ACCESSION NBR: 8802030529 DOC. DATE: 88/01/25 NOTARIZED: NO DOCKET # FACIL: STN-50-529 Palo Verde Nuclear Station, Unit 2, Arizona Publi 05000529 AUTH. NAME AUTHOR AFFILIATION

SHRIVER, T. D. HAYNES, J. G.

Arizona Nuclear Power Project (formerly Arizona Public Serv Arizona Nuclear Power Project (formerly Arizona Public Serv

RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 88-001-00: on 880106, personnel error resulted into

incomplete Tech Spec sample analysis. Addl controls for

tracking & storing samples will be implemented. W/880125 ltr.

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

NOTES: Standardized plant.

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	RECIPIENT	COPI	ES	RECIPIENT	COP	IES
•	ID CODE/NAME	LTTR	ENCL	ID CODE/NAME	LTTR	ENCL
	PD5 LA	1	1	PD5 PD	i	i
	LICITRA, E	1	1	DAVIS, M	i	1
INTERNAL:	ACRS MICHELSON	1	1	ACRS MOELLER	2	2
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	NRR/DEST/ADS	1	0	NRR/DEST/CEB	1	1
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	NRR/DEST/PSB	1	1	NRR/DEST/RSB	1	1
	NRR/DEST/SGB	1	1	NRR/DLPQ/HFB	1	1
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EXTERNAL:	EG&G GROH, M	5	5	FORD BLDG HOY, A	1	1
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At approximately 0924 MST on January 6, 1988, Palo Verde Unit 2 was in Mode 1 (POWER OPERATION) at 100% power when it was determined that a weekly Condenser Vacuum Pump/Gland Seal Exhaust Radiation Monitor (SH)(IL)(RI) sample had not been retained for inclusion with the quarterly composite Strontium - 89/90 sample. This resulted in an inability to fully meet the sampling requirements of Technical Specification 4.11.2.1.2.

The root cause of this event was a personnel error in that inadequate measures were established to provide positive controls over the samples while they were being stored awaiting shipping for off-site analysis. Procedural controls were evaluated and determined to be adequate.

As corrective action to prevent recurrence, additional controls for tracking and storing samples will be implemented. Unit Chemistry Department personnel will receive appropriate training.

Similar events were reported in Unit 1 LER's 86-007-00 and 87-028-00.

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

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION APPROVED OMB NO 3150-0104

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At approximately 0924 MST on January 6, 1987, Palo Verde Unit 2 was in Mode 1 (POWER OPERATION) at 100% power with the reactor coolant system (RCS)(AB) at normal operating pressure and temperature when it was determined that a weekly Condenser Vacuum Pump/Gland Seal Exhaust Radiation Monitor's (SH)(IL)(RI) particulate filter (FLT) had not been retained for quarterly composite Strontium - 89/90 analysis resulting in an inability to fully meet Technical Specification 4.11.2.1.2 surveillance requirements.

Technical Specification (T.S.) 4.11.2.1.1 requires that a Condenser Vacuum Pump/Gland Seal Exhaust Radiation Monitor particulate sample be analyzed four times per month for principal gamma emitters. Additionally, a monthly composite sample analysis is required for gross alpha and a quarterly composite sample analysis is required for Strontium - 89/90. The sampling methodology employed involves changing the filter media in the Condenser Vacuum Pump/Gland Seal Exhaust Radiation Monitor weekly, analyzing the filter media for principal gamma emmitters and gross alpha, and then retaining the filter media for off-site quarterly composite Strontium - 89/90 analysis. monthly composite requirement is satisfied by totaling the weekly analysis results and verifying that monthly limits are not exceeded. Palo Verde does not have the capability to analyze for Strontium - 89/90; therefore, the weekly samples are retained in a central location in each unit for quarterly off-site analysis by an approved vendor.

During the process for preparing the fourth quarter 1987 quarterly composite sample for off-site shipment on January 6, 1988, it was discovered by a technician (utility, non-licensed) that two weekly samples were missing. Subsequent attempts located one of the samples; however, the weekly sample that was taken January 1, 1988 from the Condenser Vacuum Pump/Gland Seal Exhaust Radiation Monitor's could not be located. The missing sample had been analyzed for gross alpha and principal gamma emitters by Chemistry Department personnel (utility, non-licensed). Based upon not being able to locate the sample for the period of December 23, 1987 to January 1, 1988, it was determined on January 7, 1988 that the requirements of Specifications 4.11.2.1.2 could not be fully met since the quarterly composite sample requirement for Strontium - 89/90 could not be completed.

