at VRS-2500.

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DONALD C. COOK NUCLEAR PLANT UNIT 2	0 5 0 0 0 3 1 6	8 8	— 0 0 1	— 0 0	0 2 OF 0 4

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

Conditions Prior to Occurrence

Unit 2 at 80 percent reactor thermal power.

Description of Event

On January 6, 1988 at 1310 hours, while obtaining a weekly sample from VRS-2500, Unit 2 Auxiliary Building Vent Radiation Monitor (EIIS/IL-MON), it was discovered that the sample valve lineup (EIIS/IL-SMV), to allow continuous monitoring of the Unit 2 Auxiliary Building Vent, was incorrect. The lineup, as found, was drawing air from the 650' auxiliary building elevation not the vent stack as required. (See attached sketch). Review of data from VRS-2500 indicates this condition had existed in all likelihood, since the last time VRS-2500 was sampled on December 30, 1987. At that time, the chemistry technician involved in sampling VRS-2500 did not restore the valving to its normal alignment as required by 2 THP 6020 LAB.135. During the time period (12/30/87 through 1/6/88), when the sample lineup was incorrect for VRS-2500, continuous noble gas monitoring or 8 hour grab samples as required by Technical Specification 3.3.3.10 Table 3.3-13 Section 3.a was not met. Other than the Auxiliary Building Vent Radiation Monitor, there were no inoperable structures, components, or systems that contributed to this event.

Cause of Event

The cause is cognitive personnel error. The valves were not restored to normal alignment after sampling VRS-2500 on December 30, 1987.

This is not the first occurrence regarding the failure to insure sample valves are in their correct alignment. Past preventive action for LERS 316/86-027-00; 316/86-001-00; 316/83-092-00 consisted of the implementation of a verification program. In the case of VRS-2500, the verification consisted of notifying the control room and remotely verifying that there were no alarms (including a flow alarm) for VRS-2500. This practice insured that there is a sample flow after sampling but does not verify correct sample flow path.

Analysis of Event

This incident is considered a missed surveillance in that the requirement for continuous noble gas monitoring in Technical Specification 3.3.3.10 Table 3.3-13 Section A was not met and is reportable under 10 CFR 50.73 (a)(2)(i).

During the time between December 30, 1987 and January 6, 1988 no gas decay tank (or other) releases were made which would cause release, via the vent

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

stack, above "normal" routine levels and therefore, we believe this event did not pose a threat to the health and safety of the public.

Corrective Action

After discovery of incorrect valve lineup on January 6, 1988, proper flow was restored to VRS-2500 and the valve lineup was verified correct (completed at 1320 hours). The technician involved was counselled as to the importance of insuring quality and procedure compliance. As preventive action a change to both 2 THP 6020 LAB.135 and 1 THP 6020 LAB.135 was written to require local independent verification of the proper valve alignment in addition to requesting Control Room personnel to verify the monitor has been returned to proper operational state.

Failed Component Identification

None

Previous Similar Events

LER 316/86-027-00; Failure to Verify Sample Flow Path, Due to Procedural Deficiency, Results in a Lack of Continuous Vent Stack Tritium Monitoring.

LER 316/86-001-00; Unit Vent Effluent Tritium

LER 316/83-092-00; Sample Valves at Outlet of Boron Injection Tank Left Partially Open.

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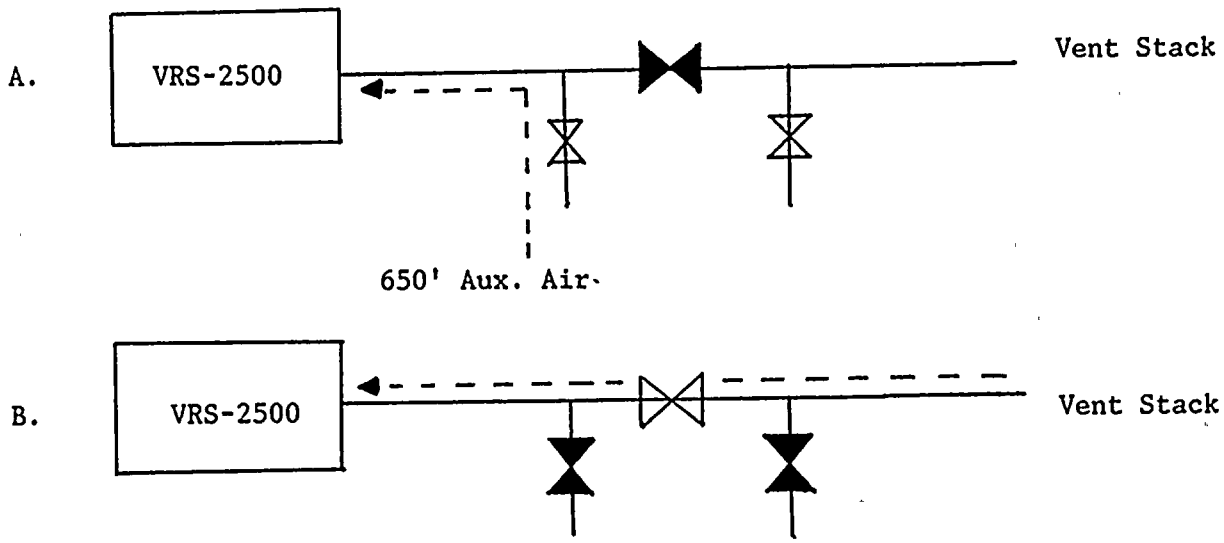
TEXT *(If more space is required, use additional NRC Form 366A's)* (17)



Configuration A reflects the as found condition. Configuration B is the correct by procedure flow path.