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)
Virgil C. Summer Nuclear Station	0 5 0 0 0 3 9 5	1 OF 0 3

TITLE (4)
Liquid Effluent Radiation Monitor Isolation

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
1 1	0 9	8 4	8 4	–	0 4 7	–	0 0	1 2	0 6	8 4		0 5 0 0 0

OPERATING MODE (9)	6	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
A. R. Koon, Jr., Assoc. Manager, Regulatory Compliance	8 0 3 — 3 4 5 – 5 2 0 9

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	W D			N							

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	XX NO				

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

On November 9, 1984, a liquid waste batch release was made from Waste Monitor Tank (WMT) No. 1 to the penstocks of the Fairfield Pumped Storage Facility. During the release, radioactive liquid effluent radiation monitors RM-L5 and RM-L9 were inoperable because of closed inlet and outlet isolation valves. Technical Specification 3.3.3.8 requires the operability of at least one of the monitors during the release of liquid effluents. The pre-release analysis performed in accordance with Technical Specification 3.11.1.1 provides assurance that release limits were not exceeded.

The cause of the unmonitored release was personnel error. The inoperable condition of the radiation monitors was discovered and corrected during the subsequent release of WMT No. 2. To prevent a recurrence of this event, the Licensee has taken the following actions:

1) Counseling sessions have been held with involved personnel and,

2) The details of this event will be reviewed with the appropriate personnel by December 15, 1984, to emphasize procedural compliance and attention to detail.

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

On November 9, 1984, a liquid waste batch release was made from Waste Monitor Tank (WMT) No. 1 to the penstocks of the Fairfield Pumped Storage Facility. During the release, radioactive liquid effluent radiation monitors RM-L5 and RM-L9 were inoperable because of closed inlet and outlet isolation valves. Technical Specification 3.3.3.8, "Radioactive Liquid Effluent Monitoring Instrumentation," requires the operability of at least one (1) of these monitors during the release of radioactive liquid effluents. The pre-release analysis performed in accordance with Technical Specification 3.11.1.1 provides assurance that release limits were not exceeded.

The unmonitored release is attributed to personnel error. The sequence of events and discussion of these errors are as follows:

1) At approximately 0500 hours on November 9, 1984, Instrument and Control (I&C) personnel were requested to replace the radiation monitor cannisters. The cannister replacement was procedurally controlled by Instrument and Control Procedure (ICP) 360.020 and reduced the background prior to the batch release. As an added precaution, the duty Shift Supervisor directed that the isolation valves for the radiation monitors be closed even though ICP 360.020 provided adequate equipment isolation to safely perform the task. The valve closures were not procedurally controlled or included in the shift turnover at 0700 hours.

2) System Operating Procedure (SOP) 108 required the local operator to verify flow through the radiation monitors after the release was initiated at 0940 hours. The operator thought there was flow and signed the step off as complete. However, actual flowrate was not verified prior to the operator being assigned another task of an urgent nature.

3) An additional personnel error occurred when the Control Room operator recorded the radiation monitor indication ten (10) minutes into the release per instructions in SOP-108. The operator failed to observe the low flow annunciator alarm or question the fact that no difference existed between the ten (10) minute reading of 5000 CPM and normal background for the radiation monitors. When a release was initiated for WMT No. 2, at 1105 hours, the Shift Supervisor noted the radiation monitor low flow annunciator alarms and questioned the indications. The release was then terminated until the closed valves were discovered and opened.

A review of the incident determined that the procedural controls for the liquid waste release were adequate and were not a contributing factor to the personnel errors. There have been 426 satisfactory releases of the WMT's in 1984 prior to the November 9 event.

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

The Licensee has taken the following corrective actions to prevent a recurrence:

1) After discovery of the radiation monitor isolations, the Control Room operator received additional instructions from the Shift Supervisor concerning attention to detail during the performance of Control Room activities. The operator had failed to recognize either the low flow alarms or the lack of change in radiation monitor indications during the release.

2) On November 12, 1984, a counseling session was conducted with the local operator concerning the seriousness and consequences of signing off an action which had not been performed.

3) The Shift Supervisor who required the closure of the isolation valves was counseled on November 17, 1984. His action was not in accordance with Station Administrative Procedure (SAP) 200, "Conduct of Operations," which requires all radioactive waste activities to be performed in accordance with approved procedures.

4) The details of this event will be reviewed with I & C and Operations personnel by December 15, 1984. This review will emphasize procedural compliance and attention to detail in performance of work at the Virgil C. Summer Nuclear Station.

SOUTH CAROLINA ELECTRIC & GAS COMPANY
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COLUMBIA, SOUTH CAROLINA 29218

O. W. DIXON, JR.
VICE PRESIDENT
NUCLEAR OPERATIONS

December 6, 1984

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

SUBJECT: Virgil C. Summer Nuclear Station
Docket No. 50/395
Operating License No. NPF-12
LER 84-047

Dear Sir:

Attached is Licensee Event Report #84-047 for the Virgil C. Summer Nuclear Station. This Report is submitted pursuant to the requirements of 10CFR50.73(a)(2)(i).

Should there be any questions, please call us at your convenience.

Very truly yours,

O. W. Dixon, Jr.

CJM:OWD/lcd
Attachment

cc: V. C. Summer
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