

## ACCELERATED DISTRIBUTION DEMONSTRATION SYSTEM

## REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 8910240251 DOC. DATE: 89/10/17 NOTARIZED: NO DOCKET #  
 FACIL: STN-50-530 Palo Verde Nuclear Station, Unit 3, Arizona Publi 05000530  
 AUTH. NAME AUTHOR AFFILIATION  
 SHRIVER, T.D. Arizona Public Service Co. (formerly Arizona Nuclear Power  
 LEVINE, J.M. Arizona Public Service Co. (formerly Arizona Nuclear Power  
 RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 89-010-00: on 890923, surveillance interval exceeded for  
 radioactive effluent monitoring sys.

W/8 1ltr.

DISTRIBUTION CODE: IE22T COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 6  
 TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

NOTES: Standardized plant.

05000530

	RECIPIENT ID CODE/NAME	COPIES LTTR ENCL	RECIPIENT ID CODE/NAME	COPIES LTTR ENCL
	PD5 LA	1 1	PD5 PD	1 1
	DAVIS, M.	1 1		
INTERNAL:	ACRS MICHELSON	1 1	ACRS MOELLER	2 2
	ACRS WYLIE	1 1	AEOD/DOA	1 1
	AEOD/DSP/TPAB	1 1	AEOD/ROAB/DSP	2 2
	DEDRO	1 1	NRR/DEST/ESB 8D	1 1
	NRR/DEST/ICSB 7	1 1	NRR/DEST/MEB 9H	1 1
	NRR/DEST/MTB 9H	1 1	NRR/DEST/PSB 8D	1 1
	NRR/DEST/RSB 8E	1 1	NRR/DEST/SGB 8D	1 1
	NRR/DLPQ/HFB 10	1 1	NRR/DLPQ/PEB 10	1 1
	NRR/DOEA/EAB 11	1 1	NRR/DREP/RPB 10	2 2
	NUDOCS-ABSTRACT	1 1	<del>REG-FILE-02</del>	1 1
	RES/DSIR/EIB	1 1	<del>RGNS-FILE-01</del>	1 1
EXTERNAL:	EG&G WILLIAMS, S	4 4	L ST LOBBY WARD	1 1
	LPDR	1 1	NRC PDR	1 1
	NSIC MAYS, G	1 1	NSIC MURPHY, G.A	1 1
	NUDOCS FULL TXT	1 1		
NOTES:		1 1		

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Arizona Public Service Company

PALO VERDE NUCLEAR GENERATING STATION  
P O BOX 52034 • PHOENIX, ARIZONA 85072-2034

192-00538-JML/TDS/DAJ  
October 17, 1989

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

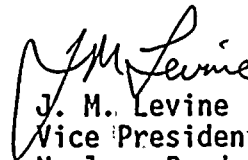
Dear Sirs:

Subject: Palo Verde Nuclear Generating Station (PVNGS)  
Unit 3  
Docket No. STN 50-530 (License No. NPF-74)  
Licensee Event Report 89-010-00  
File: 89-013-00

Attached please find Licensee Event Report (LER) No. 89-010-00 prepared and submitted pursuant to 10CFR 50.73. In accordance with 10CFR 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. D. Shriver, Compliance Manager at (602) 393-2521.

Very truly yours,

  
J. M. Levine  
Vice President  
Nuclear Production

JGH/TDS/DAJ/kj

Attachment

cc: W. F. Conway (all w/a)  
E. E. Van Brunt, Jr.  
J. B. Martin  
T. J. Polich  
M. J. Davis  
A. C. Gehr  
INPO Records Center

8910240251 891017  
PDR ADDCK 05000530  
S PDC

LER 22  
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## LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1) Palo Verde Unit 3										DOCKET NUMBER (2) 0 5 0 0 0 5 3 0										PAGE (3) 1 OF 0 5									
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TITLE (4) Surveillance Interval Exceeded for Radioactive Effluent Monitoring System																													
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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	9	2	3	8	9	8	9	0	1	0	0	1	0	1	7	8	9	N/A									0 5 0 0 0								
																		N/A									0 5 0 0 0								

OPERATING MODE (9) 5		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)										20.405(c)										50.73(a)(2)(iv)										73.71(b)									
		20.405(a)(1)(i)										50.38(c)(1)										50.73(a)(2)(v)										73.71(c)									
		20.405(a)(1)(ii)										50.38(c)(2)										50.73(a)(2)(vi)										OTHER (Specify in Abstract below and in Text, NRC Form 366A)									
		20.405(a)(1)(iii)										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 Timothy D. Shriver, Compliance Manager														TELEPHONE NUMBER 6 0 2 3 9 3 1 2 5 2 1													

