

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 8706100353 DOC. DATE: 87/06/04 NOTARIZED: NO DOCKET #
 FACIL: STN-50-529 Palo Verde Nuclear Station, Unit 2, Arizona Publi 05000529
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 RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 87-009-00: on 870506, discovered particulate & iodine channels of condenser vacuum pump/gland seal exhaust radiation monitor inoperable Caused by personnel error. Procedure change notice issued. W/870604 ltr.

DISTRIBUTION CODE: IE22D COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 4
 TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

NOTES: Standardized plant. M. Davis, NRR: 1Cy.

05000529

	RECIPIENT ID CODE/NAME	COPIES LTTR ENCL	RECIPIENT ID CODE/NAME	COPIES LTTR ENCL
	PD5 LA	1 1	PD5 PD	1 1
	LICITRA, E	1 1	DAVIS, M	1 1
INTERNAL:	ACRS MICHELSON	1 1	ACRS MOELLER	2 2
	AEOD/DOA	1 1	AEOD/DSP/ROAB	2 2
	AEOD/DSP/TPAB	1 1	DEDRO	1 1
	NRR/DEST/ADE	1 0	NRR/DEST/ADS	1 0
	NRR/DEST/CEB	1 1	NRR/DEST/ELB	1 1
	NRR/DEST/ICSB	1 1	NRR/DEST/MEB	1 1
	NRR/DEST/MTB	1 1	NRR/DEST/PSB	1 1
	NRR/DEST/RSB	1 1	NRR/DEST/SGB	1 1
	NRR/DLPQ/HFB	1 1	NRR/DLPQ/QAB	1 1
	NRR/DOEA/EAB	1 1	NRR/DREP/RAB	1 1
	NRR/DREP/RPB	2 2	NRR/PMAS/ILRB	1 1
	NRR/PMAS/PTSB	1 1	REG FILE 02	1 1
	RES DEPY GI	1 1	RGNS FILE 01	1 1
EXTERNAL:	EG&G GROH, M	5 5	H ST LOBBY WARD	1 1
	LPDR	1 1	NRC PDR	1 1
	NSIC HARRIS, J	1 1	NSIC MAYS, G	1 1
NOTES:		1 1		

TOTAL NUMBER OF COPIES REQUIRED: LTIR 44 ENCL 42

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Palo Verde Unit 2										DOCKET NUMBER (2) 0 5 0 0 0 5 2 9										PAGE (3) 1 OF 0 3									
TITLE (4) Radiation Monitor Particulate and Iodine Channels Inoperable Due to Lack of Installed Sample Collection Media																													
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	6	8	7	8	7	0	0	9	0	0	0	6	0	4	8	7	N/A						0	5	0	0	0
OPERATING MODE (9) 1			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)																										
POWER LEVEL (10) 1 0 0			20.402(b)				20.406(c)				60.73(a)(2)(iv)				73.71(b)														
			20.406(a)(1)(i)				60.36(c)(1)				60.73(a)(2)(v)				73.71(c)														
			20.406(a)(1)(ii)				60.36(c)(2)				60.73(a)(2)(vi)				OTHER (Specify in Abstract below and in Text, NRC Form 365A)														
			20.406(a)(1)(iii)				X 60.73(a)(2)(i)				60.73(a)(2)(viii)(A)																		
			20.406(a)(1)(iv)				60.73(a)(2)(ii)				60.73(a)(2)(viii)(B)																		
			20.406(a)(1)(v)				60.73(a)(2)(iii)				60.73(a)(2)(ix)																		
LICENSEE CONTACT FOR THIS LER (12)																													
NAME Thomas R. Bradish, Compliance Supervisor (Ext. 6936)										TELEPHONE NUMBER 6 0 2 9 3 2 - 5 3 0 0																			
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																													
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC																			
SUPPLEMENTAL REPORT EXPECTED (14)										EXPECTED SUBMISSION DATE (15)																			
YES (If yes, complete EXPECTED SUBMISSION DATE)										X NO																			
ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single space typewritten lines) (16)																													
<p>At 0130 MST on May 6, 1987, with Palo Verde Unit 2 in Mode 1 (POWER OPERATION) operating at 100 percent power, it was discovered that the Condenser Vacuum Pump/Gland Seal Exhaust Radiation Monitor (RU-141) did not have the Particulate and Iodine (P&I) sample collection media installed in the on-line sample flowpath thus rendering the P&I Channels of RU-141 inoperable. This is not in accordance with Technical Specification 3.3.3.9, Table 3.3-12 which requires continuous sample collection of P&I in Mode 1.</p> <p>A review of the event has been conducted. The review could not verify if the sample collection media had been improperly installed/lined up during the surveillance testing conducted on April 30, 1987 to declare RU-141 operable or if subsequent activities resulted in the incorrect sampling flowpath lineup. Regardless, in each of the possible scenarios, the cause of the missing sample media is attributed to a personnel error which is contrary to approved procedural controls.</p> <p>Interim corrective actions to prevent recurrence include the implementation of a Procedure Change Notice (PCN) to require that the Radiation Protection Technicians (RPT) identify which sample flowpath (primary or standby) is in service. Also, all RPTs have been briefed on the event, the PCN, and the need to ensure that P&I sample collectors for both flowpaths are installed.</p>																													
8706100353 870604 PDR ADOCK 05000529 S PDR																													

