

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Palo Verde Unit 1	DOCKET NUMBER (2) 0 5   0   0   0   5   2   8	PAGE (3) 1 OF 0   3
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TITLE (4)  
Technician Performed Incorrect Sample Lineup on Radiation Monitor

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)												
1	2	18	8	5	8	5	8	5	0	9	3	0	0	0	0	0	0	0	5	0	0	0	0

OPERATING MODE (9)  2

POWER LEVEL (10) 0 | 1 | 0 | 2

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §. (Check one or more of the following) (11)

<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(c)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)
<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(i)(2)(vii)	<input type="checkbox"/> OTHER (Specify in Abstract below and in Text, NRC Form 366A)
<input type="checkbox"/> 20.405(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)	
<input type="checkbox"/> 20.405(i)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)	
<input type="checkbox"/> 20.405(i)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
William F. Quinn, Manager - Nuclear Licensing (Extension 4087)	61012 91413   -   1712   10   10

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRPDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRPDS

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)

At 0200 on December 21, 1985, a utility Radiation Protection Technician discovered an improper valve lineup on a radiation monitor (RU-141).

When low range monitor RU-141 is inoperable, the high range monitor (RU-142) is also inoperable because it is dependent on RU-141 for actuation on high radiation level. A Special Report (Report Number 1-SR-85-036) is required within 30 days after the high range monitor is inoperable for greater than 72 hours. This LER also addresses the required Special Report.

- To prevent recurrence, the following actions have been taken:
1. Instrumentation and Control procedures have been revised in accordance with response to LER 85-061-01 to include a low flow alarm check as part of scheduled surveillance tests.
  2. The applicable procedures have been changed to require the Radiation Protection Technicians to read vacuum gauge reading after establishing valve lineups.
  3. A step has been added to the applicable procedures to verify that O-rings are installed correctly on the sample holders when the sample media are changed.
  4. The Radiation Protection Technicians have been counseled to verify installation of O-rings as well as assuring they make proper valve lineups when changing out samples.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

At 0200 on December 21, 1985, Palo Verde Unit 1 was in Mode 2 at 2% reactor power, a utility Radiation Protection Technician discovered an improper valve lineup on a radioactive gaseous effluent monitor (RU-141)(IL) in the condenser evacuation system (SH). Both sample lines were found isolated. The technician immediately returned the valves to the correct lineup.

One sample line had the inlet valve closed and the outlet valve open, the other had the inlet valve open and the outlet valve closed. This caused the particulate/iodine sample media to be isolated from the sample flow path since the last filter change performed on December 16, 1985, at 2200, and resulted in RU-141 being inoperable.

Low flow had not been indicated on the Radiation Monitoring Annunciator System (IB). Upon investigation, it was discovered that an O-ring was missing from one of the sample holders allowing outside air to pass through the monitor without causing a low flow alarm.

The improper valve lineup by a Radiation Protection Technician, on December 16, 1985, was the root cause of the event. A contributing factor to the valve lineup error was the missing O-ring which prevented the low flow alarm from occurring.

When the low range monitor (RU-141) is inoperable, the high range monitor (RU-142) is also inoperable. The low range monitor actuates the high range monitor when a high radiation signal is received. A Special Report (Report Number 1-SR-85-036) is required within 30 days after the high range monitor is inoperable for greater than 72 hours. The monitors were inoperable for approximately 100 hours. This LER also addresses the required Special Report.

RU-141 and RU-142 monitor the condenser evacuation system for radiation in the event steam generator tube leaks. Other means were available to notify operators of steam generator tube leaks. Also, backup measures were available to assess offsite doses in the event a primary to secondary leak occurred. Therefore, this event had no impact on the safe operation of the plant.

The event is similar to an event that occurred on August 9, 1985, and was reported in LER 85-061-00. Additional corrective action submitted in LER Supplement 85-061-01 was in the process of being implemented at the time of this occurrence.

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

To prevent recurrence, the following actions have been taken:

1. Instrumentation and Control procedures have been revised in accordance with response to LER 85-061-01 to include a low flow alarm check as part of scheduled surveillance tests. The tests will be used to check the alarm status when sample flow is isolated from the monitor.
2. The applicable procedures have been changed to require the Radiation Protection Technicians to read the vacuum gauge reading after establishing the valve lineups and to assure that the reading is within a prescribed band which will constitute an independent verification of valve lineup.
3. A step has been added to the applicable procedures to verify that O-rings are installed correctly on the sample holders when the sample media are changed.
4. The Radiation Protection Technicians have been counseled to verify installation of O-rings as well as assuring they make proper valve lineups when changing out samples.



## Arizona Nuclear Power Project

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

January 20, 1986  
ANPP-34718-EEVB/KLM/98.07

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

Subject: Palo Verde Nuclear Generating Station (PVNGS)  
Unit 1  
Docket No. STN 50-528 (License NPF-41)  
Licensee Event Report - 85-093-00;  
Special Report - 1-SR-85-036  
File: 86-020-404

Dear Sirs:

Attached please find Licensee Event Report (LER) No. 85-093-00 prepared and submitted pursuant to 10 CFR 50.73. This LER also satisfies the requirement for a Special Report (1-SR-85-036) pursuant to Technical Specification 3.3.3.9 and 6.9.2. In accordance with 10 CFR 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 me.

Very truly yours,

E. E. Van Brunt, Jr.  
Executive Vice President  
Project Director

EEVB/KLM/rw  
Attachment

cc: J. B. Martin (all w/a)  
R. P. Zimmerman  
A. L. Hon  
E. A. Licitra  
A. C. Gehr  
INPO Records Center

1022  
1/1

• Document Control Desk  
Licensee Event Report - 85-093-00  
Special Report - 1-SR-85-036  
ANPP-34718  
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bcc: J. G. Haynes (all w/a)  
R. M. Butler  
J. R. Bynum  
O. J. Zeringue  
J. M. Allen  
R. J. Adney  
R. E. Younger  
K. W. Gross  
A. C. Rogers  
W. E. Ide  
D. N. Stover  
J. R. LoCicero  
W. F. Quinn  
D. R. Canady  
M. K. Hartsig  
J. D. Houchen  
C. F. Ferguson  
L. E. Brown  
LCTS Coordinator  
Licensing File (85-093-00) & (1-SR-85-036)