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

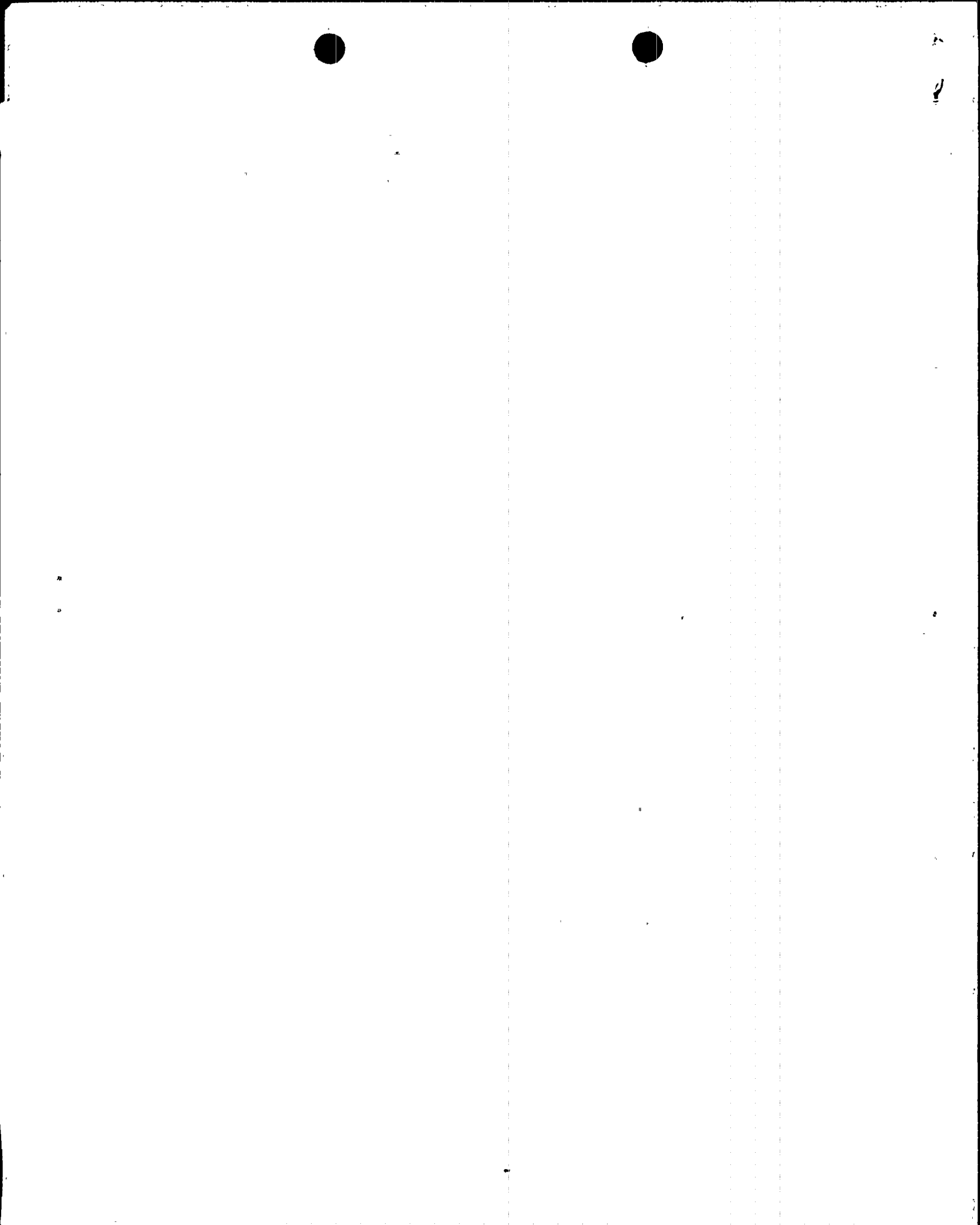
ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

At approximately 1535 MST on September 23, 1989 Palo Verde Unit 3 was in Mode 5 (COLD SHUTDOWN) when a PVNGS technician (utility, non-licensed) discovered that the surveillance testing interval for the radioactive effluent monitoring system had been exceeded. The surveillance testing is required to be performed at least once per 24 hours pursuant to Specification 4.3.3.8 and was required to have been performed no later than 1500 MST on September 23, 1989 (this includes the 25 percent maximum allowable extension pursuant to Specification 4.0.2). The effluent monitoring system surveillance test was satisfactorily completed at approximately 1550 MST on September 23, 1989. The effluent monitoring system was administratively inoperable for approximately 50 minutes. There were no safety system responses and none were necessary.