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO 3150-0104

EXPIRES: 8/31/86

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Palo Verde Unit 2	0 5 0 0 0 5 2 9	8 7	— 0 0 9	— 0 0	0 2	OF	0 3

TEXT (If more space is required, use additional NRC Form 365A's) (17)

At 0130 MST on May 6, 1987, with Palo Verde Unit 2 in Mode 1 (POWER OPERATION) operating at 100 percent power, it was discovered that the Condenser Vacuum Pump/Gland Seal Exhaust Low Range Radiation Monitor (RU-141)(IL)(RI) did not have the Particulate and Iodine (P&I) sample collection media installed in the on-line sample flowpath thus rendering the P&I Channels (CHA) of RU-141 inoperable. This is not in accordance with Technical Specification 3.3.3.9, Table 3.3-12 which requires continuous sample collection of P&I in Mode 1.

RU-141 had been declared operable and returned to service at 2056 on April 30, 1987 following the completion of maintenance and surveillance testing activities. On May 6, 1987 while performing the weekly changout of the P&I sample collection media, a Radiation Protection Technician (contractor non-licensed) discovered that the sample collection media was not installed in the flowpath (Channel RN-02) through which the sample flow was being routed. The design of RU-141 is such that two flowpaths (primary channel and standby channel) exist which allow for continuous sampling when one of the sample collection medias has been removed for analysis. The Technician verified that the P&I sample collection media was installed in the standby flowpath (Channel RN-01).

A review of the event has been conducted. The review could not verify if the sample collection media had been improperly installed/lined up during the surveillance testing conducted on April 30, 1987 to declare RU-141 operable or if subsequent activities resulted in the incorrect sampling flowpath lineup. Regardless, in each of the possible scenarios, the cause of the missing sample media is attributed to a personnel error which is contrary to approved procedural controls.

Following the discovery of the missing sample collection media, the Radiation Protection Technician contacted the control room at 0230 on May 6, 1987 and requested the initiation of alternate sampling via the portable sample cart. This action returned the Unit to compliance with Technical Specification 3.3.3.9, Table 3.3-12. The P&I Channels of RU-141 were potentially inoperable for a period of 124 hours without meeting the required Technical Specification ACTION Statement. Palo Verde was in Mode 1 during the entire event.

Although procedural controls are considered adequate, an enhancement to procedure 75RP-9ZZ64, RMS SAMPLE COLLECTION, to require that the Radiation Protection Technicians identify which P&I flowpath is in service. In addition, Radiation Protection Technicians have been briefed on the event, the implementation of the PCN, and the need to ensure that P&I sample collectors for both flowpaths are installed when the system is required to be operable.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO 3150-0104

EXPIRES: 8/31/88

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (8)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Palo Verde Unit 2	0 5 0 0 0 5 2 9	8 7	— 0 0 9	— 0 0	0 3	OF	0 3

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

As long term corrective action to prevent recurrence, a Site Modification is being developed to remove the standby sample flowpath for P&I collection for RU-141. In addition, a new type of sample collection holder will be installed which minimizes the holder change out time. This modification will be installed in Units 1, 2 and 3 and should eliminate the possibility of installing the sample collection media in the incorrect sample flowpath.

RU-141 continuously monitors for gaseous activity resulting from primary-to-secondary system leakage (Gas Channel). It also continuously samples for airborne radioactive particulates and iodines (P&I Channels). The P&I channels are rendered inoperable when the sample collection media is not installed in the proper flowpath, however, this does not affect the Gas Channel. In the event of an accident, the majority of the P&I would collect in the condenser and the more prevalent gaseous activity would be first detected by RU-141. Additionally, radiation monitors RU-4 and RU-5 (Steam Generator A & B Blowdown Monitors) (IL) (RI) were available to detect a primary-to-secondary leak. Therefore, this event did not affect the safe operation of the plant of the health and safety of the public.

There were no structures, components, or systems that were inoperable at the start of the event, other than those previously described, that contributed to the event. There were no unusual characteristics of the work location which contributed to the events. There were no automatic or manually initiated safety system responses and no operator actions were required during the event. Should other concerns or information pertinent to this event be discovered, a supplement to this report will be issued.

A previous similar event was reported in Palo Verde Unit 1 LER 85-032-00 in which a Radiation Protection Technician improperly lined up the P&I sample collection media with the wrong sample flowpath. The corrective action which was taken in that event was specific only to the responsible individual and would not have prevented the occurrence of this event (Unit 2 LER 87-009-00).



Arizona Nuclear Power Project

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192-00220-JGH/TRB/TJB

June 4, 1987

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

Subject: Palo Verde Nuclear Generating Station (PVNGS)
Unit 2
Docket No. STN 50-529
Licensee Event Report 87-009-00
File: 87-020-404

Dear Sirs:

Attached please find Licensee Event Report (LER) No. 87-009-00 prepared and submitted pursuant to 10 CFR 50.73. In accordance with 10 CFR 50.73(d), we are herewith forwarding a copy of the LER to the Regional Administrator of the Region V Office.

If you have any questions, please contact T. R. Bradish, Compliance Supervisor at (602) 932-5300 Ext. 6936.

Very truly yours,

J. G. Haynes
Vice President
Nuclear Production

JGH/TJB/cld

Attachment

cc: O. M. DeMichele (all w/a)
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