

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 8707090386 DOC. DATE: 87/07/02 NOTARIZED: NO DOCKET #
 FACIL: STN-50-529 Palo Verde Nuclear Station, Unit 2, Arizona Publi 05000529
 AUTH. NAME AUTHOR AFFILIATION
 BRADISH, T. R. Arizona Nuclear Power Project (formerly Arizona Public Serv
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 RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 87-014-00: on 870605, discovered that auxiliary sample
 cart in svc as backup to fuel bldg ventilation radiation
 monitor turned off & inoperable. Caused by personnel error.
 Radiation protection technician terminated. W/870702 ltr.

DISTRIBUTION CODE: IE22D COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 5
 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
	PDS LA	1 1	PDS 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/GAB	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	RES TELFORD, J	1 1
	RES/DE/EIB	1 1	RGN5 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		

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Palo Verde Unit 2		DOCKET NUMBER (2) 0 5 0 0 0 5 12 9	PAGE (3) 1 OF 04
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TITLE (4) **Auxiliary Sampling Equipment for Effluent Releases Rendered Inoperable Due to Personnel Error**

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		
									N/A		
0 5 3 0	8 7	8 7		0 1 4		0 0 7	0 2 8	7	N/A		
OPERATING MODE (8) 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(a)(1)(i)	20.406(a)(1)(ii)	20.406(a)(1)(iii)	20.406(a)(1)(iv)	20.406(a)(1)(v)	20.406(c)	50.36(e)(1)	50.36(e)(2)	50.73(a)(2)(i)	50.73(a)(2)(ii)	50.73(a)(2)(iii)	50.73(a)(2)(iv)	50.73(a)(2)(v)	50.73(a)(2)(vii)	50.73(a)(2)(viii)(A)	50.73(a)(2)(viii)(B)	50.73(a)(2)(ix)	73.71(b)	73.71(c)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
										<input checked="" type="checkbox"/>											

LICENSEE CONTACT FOR THIS LER (12)

NAME Thomas R. Bradish, Compliance Supervisor (Ext. 6936)	TELEPHONE NUMBER AREA CODE: 6 1 0 2 NUMBER: 3 1 9 3 1 - 5 1 0 1 0
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDPS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDPS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE) NO

EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR

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

On June 5, 1987 it was discovered that between 0610 and 0806 MST on May 31, 1987, with Palo Verde Unit 2 in Mode 1 (POWER OPERATION) operating at 100 percent power, the auxiliary sample cart, which was in service as a backup to the Fuel Building Ventilation Radiation Monitor (RU-145) had been turned off and rendered inoperable.

Subsequent investigation of the event identified a separate concern that on May 30-31, 1987 a Radiation Protection Technician (RPT) had not been correctly performing a sample flow verification to meet an ACTION Statement for the inoperable monitor RU-145. Both of these events are being reported as a violation of Technical Specification 3.3.3.8 since the appropriate ACTION Statements were not complied with.

The root cause for the inoperable sample cart was a personnel error by an I&C Technician who inadvertently repositioned the sample cart switch while working in the area to repair RU-145. The root cause of the improperly conducted sample flow verification was a conscious personnel error by the RPT.

As corrective action the sample cart was restored to operability at 0806 on May 31, 1987. The RPT has been terminated and a letter has been issued from the Arizona Nuclear Power Project (ANPP) Executive Vice President to all ANPP personnel to reiterate the company's position regarding the unacceptability of intentionally documenting erroneous information.

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TEXT (If more space is required, use additional NRC Form 305A's) (17)

On June 5, 1987 it was identified that between 0610 and 0806 MST on May 31, 1987, with Palo Verde Unit 2 in Mode 1 (POWER OPERATION) operating at 100 percent power, the auxiliary sample cart, which was in service as a backup to the Fuel Building (ND) Ventilation System Low Range Radiation Monitor (RU-145)(IL)(RI), had been turned off and rendered inoperable.

RU-145 had been declared inoperable on May 20, 1987 and the appropriate Technical Specification (T.S.) ACTION Statements were entered. These actions included the utilization of an auxiliary sample cart to continuously sample for particulates and iodine in the Fuel Building Exhaust as required by T.S. 3.3.3.8, ACTION 40. On May 31, 1987 at approximately 0806, a Radiation Protection Technician (RPT)(contractor non-licensed) was conducting the sample flow verification required by T.S. 3.3.3.8, ACTION 36 when he discovered that the on/off switch for the auxiliary sample cart was in the off position and noted this fact in the Unit 2 Radiation Protection Logs. It was not until June 5, 1987 however, when the Senior RPT was conducting his review of the previous weeks' Radiation Protection Logs in accordance with Procedure 75ST-9ZZ03, Radioactive Gaseous Effluents and RMS Surveillance, that the discovery of the mispositioned switch was brought to management's attention. In order to emphasize the need for RPTs to immediately report inoperable T.S. equipment or other potential concerns to the appropriate supervision, a memo that discusses this event and the need for timely reporting will be issued to the RPTs for required reading.

An investigation was promptly initiated to determine the cause of the sample cart being turned off. As a result of the investigation it has been determined that the time of the event was between 0602 and 0641 on May 31, 1987. The root cause of the inoperable sample cart was concluded to be a personnel error by an Instrument and Control Technician (utility non-licensed) who inadvertently bumped the switch with his work manual while working on RU-145 which is located on the same small elevated platform in the Fuel Building. Therefore, the sample cart was inoperable for a maximum time of approximately 2 hours.