The root cause of this event was a cognitive personnel error on the part of the PVNGS technician responsible for the performance of the surveillance testing. The technician neglected to perform the required daily surveillance testing in a timely manner.

A Human Performance Evaluation System analysis of the personnel error is being conducted and appropriate corrective actions will be taken.

Previous similar events occurred as discussed in Unit 2 LER 2-88-010 and Unit 3 LER 3-88-006.



LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 500 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

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

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

## I. DESCRIPTION OF WHAT OCCURRED:

## A. Initial Conditions:

On September 23, 1989, Palo Verde Unit 3 was in Mode 5 (COLD SHUTDOWN) with the Reactor Coolant System (RCS)(AB) at approximately 100 degrees Fahrenheit and 331 pounds per square inch-absolute.

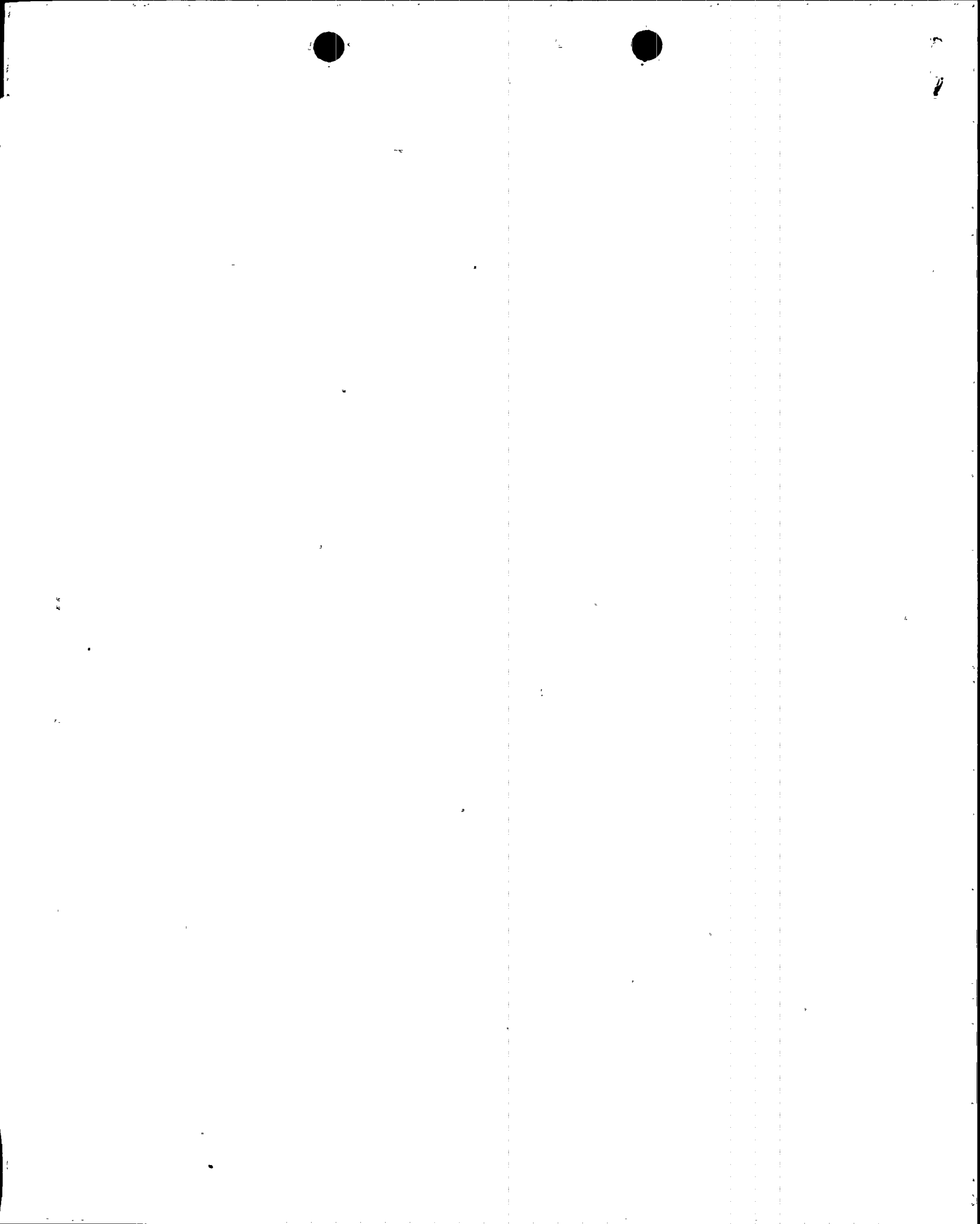
## B. Reportable Event Description (Including Dates and Approximate Times of Major Occurrences):

