

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Joseph M. Farley - Unit 1										DOCKET NUMBER (2) 0 5 0 0 0 3 4 8										PAGE (3) 1 OF 2																					
TITLE (4) Technical Specification Action Statements Not Met When R-11 Was Inoperable																																									
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 1			1 0			8 6			8 6			0 0			1			0 0			0 2			0 7			8 6									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)		0 9 9		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 365A)																			
				20.405(a)(1)(iii)						50.73(a)(2)(ii)						50.73(a)(2)(viii)(A)																									
				20.405(a)(1)(iv)						50.73(a)(2)(iii)						50.73(a)(2)(viii)(B)																									
				20.405(a)(1)(v)						50.73(a)(2)(iii)						50.73(a)(2)(ix)																									
LICENSEE CONTACT FOR THIS LER (12)																																									
NAME										TELEPHONE NUMBER																															
J. D. Woodard										AREA CODE 2 0 5 8 9 9 - 5 1 5 6																															
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)

At 1426 on 1-10-86, it was discovered that the containment atmosphere particulate radioactivity monitor (R-11) was inoperable due to improper valve alignment. The valve misalignment was the result of two valves having been mislabeled. Investigation revealed that R-11 had been inoperable since 1030 on 1-9-86. Since it had not been realized at the time that R-11 was inoperable, the Technical Specification 3.4.7.1 requirement to obtain and analyze samples of the containment atmosphere once per twenty four hours was not met. Upon discovery on 1-10-86, R-11 was returned to service.

The inoperability of R-11 was caused by personnel error. The valves had been mislabeled at some time. However, it has not been possible to determine exactly when the valves were mislabeled or who mislabeled the valves. It has been determined that the valves had been labeled properly up until 12-3-85. Since R-11 had operated properly until 1-9-86, it is believed that the valves were inadvertently mislabeled at some time between 12-3-85 and 1-9-86. The health/safety of the public was not affected by this event.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104

EXPIRES 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Joseph M. Farley - Unit 1	0 5 0 0 0 3 4 8 8 6	—	0 0 1	—	0 0	0 2 OF	0 2

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

At 1426 on 1-10-86, it was discovered that the containment atmosphere particulate radioactivity monitor (R-11) was inoperable due to improper valve alignment. Investigation revealed that R-11 had been inoperable since 1030 on 1-9-86. Since it had not been realized at the time that R-11 was inoperable, the Technical Specification 3.4.7.1 requirement to obtain and analyze samples of the containment atmosphere once per twenty four hours was not met. Upon discovery on 1-10-86, R-11 was returned to service.

On 1-9-86, two Health Physics technicians were assigned to switch R-11 and R-12 (the containment atmosphere gaseous radioactivity monitor) from the inboard pump to the outboard pump so that the inboard pump could be lubricated. This operation was completed at approximately 1030 and was performed according to procedure. However, two valves had been mislabeled previously. This led to V1 (the R-11 bypass valve) being opened and V2 (the R-11 inlet valve) being closed. Therefore, R-11 was bypassed. The operation of R-12 was not affected by the valve misalignment.

Later in the day on 1-9-86, R-11 and R-12 were switched back to the inboard pump after the lubrication had been completed. At 1426 on 1-10-86, during an investigation of problems with the operation of the inboard pump, it was discovered that valves V1 and V2 had been mispositioned due to the valves having been mislabeled. Upon discovery, R-11 was returned to proper operation by positioning the valves correctly and placing the outboard pump in operation. The identification tags on V1 and V2 were placed properly and verified. As a precaution, the valve alignment on other radiation monitors on both units covered by Technical Specifications was verified to be correct.

Due to the valve misalignment, the R-11 reading decreased from approximately 6000 to approximately 1500 counts per minute during the period from 1030 on 1-9-86 to 1426 on 1-10-86. The R-11 readings are logged by Operations personnel at least once per twelve hours and by Health Physics personnel on a daily basis. The shift supervisor and the plant operators had noticed the decrease in the count rate but failed to investigate fully. The appropriate personnel have been counseled concerning their failure to recognize the low count rate and take appropriate corrective action.

The inoperability of R-11 was caused by personnel error. The valves had been mislabeled at some time. However, it has not been possible to determine exactly when the valves were mislabeled or who mislabeled the valves. It has been determined that the valves had been labeled properly up until 12-3-85. Since R-11 had operated properly until 1-9-86, it is believed that the valves were inadvertently mislabeled at some time between 12-3-85 and 1-9-86.

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R. P. McDonald
Senior Vice President
Flintridge Building



February 7, 1986

Docket No. 50-348

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

Joseph M. Farley Nuclear Plant - Unit 1
Licensee Event Report No. LER 86-001-00

Dear Sir:

Joseph M. Farley Nuclear Plant, Unit 1, Licensee Event Report No. LER 86-001-00 is being submitted in accordance with 10CFR50.73.

If you have any questions, please advise.

Yours very truly,

R. P. McDonald

RPM/JAR:dst-D30
Enclosure

cc: IE, Region II

IE22
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