The root cause of this event has been determined to be a personnel error as a result of inadequate controls established for storing and tracking the samples (i.e., filter media). After the on-site gamma and alpha analysis, the samples are placed in a holding tray awaiting verification that all samples are accounted for and preparation for off-site shipment. The investigation conducted as a result of this event has determined that the missing sample apparently was placed in the holding tray; however, it could not be located when preparations were made for off-site shipment. It is hypothesized that the sample could have been inadvertently dislodged and then discarded with other waste from the area. There were no unusual characteristics of the work location that contributed to the event.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION APPROVED OMB NO 3150-0104 EXPIRES: 8/31/88

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As immediate corrective action to prevent recurrence, a more formal methodology has been implemented for tracking and storing samples. This consisted of developing more positive administrative controls over the samples and developing a more secure storage container. Additionally, the new tracking methodology will be discussed with all Unit 2 Chemistry Department personnel to ensure that they are aware of the requirements for retaining samples.

There were no structures, systems or components inoperable at the start of the event that contributed to the event. There were no failed components. There were no automatic or manually initiated safety responses that occurred and none were necessary.

There was no threat to the health and safety of the public as a result of this event. Specification 3.11.2.1 is provided to ensure that the dose at any time at and beyond the SITE BOUNDARY from gaseous effluents from all units on site will be within the annual dose limits of 10CFR Part 20 to UNRESTRICTED AREAS. The period represented by the missing sample makes up only a portion of the overall composite sample. All previous Strontium analysis have resulted in meeting Technical Specification requirements. Additionally, no situations existed during the two week period which would be expected to release abnormal levels of Strontium - 89/90. The sample was analyzed for gross alpha and principal gamma emmitters and no abnormal activity levels were noticed. Based upon the above, there were no safety consequences or implications of this event.

Similar events have occurred as reported in Unit 1 LER 86-007-00 dated March 28, 1986 and Unit 1 LER 87-028-00 dated January 15, 1988. A review of both events has determined that the event described herein is similar in that all three events concern the inability to meet the quarterly composite Strontium -89/90 sample analysis requirements. However, the root cause of each event has been determined to be different. The first event was caused by inadequate procedural controls for preventing inadvertent discarding of the sample. The second event was caused by personnel error in that the responsible individual (utility, non-licensed) did not follow procedures. The third event (the one reported herein) was caused by insufficient physical controls over the samples.

It should be noted that as a result of the event reported in LER 87-028-00 discovered on December 17, 1987, additional corrective measures were in the process of being implemented. However, these additional corrective measures are not expected to have prevented the event described herein due to the close proximity of the two events and? the dissimilar root causes.

NRC FORM 366A

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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The corrective actions discussed above and those being taken as a result of the event described in LER 87-028-00 are considered to be adequate. The additional corrective actions being taken as a result of the event reported in LER 87-028-00, as well as the event reported herein, are discussed below. These corrective actions will be implemented in Units 1, 2, and 3.

The forms utilized by Chemistry Department personnel for recording data obtained from samples will be revised to include precautionary notes to provide further assurance that the samples will not be inadvertently discarded. A more formal methodology for tracking and storing samples will be implemented, and the appropriate training on this new methodology conducted. Additionally, this event will be reviewed by Chemistry Department personnel as additional training to ensure that they are aware of the necessity to retain all samples.



Arizona Nuclear Power Project

P.O. BOX 52034 • PHOENIX, ARIZONA 85072-2034

192-00338-JGH/TDS/DAJ January 25, 1988

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

Dear Sirs:

Subject: Palo Verde Nuclear Generating Station (PVNGS)

Unit 2

Docket No. STN 50-529 (License No. NPF-51)

Licensee Event Report 88-001-00

File: 88-020-404

Attached please find Licensee Event Report (LER) No. 88-001-00 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. G. Haynes Vice President

Nuclear Production

JGH/TDS/DAJ/kj

Attachment

cc: 0. M. DeMichele (all w/a)

E. E. Van Brunt, Jr.

J. B. Martin

J. R. Ball

R. C. Sorenson

E. A. Licitra

A. C. Gehr

INPO Records Center