Event Classification: Conditions Prohibited by the Plant's Technical Specification

At approximately 1535 MST on September 23, 1989, Chemistry Effluent personnel (utility, non-licensed) discovered that daily surveillance testing had not been performed on the radioactive effluent monitoring system (IL) pursuant to Technical Specification 4.3.3.8. The allowable surveillance interval had elapsed at approximately 1500 MST on September 23, 1989 for the Plant Vent System (VL) high and low range monitors (RU-143 and RU-144) and the Fuel Building Ventilation System (VG) high and low range monitors (RU-145 and RU-146).

Technical Specification Surveillance Requirement 4.3.3.8 specifies that the above monitors be demonstrated OPERABLE by the performance of a CHANNEL CHECK at least once per 24 hours. These surveillance requirements are implemented via procedure 75ST-9ZZ07, "Effluent Monitoring System Daily Surveillance Testing." 75ST-9ZZ07 had been completed at approximately 0900 MST on September 22, 1989 and was due no later than 1500 MST on September 23, 1989 (This would include the maximum allowable extension of 25 percent delineated in Technical Specification 4.0.2).

The performance of 75ST-9ZZ07 is the responsibility of a designated Chemistry Department Effluent Technician. At approximately 1535 MST on September 23, 1989 the responsible Chemistry Department Effluent Technician (utility, non-licensed) remembered that 75ST-9ZZ07 had not yet been completed. Investigation revealed that the maximum allowable extension for completing the surveillance had elapsed at approximately 1500 MST. Control room personnel (utility, licensed) were notified, the monitors were declared inoperable, and the appropriate actions were taken to complete the surveillance test. At approximately 1550 MST, the surveillance test (75ST-9ZZ07) was completed and the monitors were returned to an OPERABLE status.





LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

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

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

- C. Status of structures, systems, or components that were inoperable at the start of the event that contributed to the event:

Not applicable - there were no structures, systems, or components inoperable at the start of the event that contributed to the event. However, Radioactive Effluent Monitoring System monitors described in Section I.B were administratively inoperable for approximately 50 minutes during the event.

- D. Cause of each component or system failure, if known:

Not applicable - no component or system failures were involved.

- E. Failure mode, mechanism, and effect of each failed component, if known:

Not applicable - no component failures were involved.

- F. For failures of components with multiple functions, list of systems or secondary functions that were also affected:

Not applicable - no component failures were involved.

- G. For failures that rendered a train of a safety system inoperable, estimated time elapsed from the discovery of the failure until the train was returned to service:

