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SUBJECT: Special Rept 2-SR-88-006, Suppl 1: on 881014, radiation monitoring unit inoperable for greater than 72 h.

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December 16, 1989

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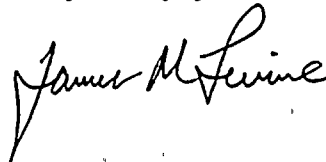
Dear Sirs:

Subject: Palo Verde Nuclear Generating Station (PVNGS)
Unit 2
Docket No. STN 50-529 (License No. NPF-51)
Supplement to Special Report 2-SR-88-006
File: 89-020-404

Attached please find Supplement Number 1 to Special Report 2-SR-88-006 prepared and submitted pursuant to Technical Specifications 3.3.3.1 ACTION 27 and 6.9.2. This report discusses an inoperable radiation monitoring unit. This report is submitted to provide updated information from the original report.

If you have any questions, please contact T. D. Shriver, Compliance Manager at (602) 393-2521.

Very truly yours,



JML/TDS/JJN/kj

Attachment

cc: W. F. Conway (all w/a)
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PALO VERDE NUCLEAR GENERATING STATION

Radiation Monitoring Unit Inoperable For Greater Than 72 Hours

License No. NPF-51

Docket No. STn 50-529

Supplement to Special Report 2-SR-88-006

This Special Report is being submitted pursuant to Technical Specification (T.S.) 3.3.3.1 ACTION 27 and T.S. 6.9.2 to report an event in which the Containment Building Atmosphere Process Monitor (RU-1) was inoperable for greater than 72 hours. The 72 hour limit for operability was exceeded at approximately 1036 MST on October 14, 1988. Pursuant to T.S. 3.3.3.1 ACTION 27b the moveable air monitor (RU-53) was placed on line.

At approximately 1036 MST on October 11, 1988, Palo Verde Unit 2 was in Mode 1 (POWER OPERATION) at approximately 100 percent power when RU-1 was taken out of service to perform Surveillance Test (ST) 36ST-9SQ05, "Radiation Monitoring Calibration Test for Baseline Process Monitors."

During the performance of the ST, the Single Channel Analyzer (SCA) amplifier board could not be adjusted within specifications. An approved work order was issued to troubleshoot and either rework or replace components as required. The SCA amplifier board was replaced and satisfactorily retested.

The original SCA amplifier board was modified in accordance with approved work documents to include a vendor designed enhancement. The saturation range adjustment resistor was changed to a lower resistance to increase the range when saturation occurs. (Saturation is an inherent characteristic of the scintillation detector/monitor and occurs when the frequency of radiation exceeds the ability of the detector/monitor to distinguish increasing levels of radiation.) The SCA amplifier board was sent to the warehouse for future use.

The performance of the ST requires the utilization of several radioactive sources including a 0.5 microcurie, Cesium-137 source and a 0.5 microcurie, Barium-133 source. These sources are utilized to calibrate RU-1's response. During the performance of the ST, the technician reviewed the procedural steps and determined that an incorrect source was utilized in a portion of the RU-1 calibration. The technician had been appropriately using an approximately 0.5 microcurie, Cesium-137 source for calibration. However, during subsequent sections of the procedure, the technician did not switch the Barium-133 source for the Cesium-137 source as required by the procedure. The applicable steps were successfully reperformed using the correct source. The delay associated with this error was approximately 45 minutes. The procedures were reviewed by the Unit 2 Instrument and Control Supervisor and were determined to be adequate regarding this aspect. However, a procedure error was identified during the subsequent performance of the ST as discussed in the following paragraph.

During the subsequent performance of the ST, the sample flow rate was



determined to be low. An approved work order was issued to troubleshoot and either rework or replace components as required. Troubleshooting determined that an automatic bypass valve was fully opened or causing the low sample flow rate. Further investigation determined that the approved ST procedure had been revised in error. The voltage power supply leads were supposed to be connected to the flow transmitter leads to ensure the bypass valve closed. Instead, the procedure instructed that voltage power supply leads shall be connected to the terminals where the flow transmitter leads had been lifted. The procedure was changed to correct the error.

The procedure had been revised to incorporate enhancements. However, the error occurred when the step to connect the voltage power supply was incorporated into the preceding step. The procedural error was reviewed and determined that the performance of the procedure could not result in the monitor being returned to service in an inoperable condition.

Upon completion of the work order and appropriate surveillance test, RU-1 was restored to an operable status on October 14, 1988 at approximately 1500 MST. The monitor was out of service for approximately 76 hours and 24 minutes.