Upon discovery of the mispositioned switch at 0806 on May 31, 1987, the RPT immediately changed out the Particulate and Iodine sampling media and took the necessary actions to restore the sample cart to an operable status. The RPT also posted a note on the sample cart to warn others that a T.S. sample was in progress and not to disturb the cart. The radionuclide concentrations for the past three days were then calculated, using a conservative assumption, and the results were determined to be within the required limits. As corrective action to prevent recurrence, the grab sample carts (4 per each Unit) will have a placard installed on them which identifies the cart as a T.S. piece of equipment and to use caution when working in the area.

While conducting the investigation on the mispositioned sample cart switch, a separate concern was identified. It was discovered that a RPT (utility non-licensed) had not been correctly performing the required sample flow verification necessary to meet T.S. 3.3.3.8, ACTION 36. ACTION 36 requires that

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every four hours the sample flow to the cart be verified consistent with an estimated flow. To accomplish this, it is necessary to enter the Fuel Building and ascend the stairs to the sample cart and read a flow meter. Based on a review of the Automated Control Access Device (ACAD) transaction printout it was determined that at approximately 0030 on May 30, 1987 and 0410 on May 31, 1987, the RPT had not entered the Fuel Building, as he had documented, to conduct the sample flow verification required by T.S. Failure to conduct the sample flow verification renders the sample cart inoperable.

The root cause of the improperly conducted sample flow verification was a conscious personnel error by an RPT who did not conduct the verification and then inappropriately documented it as complete in the Radiation Protection Logs.

As corrective action to prevent recurrence, the RPT has been terminated. In addition, a letter has been issued from the Arizona Nuclear Power Project (ANPP) Executive Vice President to all ANPP personnel to briefly discuss this event and to reiterate the company's position regarding the unacceptability and the potential consequences of intentionally documenting erroneous information. An independent evaluation has been conducted to determine if additional corrective actions are necessary. As a result, additional corrective actions including the development of a video tape message from the Executive Vice President and the initiation of random checks of various departmental activities against the ACAD transaction printouts are currently being considered for implementation.

The sample cart is utilized as a backup to RU-145 which is installed to monitor releases through the Fuel Building Exhaust which results from a fuel handling accident or a Loss of Coolant Accident (LOCA). At this time there is no spent fuel stored on site and in the case of a LOCA, an RPT would have to enter the Fuel Building and go to the sample cart to obtain a grab sample for analysis. It would then be obvious that the cart was turned off and it could be easily restored to obtain the grab sample. Therefore, this event did not adversely affect the safe operation of the plant or the health and safety of the public.

The failure to properly conduct the sample flow verifications did not present a safety concern as evidenced by the fact that the sample cart was shown to always have been operable based on the subsequent sample flow verifications which were correctly conducted following the two missed flow verifications. The sample cart continued to perform its intended function although it was not verified at the correct time intervals. Therefore, this event did not adversely affect the safe operation of the plant or the health and safety of the public.

There were no structures, components, or systems that were inoperable at the start of the events, other than those previously described, that contributed to the events. There were no unusual characteristics of the work location which contributed to the events. There were no automatic or manually initiated safety system responses. No operator actions were required as a result of the events. There are no specific procedures that were violated in either event previously described. There are no procedural controls currently in place that address

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either issue and under the circumstances described above, ANPP believes that there are no procedural controls that would have prevented the occurrences.

An additional investigation is being conducted to determine if there were any other T.S. radiation monitors which the RPT may have not conducted the appropriate actions for. Should this investigation result in additional similar findings, a supplement to this report will be issued.

There have been no previous similar events regarding a sample cart which was inadvertently turned off however, a similar event involving an RPT who intentionally documented erroneous information was previously reported in Unit 1 LER 86-058-00.

The corrective actions taken in response to the Unit 1 event were considered appropriate for the specific problem identified. The corrective actions taken to prevent recurrence of the Unit 1 problem were also considered appropriate however, they could not be expected to prevent someone from intentionally documenting erroneous information. Additionally, as a result of the previous Unit 1 event, an evaluation was conducted by the ANPP Personnel Department to determine if human factors, such as morale, working conditions, etc., could be a contributory cause to the event. No concerns of this type were identified.



Arizona Nuclear Power Project

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192-00239-JGH/TRB/TJB

July 2, 1987

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

Subject: Palo Verde Nuclear Generating Station (PVNGS)
Unit 2
Docket No. 50-529
Licensee Event Report 2-87-014
File: 87-020-404

Dear Sirs:

Attached please find Licensee Event Report (LER) No. 2-87-014 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. R. Bradish, Compliance Supervisor at (602) 393-5000, Ext. 6936.

Very truly yours,

J. G. Haynes
for J. G. Haynes
Vice President
Nuclear Production

JGH/TJB/cld

Attachment

cc: O. M. DeMichele (all w/a)
E. E. Van Brunt, Jr.
J. B. Martin
R. P. Zimmerman
R. C. Sorenson
E. A. Licitra
A. C. Gehr
INPO Records Center

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