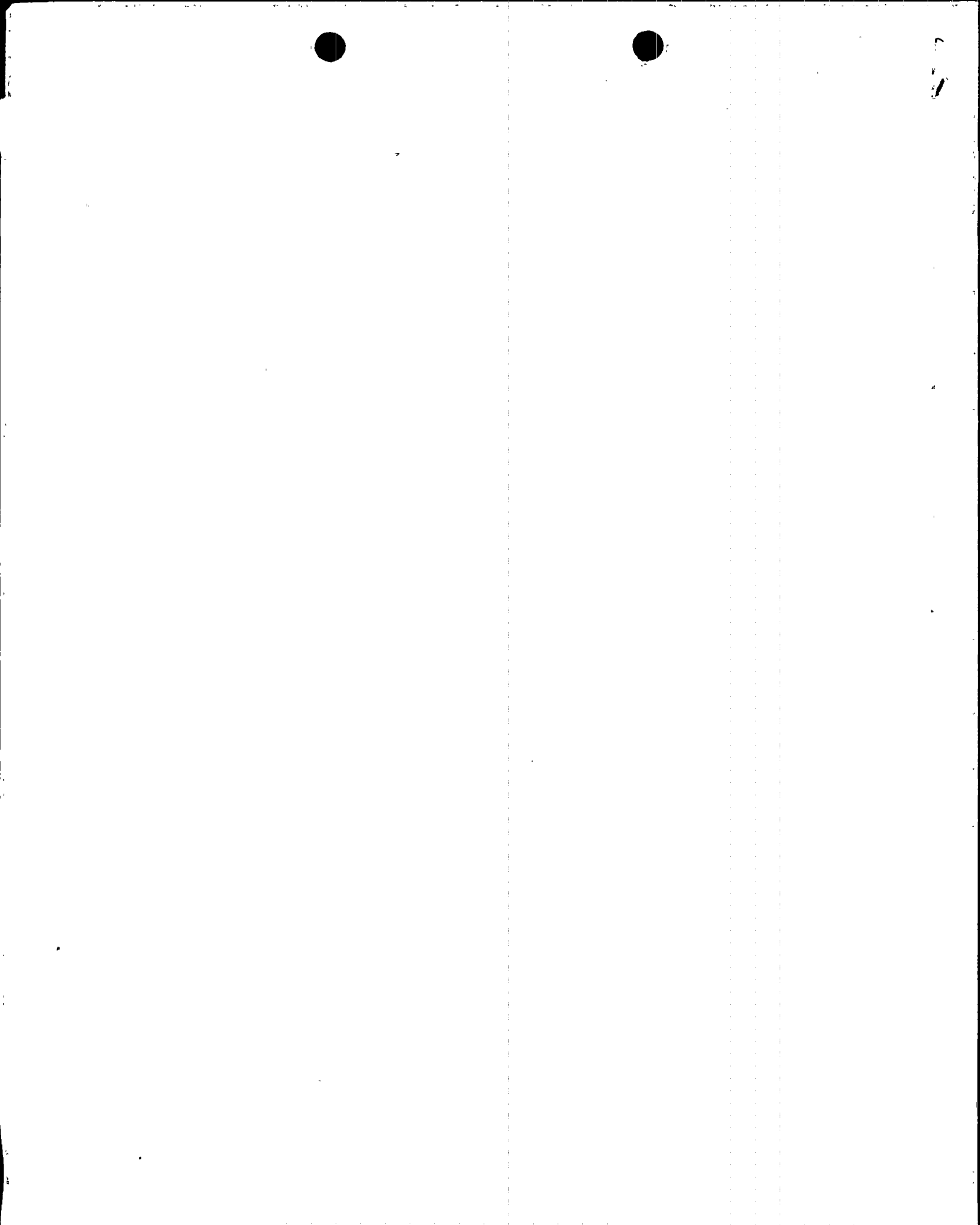
Not applicable - no failures were involved which rendered a train of a safety system inoperable. However, the Radioactive Effluent Monitoring System monitors described in Section I.B were administratively inoperable for approximately 50 minutes.

- H. Method of discovery of each component or system failure or procedural error:

Not applicable - there were no component or system failures or procedural errors.

- I. Cause of Event:

The cause of the event was a cognitive personnel error on the part of the individual (utility, non-licensed) responsible for the performance of the surveillance testing. The responsible individual did not remember to perform the surveillance test in a timely manner. The error was not a result of an error in the approved procedure and was not a result of the activity not being covered by an approved procedure. There were no unusual



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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
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Palo Verde Unit 3

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

characteristics of the work location which contributed to the event.

## J. Safety System Response:

Not applicable - there were no safety system responses and none were necessary.

## K. Failed Component Information:

Not applicable - no component failures were involved.

## II. ASSESSMENT OF THE SAFETY CONSEQUENCES AND IMPLICATIONS OF THIS EVENT:

There were no safety consequences or implications resulting from this event. Surveillance testing was successfully performed before and after the event. Therefore, the monitors were functional during the period of administrative inoperability and would have been capable of performing their intended function. Additionally, the high range monitors were not required during the period of administrative inoperability as they are provided for tracking radioactive releases during postulated accident conditions. No accidents occurred which would have required operation of the high range monitors.

## III. CORRECTIVE ACTIONS:

## A. Immediate:

As immediate corrective action, the appropriate surveillance testing was completed on the radioactive effluent monitoring system and the monitors were returned to OPERABILITY.

## B. Action to Prevent Recurrence:

As action to prevent recurrence, appropriate disciplinary measures have been taken. Additionally, a Human Performance Evaluation System analysis is being performed for the personnel error and further corrective measures will be developed and implemented if necessary. A supplement to this report will be issued if substantial additional corrective measures are developed.

## IV. PREVIOUS SIMILAR EVENTS:

Previous similar events involving the failure to perform daily radioactive effluent monitoring system surveillance testing were reported in Unit 2 LER 2-88-010 and Unit 3 LER 3-88-006. The corrective actions taken as a result of the previous events are considered adequate and could not have prevented the event described in the LER since this



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LICENSEE EVENT REPORT (LER)  
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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
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TEXT (If more space is required, use additional NRC Form 368A's) (17)

event was a result of cognitive personnel error. Additionally, the event described in Unit 2 LER 2-88-010 concerned an instance wherein the daily requirement to perform surveillance testing was misinterpreted to mean once per calendar day vice every 24 hours.

Other events have been reported which involved surveillance testing not being performed within the specified interval. These events involved other PVNGS departments or circumstances not directly related to this event.

