

James A. FitzPatrick
Nuclear Power Plant
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**New York Power
Authority**

Harry P. Salmon, Jr.
Site Executive Officer

February 26, 1996
JAFP-96-0084

United States Nuclear Regulatory Commission
Document Control Desk
Mail Station P1-137
Washington, D.C. 20555

SUBJECT: DOCKET NO. 50-333
LICENSEE EVENT REPORT: LER-96-001

Failure to Implement Radiation Monitor Instrumentation
Setpoint Changes Following Revision to the Offsite Dose
Calculation Manual (ODCM)

Dear Sir:

This report was submitted in accordance with 10 CFR 50.73
(a)(2)(i)(B), "Any operation or condition prohibited by the
plant's Technical Specifications".

There are no commitments associated with this LER.

Questions concerning this report may be addressed to Mr. W. Verne
Childs at (315) 349-6071.

Very truly yours,

HARRY P. SALMON, JR.

HPS:WVC:las
Enclosure

cc: USNRC, Region 1
USNRC Resident Inspector
INPO Records Center

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EXPIRES 04/30/98

LICENSEE EVENT REPORT (LER)

(See reverse for required number of
digits/characters for each block)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)

James A. FitzPatrick Nuclear Power Plant

DOCKET NUMBER (2)

05000333

PAGE (3)

01 OF 04

TITLE (4)

Technical Specification Violation Due To Failure To Implement Radiation Monitoring Instrumentation Setpoint Changes Following Revision To The Offsite Dose Calibration Manual (ODCM)

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 NAME	DOCKET NUMBER
01	25	96	96	-- 001	-- 00	02	26	96	N/A	05000
									FACILITY NAME	DOCKET NUMBER
									N/A	05000
OPERATING MODE (9)		N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)							
			20.2201(b)			20.2203(a)(2)(v)		X	50.73(a)(2)(i)	50.73(a)(2)(viii)
POWER LEVEL (10)		100	20.2203(a)(1)			20.2203(a)(3)(i)			50.73(a)(2)(ii)	50.73(a)(2)(x)
			20.2203(a)(2)(i)			20.2203(a)(3)(ii)			50.73(a)(2)(iii)	73.71
			20.2203(a)(2)(ii)			20.2203(a)(4)			50.73(a)(2)(iv)	OTHER
			20.2203(a)(2)(iii)			50.36(c)(1)			50.73(a)(2)(v)	Specify in Abstract below or in NRC Form 366A
			20.2203(a)(2)(iv)			50.36(c)(2)			50.73(a)(2)(vii)	

LICENSEE CONTACT FOR THIS LER (12)

NAME

Mr. W. Verne Childs, Senior Licensing Engineer

TELEPHONE NUMBER (Include Area Code)

(315) 349-6071

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)

YES (If yes, complete EXPECTED SUBMISSION DATE).		X NO		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On 01/25/96, following a review of radiological instrumentation setpoint data, it was identified that the Off-Gas Vent Pipe (Main Stack) low range radiation monitor alarm setpoint was not in compliance with Radiological Effluent Technical Specification requirements. Specifically, the Main Stack low range radiation monitor alarm setpoint limit was changed from 250,000 counts per second (cps) to 120,000 cps during a 1993 revision to the Offsite Dose Calculation Manual. However, a corresponding change to the Main Stack radiation monitor setpoint was not made.

The cause of this omission was personnel error. Corrective actions include verification of correct setpoint at this time, and review of setpoint control procedures to determine if requirements should be changed to reduce the probability of recurrence. Personnel involved in the process have been counseled on their responsibilities.

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		96	-- 001	-- 00	

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

EIIS Codes are in []

EVENT DESCRIPTION

Radiological Effluent Technical Specification (RETS) 3.1.a requires gaseous radioactive waste released from the off-gas [WF] vent pipe via the main plant stack [VL] to be monitored by the low range radiation monitor [IL] to provide: 1) an indication of the rate of release of radioactive material from the Main Stack, 2) a permanent record of the release rate of radioactive material and, 3) an alarm whenever the limits on release of radioactive material to the environment are reached or exceeded.

RETS 3.1.d requires alarm/trip setpoints for release pathway radiation monitors to be determined in accordance with the Offsite Dose Calculation Manual (ODCM). The release rate limit for the Main Stack is set at 300,000 microcuries per second in accordance with the ODCM (300,000 microcuries per second is based on limiting the offsite dose to one third the dose limits of RETS 3.2).

During December 1993, the biennial (once per 24 months) review of the ODCM and associated implementing procedures required by Technical Specification 6.5.2.9.j was conducted. As a result of this review, it was determined that the Main Stack low range radiation monitor setpoint limit contained in the ODCM required change. This change was made to the ODCM on December 28, 1993.

On January 25, 1996, it was discovered that when the December 1993 ODCM setpoint limit change was made, no corresponding radiation monitor alarm setpoint change had been made. As a result, from December 28, 1993, until January 25, 1996, the Main Stack low range radiation monitor setpoint was non-conservative with respect to the calculated setpoint limit contained in the ODCM. On January 25, 1996, ODCM setpoint limits for the Main Stack low range radiation monitor were again calculated. It was determined that the radiation monitor alarm setpoint should be changed from 120,000 cps to 50,000 cps.

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

CAUSE OF EVENT

The primary cause of the event was personnel error (Cause Code A). The Radiological and Environmental Services Department personnel involved in changing the ODCM in December 1993 did not communicate to other personnel the need to change the setpoint of the Main Stack low range radiation monitor to be consistent with the revised limit contained in the ODCM.

A root cause analysis was performed to identify primary and contributing causes to the event. Based on the results, the failure to communicate the revised setpoint limit to other personnel may have been due to personnel not using methods described in procedures for setpoint control, which were newly revised in 1993. The Radiological and Environmental Services personnel had not been trained on use of the new procedures and were not familiar with the requirements. It was also noted that the procedures provide different requirements for radiation monitor setpoints than for other instruments. This difference also contributed to the failure of personnel to communicate the need to change the radiation monitor setpoint.

ANALYSIS

This event is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B) which require Licensees to report any operation or condition prohibited by the plants Technical Specifications. Specifically, RETS Section 3.1.d states in part that "Alarm/trip setpoints shall be determined in accordance with the ODCM." When the ODCM changes were made in December 1993 and corresponding changes were not made to the Main Stack low range radiation monitor setpoint, the requirements of RETS 3.1.d were not met.

As noted above, the alarm setpoint of the Main Stack low level radiation monitor, and similar monitors in other release pathways, are intended to provide operator indication when the dose rate (due to releases) at or beyond the site boundary approaches one third of the limits of RETS 3.2.a. In addition to the conservatism that results from effluent radiation monitor setpoints that limit the release to one third of the limits of RETS 3.2.a, the ODCM calculation methods also contain additional conservatism. As a result, the event was not safety significant.

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

CORRECTIVE ACTIONS

1. The Main Stack low level radiation monitor alarm setpoint was verified to be conservative with respect to the most recently calculated limits contained in the ODCM. **[complete]**
2. Radiological and Environmental Services Department personnel involved with ODCM changes have been counseled on their responsibilities for radiation monitor setpoint changes. **[complete]**
3. Procedures for control of setpoints will be reviewed to determine if requirements associated with radiation monitor setpoints should be changed to reduce the probability of recurrence. **[Due Date: June 1, 1996]**

ADDITIONAL INFORMATION

- A. Failed Components: none
- B. Previous Similar Events: none